

Travelling Companions Data Analysis Report

By Ella Donoghue and Hannah Turner,
Age UK Wellbeing Department



Contents

Introduction to the service	3
About this report	4
Executive Summary	5
Client Journey	6
Referrals	8
Client Demographics	11
Loneliness and Isolation Risk Factors	15
Travelling Companion Demographic Data	18
Session Data	20
Goal Setting	26
Outcome Data	29
Conclusion	40
References	41
Appendix	42

Acknowledgements

The report authors would like to thank Age UKs Data Analysts within the Service & Business Improvement team who gave their time and expertise to contribute to the authoring of this report. We would also like to acknowledge the local Age UK project teams who contributed their time to compile and share the data that this report is based on.

Introduction to the service

In June 2022, Age UK set up a pilot programme to support lonely and isolated older people to get out and about, by matching them with trained volunteers or staff members called Travelling Companions. The pilot programme ended in July 2023.

We were able to run the pilot programme thanks to funding from the **Department for Transport's Tackling Loneliness with Transport Fund**. The funding was given to a total of 12 organisations (including Age UK) to explore how transport could contribute to reducing loneliness in communities. The Travelling Companions service used a person-centred approach by:

- Exploring an older person's experience of loneliness so they can understand their own circumstances and feelings.
- Supporting the older person to come up with solutions.
- Working together with the older person to set goals and create a support plan.

Each older person then received personalised and specific one-to-one support from their matched Travelling Companion. This support was based on what the older person identified in their support plan and was shaped by what they needed to build the confidence to travel independently. The support was offered as a short-term (six to eight week) intervention.

The aim of the Travelling Companions service was to help older people to:

- Feel more confident and less anxious about getting out and about.
- Interact with more people.
- Access the support they need and reduce potential feelings of loneliness.

To find out more about the pilot programme, please read our webpage, which can be found **here**. If you are interested in setting up this service in your local area or developing it as part of an existing service, or for any further information, please get in touch via **travelling.companions@ageuk.org.uk**.

About this report

The following report analyses the data collected over the course of the programme, specifically during the 11-month delivery period (between September 2022 and July 2023). The data collected covers:

- Demographic data of the older people supported through the service.
- Pre- and post-intervention outcome data of the older people supported through the service.
- Goal setting and session data from the interventions delivered.
- Demographic data of the Travelling Companions that supported the service.

The seven local Age UKs involved in delivering the Travelling Companions service gathered and reported data each month. This has helped us to contribute to the evidence base for understanding the role that transport can play in tackling loneliness. We wish to thank the following local Age UKs for their contributions:

- Age UK Calderdale and Kirklees (Yorkshire and Humber)
- Age UK North, South and West Dorset (South West England)
- Age UK Norfolk (East of England)
- Age UK Richmond upon Thames (Greater London)
- Age UK Stockport (North West England)
- Age UK Wiltshire (South West England)
- Age UK Worcester and Malvern Hills (West Midlands)

The Travelling Companions pilot programme engaged 320 older people. The contribution of each local service can be seen in Table 1.

Table 1. Count of clients supported by each local Age UK.

Age UK	Number of older people
Calderdale and Kirklees	36
North, South and West Dorset	56
Norfolk	51
Richmond Upon Thames	53
Stockport	28
Wiltshire	54
Worcester and Malvern Hills	42
TOTAL	320

Throughout this report, you will notice references to data categorised as ‘Unknown’. This indicates missing fields in the data received from local Age UK reports. We have drawn conclusions with the data available, but it is important to note the impact the missing data potentially could have had on the findings of this report. The quantity of unknown data suggests that workforce development and training may be required in relation to justifying the importance of accurate and comprehensive data collection.

Executive Summary

This analysis report explores the data collected over the course of the Travelling Companions pilot programme between June 2022 and July 2023. The Travelling Companions pilot tested whether a new, evidence-based intervention could reduce older people's feelings of loneliness. Loneliness is defined as 'the feeling experienced when people are unable to have the meaningful conversations and interactions that they desire and need'¹. We predicted that supporting older people to access transport, get out and about and become more confident making journeys, would help them to build and maintain meaningful relationships, and in-turn tackle loneliness.

The target group for this service was any older person experiencing loneliness and social isolation that needed support to get out and about. We looked to engage individuals who were physically capable of independent travel and who wanted to make journeys but were not doing so, as we believed we could make the biggest difference to these individuals.

In regard to the sample of 320 older people that engaged with the programme:

- 66.3% were aged between 70 – 89 years old.
- 70.6% reported having at least one physical or mental health problem or disability.
- 66.9% lived alone.
- 73.4% were retired.

These older people were supported by 80 Travelling Companions, who worked with them to achieve their travel-related goals and encourage them towards independence. We estimate that approximately 85% of these Travelling Companions were volunteers.

Overall, 679 sessions were delivered to 209 clients, meaning the average number of sessions each client received was between 3 and 4. Local Age UKs reported that they typically offered sessions once per fortnight to clients, meaning that clients received sessions for an average of between 6-8 weeks.

When analysing the aims older people made at the beginning of the programme, and the contents of the sessions delivered, we can assume that:

- Making journeys by bus and walking are the most popular transport modalities.
- In the majority of cases, older people wished to utilise this service to learn how to travel to a specific destination (i.e., a service, activity or club).
- The most popular referrals that were made after older people finished their Travelling Companions sessions were Age UK clubs (i.e., lunch/coffee club, knitting and allotment classes, Men in Sheds groups), befriending services and exercise classes.

In terms of the difference the service made to the clients, we asked them a series of questions before and after taking part in their Travelling Companion sessions. We have 159 full responses, which demonstrate that:

- 44.6% increased their level of reported social interaction.
- On average, the number of journeys completed per week by active travel increased from 0.22 to 1.46.
- On average, the number of journeys completed per week by public transport increased from 0.5 to 1.08.
- Overall, travel-related confidence increased, and travel-related anxiety decreased.
- Importantly, the intervention observed a change in mean combined loneliness score. Before the intervention, the sample had a mean loneliness score of 6.51. This dropped to 5.25 after the intervention. The change in mean score is 1.25, which represents a statistically significant difference and suggests that we can be 95% confident that the intervention supported older people to reduce their feelings of loneliness.

Client Journey

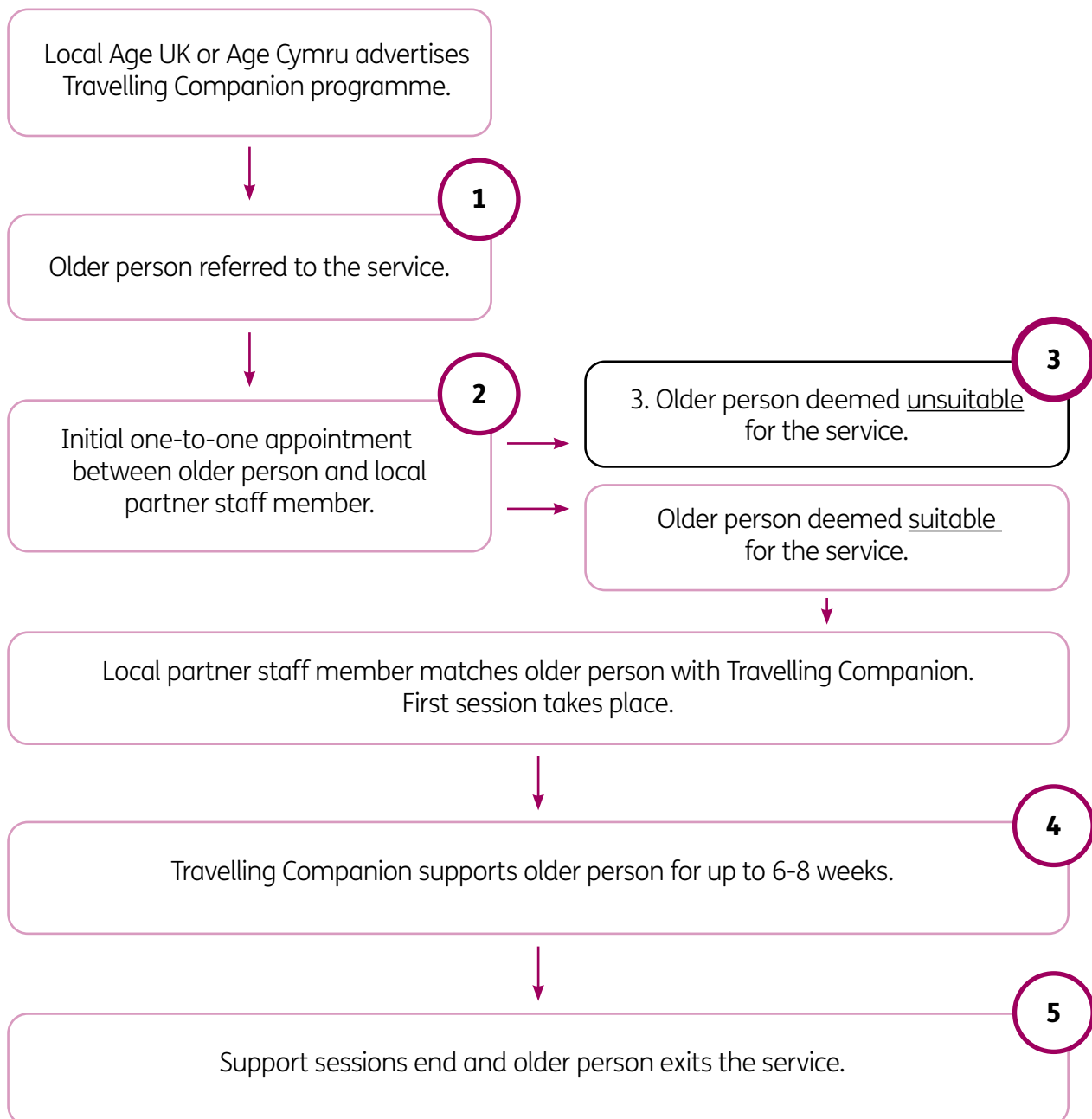


Figure 1. Client Journey model, with each client status indicated numerically.

The specific target group of this service are older people who are physically capable of independent travel and who want to get out and about but are not currently doing so. The expected client journey for this target group is detailed in figure 1. However, we observed that at different stages of the journey, older people occasionally dropped out of the service. In some instances, this was driven by the older people themselves. For example, they decided they were not ready to engage with the service or became uncontactable by the local Age UK staff. Unfortunately, some older people experienced worsening physical or mental health that meant they could no longer receive the service.

Additionally, some level of dropout was driven by the local Age UKs because the client did not fit the target group for the service. They often had to refer clients elsewhere if they were deemed not suitable for this support, or in cases where it would be unethical to offer the support for only a defined period. The most common reasons for this were: 1) individuals that were not capable of independent travel due to a variety of physical or mental impairments, 2) individuals that were looking for an ongoing service, not short-term support, or 3) individuals that had no interest in going out but wanted a visiting befriender to reduce their isolation.

Each older person was assigned a status that aligned to the above customer journey model. This status changed throughout the period they were engaged in the service. The different statuses that were assigned are as below, and correspond to the numbers in figure 1:

1. Referred
2. Goals Set
3. Not Suitable for the Project
4. Completing Sessions
5. Case Closed

An overview of the stage at which each older person reached in the service by the end of July 2023 can be found in table 2.

Table 2. Count and percentage of clients reported within each status, at the end of the delivery period in July 2023.

Client status:	Number of older people:	Percentage of older people:
1. Referred	11	3.4%
2. Goals Set	11	3.4%
3. Not Suitable for the Project	107	33.4%
4. Completing Sessions	41	12.8%
5. Case Closed	150	46.9%
TOTAL	320	

The majority of clients reached the latter stages of the client journey (Completing Sessions or Case Closed). However, over one third of clients exited the service at the mid-point as it became clear they were not suitable for this type of support.

As a pilot programme, we were interested in exploring the self-selected sample of older people interested in engaging with the service. We have learnt that more consideration needs to be given to sourcing “well-aligned” clients, that fit the target group for the service. This would avoid unnecessary work for local partners when moving client’s part-way through the service and reduce the number of clients that need to be referred elsewhere.

Referrals

The pilot programme launched in June 2022, with the seven local Age UKs beginning work on the service in August 2022. In most cases, sessions did not take place until at least two months later when enough Travelling Companions had been trained and were available to deliver the intervention. Each local Age UK's set-up period varied, and the full delivery period of each area can be seen in table 3.

Table 3. Start date (based on first session delivered) and end date (based on the date at which the service was closed) at each local Age UK.

Age UK:	Start of delivery:	End of delivery:
Calderdale and Kirklees	1st November 2022	31st May 2023
North, South and West Dorset	1st October 2022	30th June 2023
Norfolk	1st November 2022	14th July 2023
Richmond Upon Thames	1st October 2022	31st May 2023
Stockport	1st September 2022	31st May 2023
Wiltshire	1st October 2022	30th June 2023
Worcester and Malvern Hills	1st December 2022	30th June 2023

Figure 2 demonstrates the number of clients referred onto the service per month over the course of the pilot programme. Referrals indicate the date at which the local Age UKs first received an expression of interest regarding each individual, and how this expression was received. This could be a self-referral, an internal referral from the local Age UK or an external referral from social services, health professionals or other community organisations. A breakdown of referral source can be found in table 4.

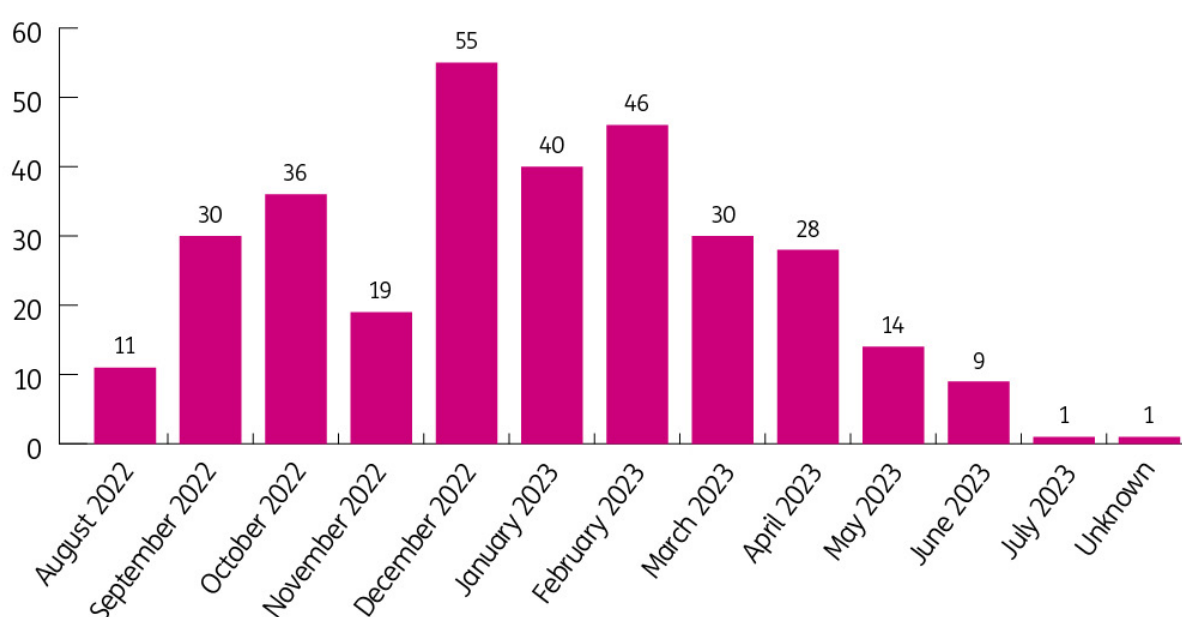


Figure 2. Count of clients referred to the service per month.

Analysing figure 2, the referrals per month seem to follow a primarily normal distribution. This is likely due to the staggered start and end dates of each local service, as demonstrated in table 3. Also, local Age UKs reported that the service picked up momentum over the delivery period and began to wind-down as the service came to a close.

The two outliers to the normal distribution in figure 2 are November and January. One possible explanation for this is that harsh winter weather during these months deterred older people from engaging with a service that involved getting out and about. December had high referral rates due to links with Christmas events and the significance of this period to connect with others. Another explanation for the decline in November is that ahead of opening the service, Age UKs were able to put all their resources towards getting referrals lined up, but when the service was operational, there was a lack of time to push for referrals.

Comparing table 3 and figure 2, although referrals began coming into the service in August, sessions did not begin until a few months later. This is evidence that there is a reasonable amount of set-up time required before local Age UKs can begin delivering sessions. Also, it demonstrates that it may take a significant amount of time to move clients from stage 1 (referred) to stage 4 (completing sessions) in the client journey (figure 1).

Over one third of referrals came internally from local Age UKs (I&A services, lunch clubs and other local Age UK services). This was followed by self-referrals and external referrals, respectively (a full breakdown can be found in table 4). One explanation for the skew towards internal referrals is because more than six in 10 clients reported having previous contact with Age UK prior to the Travelling Companions service.

Analysing referral source by only those clients that reached status 4 or 5 (Completing Sessions or Case Closed), demonstrates which referral source had the greatest dropout rate (table 4). I&A service had the greatest dropout rate at 60.0%, followed by friends, families and carers, and other external organisations with a percentage decrease of 41.7% and 41.5%, respectively. This demonstrates the importance of appropriate referrals.

Analysing table 4, in terms of inappropriate referrals made internally from local Age UKs (I&A service and other local Age UK service), there is a significant dropout rate (60% and 33.7%, respectively). This indicates that local Age UK may not have fully understood the target group for this service, or that project teams did not relay this information to other colleagues effectively. Additionally, it may demonstrate an eagerness to offer the service to a large number of older people, or potentially reach a numerical target with their referrals. Overall, it suggests that identifying the target group for appropriate referrals may need to be a key focus of local Age UKs in the set-up phase of this service, specifically reviewing and developing the internal pathway route.

In terms of external referrals, in some instances, referrals were made on the behalf of the older person without careful consideration of whether the intervention was a good fit for their circumstances. Local Age UKs reported numerous wishful referrals, with the hope that the service would be different or more flexible than advertised. It is important to consider how services such as Travelling Companions can reduce inappropriate referrals, and communicate to external parties, and family, friends, and carers about the details of the service offer.

Table 4. Count and percentage of clients by referral source, and dropout rate.

Referral source:	Number of older people:	Percentage of older people:	Number of older people that reached status 4 or 5:	Percentage decrease, or dropout rate:
Other local Age UK service	98	30.6%	65	33.7%
Self-Referral	72	22.5%	49	31.9%
Other external organisation	53	16.6%	31	41.5%
Friends/ family/ carer	24	7.5%	14	41.7%
I&A Service	10	3.1%	4	60.0%
Lunch Club	3	0.9%	3	0.0%
Other	34	10.6%	23	32.4%
Unknown	26	8.1%	2	92.3%
TOTAL	320		191	

Client Demographics

Age

The Travelling Companions service was aimed at any individuals aged over 50 years old, however it seemed to disproportionately appeal to an older age group. We know that in general, older people are at a higher risk of experiencing loneliness due to a range of factors that increase as we age (i.e., bereavement, living alone, being a carer). This is a possible explanation for the skew towards older age groups in the referrals for this service.

More than four in 10 clients that were referred to the service were aged between 80 and 89 years old. The mean and median age of clients engaged with the service was 79 and 81, respectively, and the oldest client that engaged in the service was 101 years old. A full breakdown of age categories that engaged with the programme can be found in table 5.

Table 5. Count of client by age category and dropout rate.

Age category, in years:	Number of older people:	Number of older people that reached status 4 or 5:	Percentage decrease, or dropout rate:
Less than 50	1	1	0.0%
50-54	2	2	0.0%
55-59	10	6	40.0%
60-64	17	10	41.2%
65-69	16	14	12.5%
70-74	31	20	35.5%
75-79	49	31	36.7%
80-84	61	40	34.4%
85-89	71	45	36.6%
90-94	25	18	28.0%
More than 95	8	3	62.5%
Unknown	29	1	96.6%
TOTAL	320	191	

When considering only the individuals that progressed to client status 4 and 5 (Completing Sessions and Case Closed), the lowest dropout rate can be seen amongst clients aged 50-54 and 65-69 years old (table 5), with the highest dropout rate seen in those aged 95 years and older. However, the remaining age categories have similar percentages decreases, thus dropout rate does not seem to be linked with age. This suggests that the service is accessible to those of all ages.

Gender

Over two-thirds (214) of the older people that were referred to the Travelling Companions service were female, compared to only 62 male clients (demonstrated in figure 3). Only one client identified as non-binary, and one preferred not to say. It is important to reflect on why services such as Travelling Companions may be more appealing to a female audience and consider how to advertise such services in the future to ensure it is equally appealing to a wider audience.

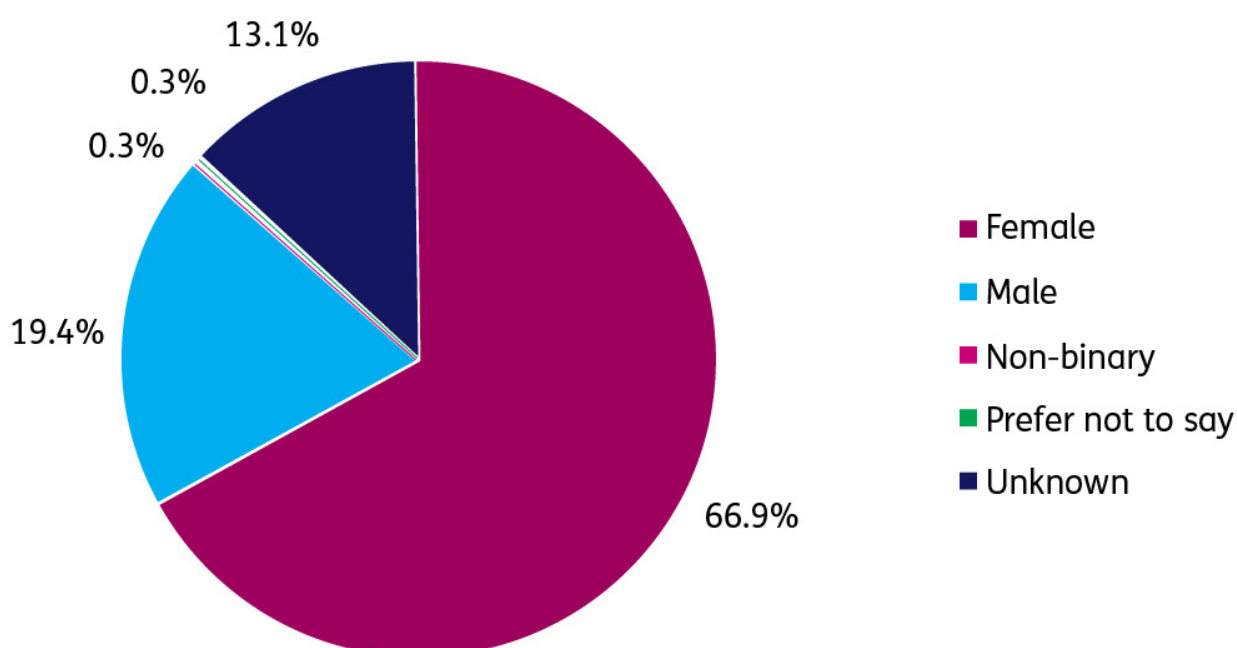


Figure 3. Percentage of clients by gender.

Disability

Seven in 10 clients reported having at least one physical or mental health problem or disability (table 6). This suggests that the intervention offered by the Travelling Companions service is appealing to those with mental and physical impairments, and that the service could offer a solution to any anxiety or lack of confidence to make journeys, brought about by several different disabilities.

Adjusting table 6 to include only the clients that reached status 4 or 5 (Completing Sessions or Case Closed), the older people reporting to have no disability reduces by 37% (31 individuals). Whereas those with one and more than one disability reduces by only 32% (88) and 29% (66), respectively. Therefore, slightly more older people that reported having no disabilities dropped out of the service, compared to those that reported having one or more disabilities. This means that disability was not the primary barrier to engagement in this service, suggesting that the intervention is accessible.

Table 6. Count of client by disability category.

Physical or mental health problems or disabilities that have lasted, or are expected to last 12 months or more:	Number of older people:	Percentage of older people:
Yes, one	129	40.3%
Yes, more than one	97	30.3%
No	49	15.3%
Prefer not to say	2	0.6%
Unknown	43	13.4%
TOTAL	320	

The distribution of disability type reported by the sample, can be found in figure 4. Mobility impairment was the most commonly reported disability type by more than double the next highest value, both within the overall sample and within those that reached status 4 or 5. This suggests that increasing poor mobility may trigger the need for a Travelling Companion, and thus local Age UKs may find it beneficial to focus referrals efforts towards this population, for example by engaging with Home from Hospital services or physiotherapists. This highlights the importance of the service offering a thorough risk assessment and mitigation process to ensure clients with mobility impairments are safeguarded. Additionally, physical limitations will have to be taken into consideration when planning for the service to ensure the sessions are accessible. The next most commonly reported disability types are long term health conditions, mental health difficulty and neurological conditions, respectively.

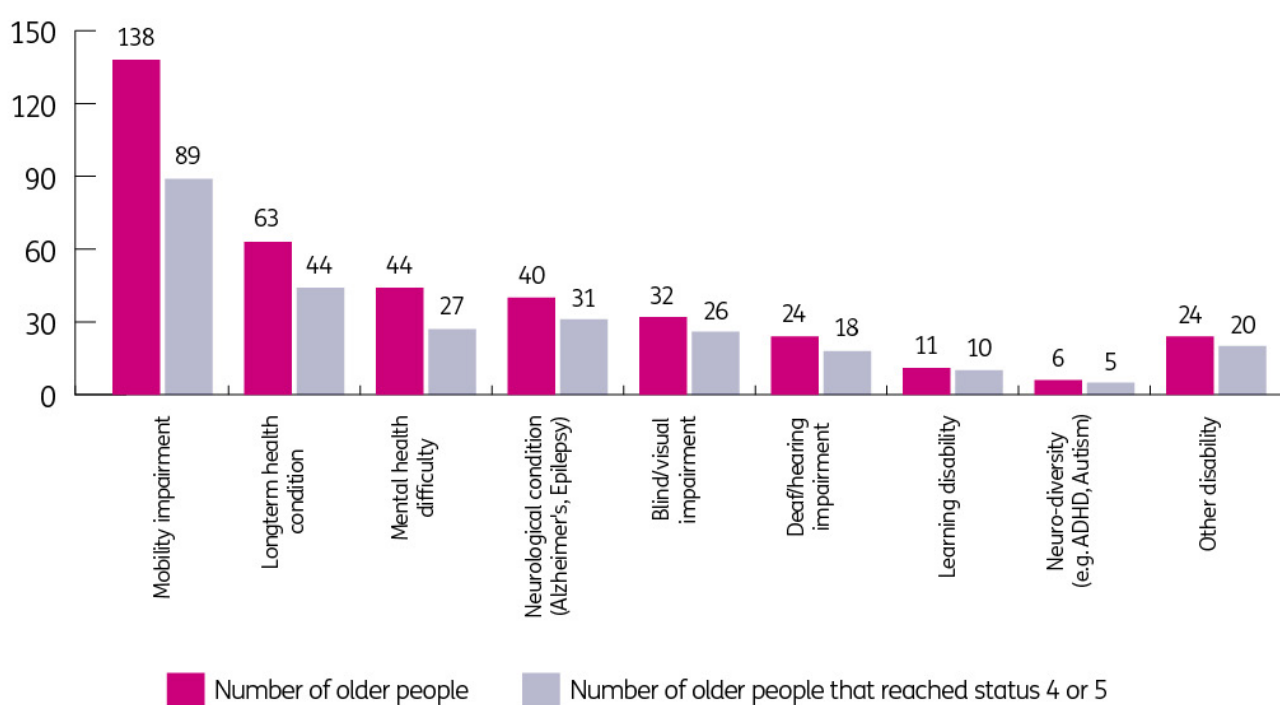


Figure 4. Count of clients by disability type.

Figure 4 demonstrates that dropout rate was greatest amongst clients reporting mental health difficulties (39% decrease) and mobility impairments (36% decrease). It is important to note that these values may be disproportionately greater because of the effects of comorbidity (one third of clients reported having more than one disability) and because these were the most frequently reported disability types.

Overall, it is positive that no singular disability type fully prevented participation in the intervention, demonstrating the person-centred nature of the support offered by this service and the ability of the Travelling Companions to adjust the intervention to suit a range of physical and mental health problems and disabilities.

Two Age UK reports^{1 2} demonstrate the link between poor physical and mental health and loneliness. They explain that physical or mental health problems or disabilities can reduce an older person's ability to participate in community activities and establish and maintain meaningful relationships. They state that those in poor health are 3.7 times more likely to be often lonely compared with older people who are in good or excellent health. Additionally, following the Covid-19 lockdown, those with disabilities may face more barriers to reconnect in their local community, increasing their risk of persistent loneliness. Furthermore, feelings of loneliness can often compound older people's poor physical and mental health, creating a negative feedback loop. Therefore, it is encouraging to see the high number of clients engaged in the Travelling Companions service that report having at least one physical or mental health problem or disability, as it suggests the service is supporting those at an increased risk of loneliness and social isolation.

Ethnicity and socio-economic group

82% of the clients referred to the service were White British, and 13% were reported as unknown. Only 16 clients were of other ethnicities, including Caribbean, Chinese, Indian, and other Black, Asian, and mixed backgrounds.

We gathered clients' postcodes and converted them to Indices of Multiple Deprivation (IMD) deciles, based on the IMD 2019 postcode lookup tool, the distribution of IMD decile can be found in figure 5.

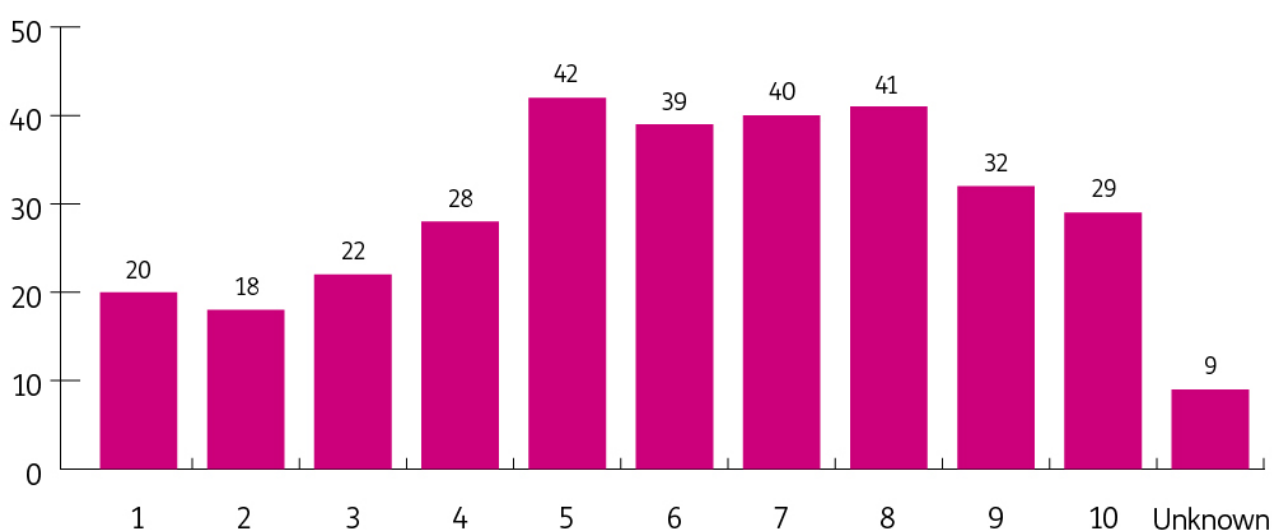


Figure 5. Count of client by IMD decile.

Figure 5 demonstrates that half of older people referred onto the service lived in postcode areas of decile 5-8. Only one in 10 clients could be considered as being within a lower-socio economic group, by living in an area categorised as the top 20% most deprived (decile 1 and 2).

The Travelling Companions pilot programme was interested in assessing the self-selected sample of older people who were referred or self-referred for the service. However, it is important to consider why the service did not seem to appeal widely to ethnicities other than White British, and to those from areas of deprivation. In future deliveries of this service model, it is important that we aim to prioritise lower socio-economic groups and ethnic minorities towards the service, to gather meaningful data as to whether this support model is effective. This may require targeted advertisement to reach these individuals and to communicate the value of the support on offer.

Loneliness and Isolation

Risk Factors

Beyond the demographic data explored above, this section provides data on several additional factors that can reduce someone's opportunity and ability to have meaningful conversations, interactions, and relationships with others. Within this section, we reference people reporting feeling 'often' lonely. This refers to the response of individuals when asked the single-item loneliness question of 'How often do you feel lonely?'. The factors that have been evidenced as linked to loneliness and social isolation, and that were also reported on for the Travelling Companions pilot are as follows:

Household (table 7)

Older people are 1.6 times more likely to be often lonely if they live alone, compared with those who live with somebody.²

Employment status (table 8)

Retirement can contribute to feelings of loneliness due to having an increased amount of time available and a loss of meaningful activity to fill it with. Additionally, leaving the workplace can result in the loss of regular contact with colleagues.²

Relationship status (table 9)

Older people are 5.2 times more likely to be often lonely if they are widowed, compared with those who are in a relationship. A partner is often the most significant relationship to an individual, so dealing with the bereavement of losing this can contribute significantly to feelings of loneliness.²

Being a carer (table 10)

Being a carer can increase the likelihood of an individual feeling lonely and socially isolated. Caring responsibilities can prevent an individual from leaving the house regularly and thus prevent them from participating in the community. Additionally, carers often lose touch with their friends and family as a result of caring responsibilities, so it inhibits their ability to maintain or establish new and meaningful relationships.³

Access to a car (table 11)

A car offers convenient private transport, without which older people must rely on public and community transport or active travel. Lack of access to transport inhibits older people's opportunity to maintain relationships and access services which can foster new relationships.⁴

The key loneliness risk factors that were present in the Travelling Companion sample were living alone (67%), being widowed (44%), being retired (73%) and having no access to a car (70%). The one risk factor that was lacking within the sample was carers (8%). It is important to consider how the service could be modified to better appeal to carers (i.e., organising relief for caring responsibilities during session times, offering two Travelling Companions to allow both the carer and the individual they care for to get out and about), as they are a group at high risk of experiencing loneliness and social isolation.

Table 7. Count of client by household category.

Household:	Number of older people:	Percentage of older people:
One person living alone	214	66.9%
Living with another person/ other people	51	15.9%
Prefer not to say	3	0.9%
Unknown	52	16.3%
TOTAL	320	

Table 8. Count of client by employment status.

Employment status:	Number of older people:	Percentage of older people:
Retired	235	73.4%
Not working and not looking for work	17	5.3%
Not working and looking for work	7	2.2%
Employed/ self-employed	2	0.6%
Prefer not to say	2	0.6%
Unknown	57	17.8%
TOTAL	320	

Table 9. Count of client by relationship status.

Relationship status:	Number of older people:	Percentage of older people:
Widowed	140	43.8%
Married or in a legally recognised civil partnership	38	11.9%
Never married/ in a legally recognised civil partnership	25	7.8%
Divorced	24	7.5%
Separated, but still legally married/ in a legally recognised civil partnership	5	1.6%
Prefer not to say	28	8.8%
Unknown	60	18.8%
TOTAL	320	

Table 10. Count of client by carer status.

Is the client a carer?	Number of older people:	Percentage of older people:
Yes	25	7.8%
No	230	71.9%
Prefer not to say	1	0.3%
Unknown	64	20.0%
TOTAL	320	

Table 11. Count of client by car access.

Does the client have access to a car?	Number of older people:	Percentage of older people:
Yes	42	13.1%
No	225	70.3%
Prefer not to say	1	0.3%
Unknown	52	16.3%
TOTAL	320	

Travelling Companion Demographic Data

80 Travelling Companions supported the delivery of the service over the course of the 11-month delivery period (between September 2022 and July 2023). The distribution of these Travelling Companions between the local Age UKs can be observed in table 12.

Table 12. Count of Travelling Companions that supported the service at each local Age UK.

Age UK:	Number of Travelling Companions:
Calderdale and Kirklees	11
North, South and West Dorset	15
Norfolk	7
Richmond Upon Thames	7
Stockport	8
Wiltshire	16
Worcester and Malvern Hills	16
TOTAL	80

In terms of gender, 70% of the Travelling Companions that supported the pilot programme identified as female (56 individuals), compared to 30% male. 93.8% identified as White British, with 5 Travelling Companions identifying as any other ethnicity, including other White backgrounds, White and Asian, Indian, and Chinese. The average age (excluding any individuals with unknown ages) was 61 years old. A full breakdown of age categories that supported the programme can be found in table 13.

Table 13. Count of Travelling Companions, by age category

Does the client have access to a car?	Number of Travelling Companions:	Percentage of Travelling Companions:
Less than 29	2	2.5%
30-39	5	6.3%
40-49	5	6.3%
50-59	15	18.8%
60-69	18	22.5%
70-79	16	20.0%
Above 80	4	5.0%
Unknown	15	18.8%
TOTAL	80	

In terms of volunteer status, we are aware that at least 10 Travelling Companions were part-time or casual staff members, not volunteers. The pilot programme found that in some areas it was more difficult to recruit volunteers, so staff members took on the role of a Travelling Companion. Often, staff members were utilised for complex cases whereby clients had mobility or cognitive impairments, were extremely anxious about leaving the house, or lived further afield where no volunteers could access them. By doing so, it allowed more clients to be supported by the service, and reduced waiting times for older people to be matched with Companions.



Session Data

The pilot programme delivered 679 Travelling Companion sessions over the 11-month delivery period. The contribution of each local service can be seen in Table 14. The average number of sessions delivered per month varied widely between each local Age UK, with a range value of 19 sessions. The mean and median values are 12 and 14 sessions per month, respectively. Local Age UKs reported that a disparity between the number of Travelling Companions available and the number of older people awaiting matches was often responsible for low session numbers. Specifically, sourcing enough volunteers for the Travelling Companions role was difficult and acted as a limiting factor to the number of sessions able to be delivered.

Table 14. Count of sessions delivered, and average number of sessions per older person that reached client status 4 or 5, by local Age UK.

Age UK:	Number of sessions:	Number of older people that reached status 4 or 5:	Sessions per person:
Calderdale and Kirklees	38	15	2.5
North, South and West Dorset	57	41	1.4
Norfolk	133	26	5.1
Richmond Upon Thames	108	32	3.4
Stockport	25	10	2.5
Wiltshire	168	25	6.7
Worcester and Malvern Hills	150	42	3.6
TOTAL	679	191	3.6

Analysing table 15, the number of clients decrease as the number of sessions increase, demonstrating a negative correlation. 111 clients received zero sessions, and the remaining 209 clients received at least one session. Table 2 demonstrates that only 191 clients reached status 4 or 5 (Completing Sessions or Case Closed), therefore 18 clients who only reached status 3 (Not Suitable for the Project) received a session. These 18 clients received one session before being deemed unsuitable for the service. Local Age UKs reported that often older people misinterpreted or underplayed their circumstances during the initial appointment. However, the older person's abilities and limitations became clear during the first session with the Travelling Companion, and in some cases the client was deemed unsuitable at this stage. The reasons for this included complex cognitive impairments or mobility issues whereby the client was not able to reach independence through a short-term intervention. In these cases, it was deemed unethical to offer support for only a short period, so onward referrals were offered instead.

Based on the 209 clients that received at least one session, the average number of sessions is 3.2 per older person. But when removing the 18 clients that were eventually deemed unsuitable and only received one session, this increases to 3.6 sessions on average per person (table 14) .

Local Age UKs reported delivering sessions on average once a fortnight to clients, suggesting the average intervention length was between 6-8 weeks, as expected.

Table 15. Count of client by number of sessions completed.

Number of sessions completed:	Number of older people:
0	111
1	68
2	30
3	30
4	34
5	23
Between 6 and 9	17
10 or more	7
TOTAL	320

209 clients received at least one support session from their Travelling Companion (table 15), and one third of these received only one. This is a higher proportion than expected, as it was anticipated that it would take older people at least a few weeks of support to initiate behaviour change. However, the findings in Table 15 suggest that perhaps one session of personalised support is sufficient. This substantiates the service model, specifically the use of goal setting and support planning prior to the intervention, as a robust approach to behaviour change. The findings suggest that with this method it may only take one support session to achieve the goals the older person has set.

Figure 6 demonstrates that 41% of sessions lasted longer than two hours. This extensive length of support offered may provide an alternate explanation for the quantity of one-session interventions (table 15). Additionally, 54% of sessions were of a one-to-one nature (figure 7). This indicates that the Travelling Companions were often able to support their matched older person in a person-centred manner, working through their individual challenges and concerns. This may also have enabled faster progression through goals, hence only needing one session.

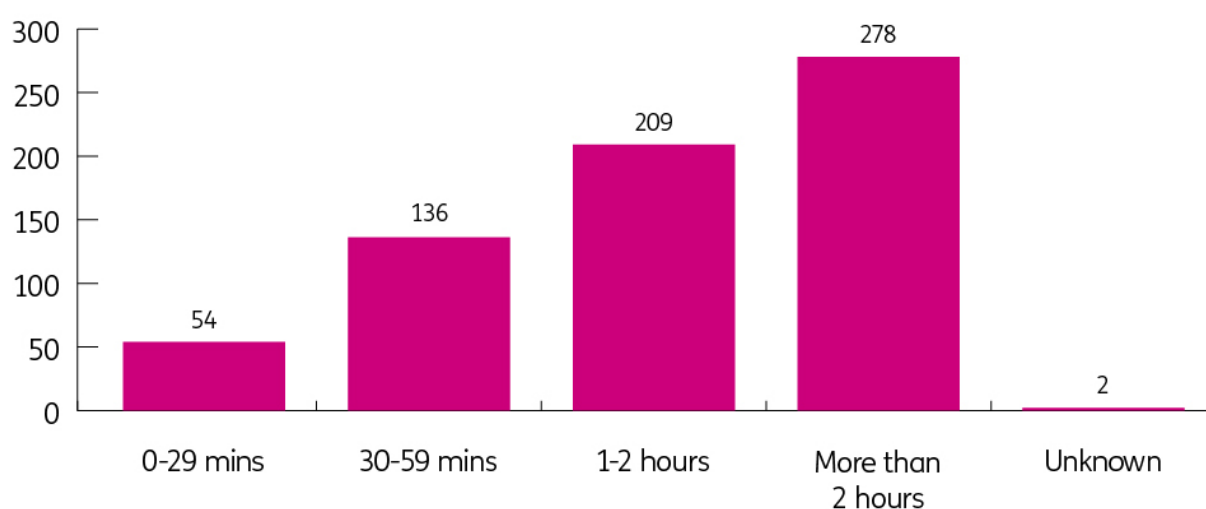


Figure 6. Count of session by length.

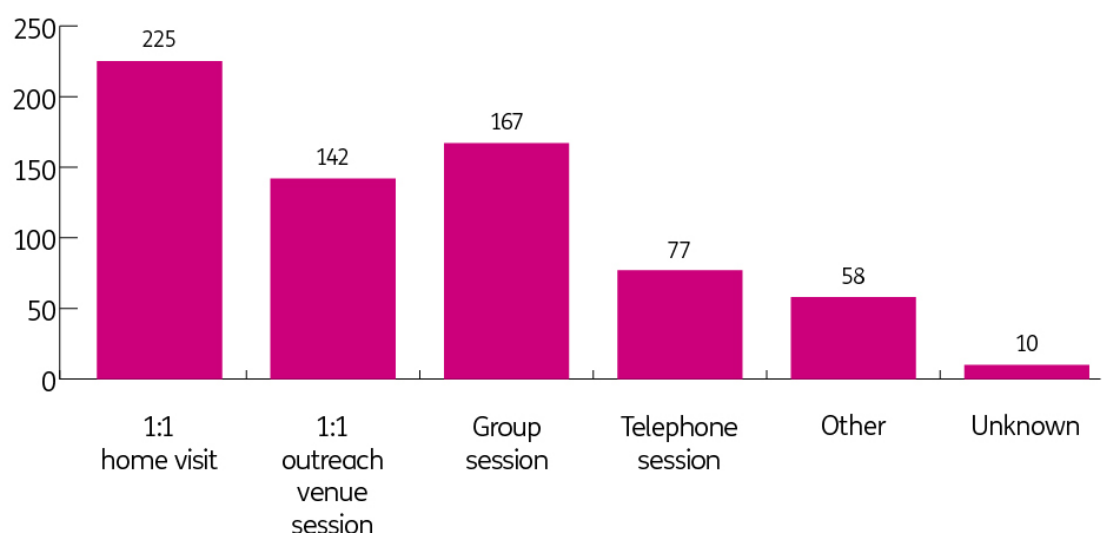


Figure 7. Count of session by type.

One quarter of sessions were group sessions (figure 7). Although this session type is outside of the conventional service model, these were often introduced by local Age UKs as older people progressed through the programme. Group trips via public transport to community spaces and events (i.e., markets, garden centres, shows) were a popular journey type towards the end of the project to foster new relationships between clients on the programme and bridge the gap between one-to-one support sessions and independence.

The type of support that can be offered during sessions:

The Travelling Companions service is tailored to each older person's needs and goals. It can offer a wide range of support to help people overcome challenges that are stopping them from leaving their home. Below are a few examples:

- Talking through their goals, what they want to achieve and creating a step-by-step plan about how they can achieve these.
- Talking through the concerns and challenges that are stopping them from currently achieving their goals.
- Talking through what they have achieved so far during sessions, and what they want to achieve moving forward.
- Completing practice journeys to help build the skills needed to make journeys independently.
- Discussing any anxieties or lack of confidence they have around travelling, and why this may be, and helping them to overcome this.
- Digital barriers:
 - Providing support to help them access public transport timetables online and find transport maps.
 - Helping to apply for a travel pass, like a bus pass, or local taxi schemes funded by the council.
 - Showing them how to buy bus tickets online or book community transport.
- Physical barriers:
 - Providing advice about and signposting to information on how to manage long-term health conditions.
 - Recommending exercises to improve strength and balance and prevent falls.

- Understanding of the local area and transport:
 - Identifying the nearest bus stop.
 - Understanding local public transport and walking routes.
 - Researching how to access taxis or community transport.
- Talking through local support services and groups available to manage loneliness and social isolation.
- Discussing relevant transport-related Covid-19 guidance.

The above list was summarised in a session data form which captured the content of each session delivered on the programme. Multiple types of support can be offered during each session, and the breakdown of session content is demonstrated in figure 8. The most-often employed support was discussing the clients' goals and the concerns. Local Age UKs reported that more sessions than expected involved the Travelling Companion and older person having discussions about their circumstances and anxieties, as opposed to teaching them skills and getting out and about together. This demonstrates the value of active listening, conversations and interactions when tackling loneliness.

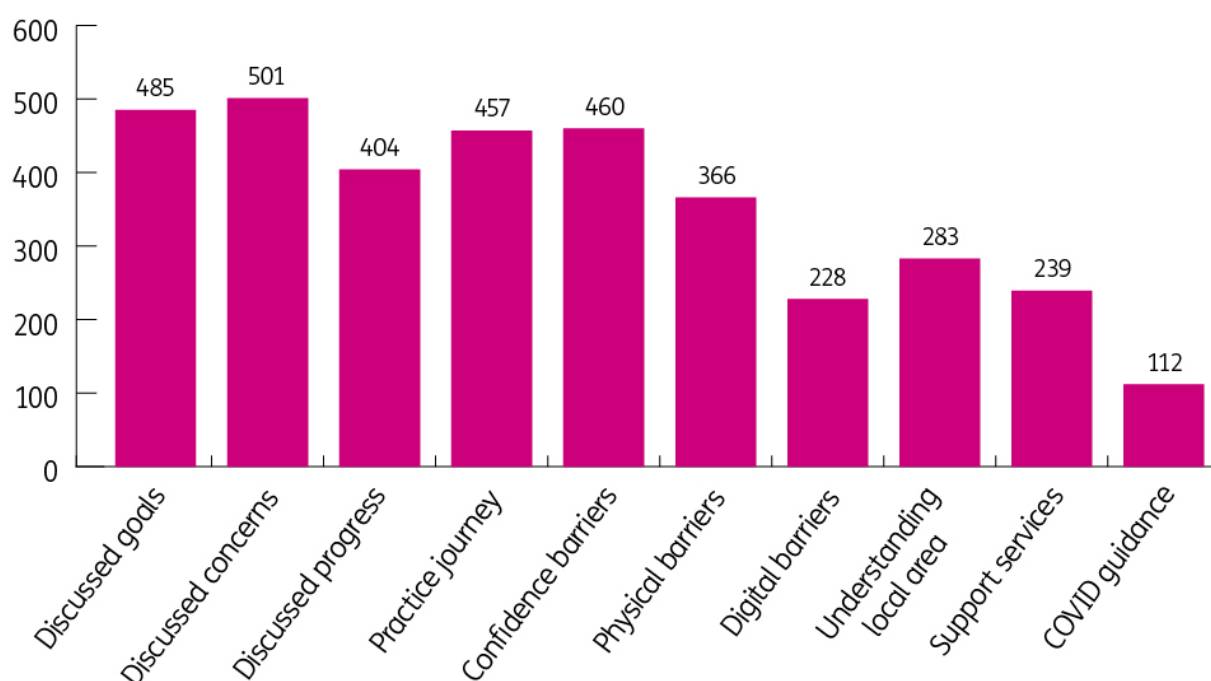


Figure 8. Count of session content.

There are two session content types (figure 8) that we collected further information about, these are:

1. Practice journeys (457 sessions)
2. Support services (239 sessions)

For each practice journey completed, we gathered the primary mode of transport used. Table 16 shows that buses, walking, and community transport were the most used modes of transport, respectively. Local Age UKs frequently reported that local transport provisions were reduced following Covid-19, so walking was often the only form of transport available to geographically isolated clients. Undertaking this programme helped local Age UKs to identify gaps in local transport provisions and build relationships with transport providers.

Table 16. Count and percentage of practice journeys by transport type.

Transport type	Number of sessions:	Percentage of sessions:
Bus	150	32.8%
Walking	127	27.8%
Community transport	110	24.1%
Taxi	50	10.9%
Car	10	2.2%
Mobility scooter	7	1.5%
Train	2	0.4%
Cycling	1	0.2%
TOTAL	457	

Table 17 demonstrates that almost three quarters of practice journeys lasted longer than 30 minutes. The length of these journeys may reflect on the frequency and availability of transport provisions, or on the geographical isolation of the clients on the programme. It may also suggest that older people are more anxious about undertaking longer journeys, hence the need for support from a Travelling Companion.

Table 17. Count of practice journeys by length.

Practice journey length	Number of sessions:
0-5 mins	4
5-10 mins	16
10-20 mins	41
20-30 mins	60
More than 30 mins	336
TOTAL	457

In terms of support services, the most common referral was to an Age UK club (i.e., lunch/coffee club, knitting and allotment classes, and Men in Sheds groups). This demonstrates how well-placed local Age UKs are to deliver this service, as they have a wealth of adjacent support available to support older people to tackle loneliness in the long-term. A full breakdown of service referrals can be found in table 18.

Table 18. Count of service referrals by category.

Support session category	Number of referrals:
Age UK club	64
Befriending	48
Exercise class	46
Information & advice	22
Day to day support service	19
Community transport	15
Long term health condition support	9
Digital inclusion	9
Walking group	4
Mental health support	3
TOTAL	239

When the clients were asked whether they were attending the support service they had been referred to, the most common answer was ‘Not yet, but working towards it’ (table 19). Local Age UKs reported that if Travelling Companions were able to attend a session with their matched client, it helped to alleviate anxieties around meeting new people and visiting new places.

3 in 10 responses indicated that older people were attending the referred service on a monthly or weekly basis. This is a positive indication that the service introduces older people to further support that can help them foster new and meaningful relationships, which may alleviate their loneliness.

Table 19. Count of attendance at referred services.

Is the client attending the service?	Number of responses:
Yes, daily	0
Yes, weekly	57
Yes, monthly	13
Not yet, but working towards it	125
No	8
I don't know	36
TOTAL	239

Goal Setting

Older people supported by the Travelling Companions service were tasked with setting goals for change at stage 2 of the client journey (figure 1). These goals were intended to capture attainable steps that the older person and their Travelling Companion could work on together.

For this section, Age UK Worcester and Malvern Hills have been excluded from the analysis, due to their informal approach to goal setting and the extent of goal repetition.

Based on data from the six local Age UK's, 267 clients reached status 2 on the client journey, however 107 of these went on to be deemed unsuitable for the project so may not have had their goals reported (table 20). 184 clients are confirmed to have undertaken the goal setting activity and had at least one goal noted on the report (table 21).

Table 20. Count of clients that reached different stage of the client journey, by local Age UK.

Age UK:	Number of older people that reached status 2, 3, 4 or 5:	Number of older people that reached status 2, 4 or 5 (excluding Not suitable):
Calderdale and Kirklees	36	15
North, South and West Dorset	56	42
Norfolk	46	30
Richmond Upon Thames	47	38
Stockport	28	10
Wiltshire	54	25
TOTAL	267	160

Clients were offered to set up to three goals. Guidance suggested for the goals to become more challenging over time, to allow the older person to progress during the sessions. 112 clients set the maximum of three goals, see table 21 for a full breakdown.

Table 21. Count of clients by number of goals set.

Goal status:	Number of older people:
Set one goal	184
Set two goals	139
Set three goals	112
TOTAL NUMBER OF GOALS SET	435

The content of each goal was captured as a narrative by the local Age UKs. Thematic analysis has been completed on these goal descriptions and this is summarised in table 22.

Table 22. Breakdown of goals set by theme.

Goal themes:	Number of goals:	Percentage of goals:
Travel to event/activity/other:		37.2%
Engage with local Age UK or community activity	79	18.2%
Travel to a seasonal event	35	8.1%
Trip	27	6.2%
Travel to any other place	21	4.8%
Walking:		19.1%
Walk around neighbourhood	42	9.7%
Walk to the shops	10	2.3%
Walk to the bus stop	9	2.1%
Walk using new walking aid - including mobility scooter	8	1.8%
Walk to get a coffee	6	1.4%
Walk around local park	6	1.4%
Walk to the train station	1	0.2%
Walk to the GP	1	0.2%
Bus:		16.1%
Bus to local town	45	10.3%
Bus to community location	20	4.6%
Bus to the park	5	1.2%
Wellbeing & mental health:		12.2%
Getting out and about – general	26	6.0%
Making friends	20	4.6%
Wellbeing and improving mental health	7	1.6%
Confidence:		9.7%
Build confidence leaving the house	18	4.1%
Build confidence using bus service	13	3.0%
Build confidence in walking further distance	11	2.5%
Planning:		3.9%
Planning of journey	17	3.9%
Other transport:		1.8%
Taxi	4	0.9%
Active transport - not walking	3	0.7%
Train	1	0.2%
TOTAL	435	

The most popular goal theme was travel to event/activity/other, and the sub-theme of engaging with a local Age UK or community activity was the most set goal. This suggests that older people engaging with the service understand the importance of becoming an active member of the community, and the alleviation this can have on feelings of loneliness.

For each goal, local Age UKs captured whether the older person was able to achieve it by the end of their sessions. The categories assigned were:

1. Not achieved
2. Partially achieved
3. Fully achieved

Overall, 43% of goals were fully achieved by the end of the intervention period (table 23). When analysing goal completion status by goal number, the fully achieved status is increased to 59% for just goal 1 but decreased to 23% for goal 3 (table 24). As above, guidance recommended that the goals should begin attainable and become more challenging. The findings in table 24 support this as the not achieved status increased by goal number. This is not to say that the older person did not go on to achieve their second or third goal, but they agreed to cease sessions before achieving them. This may be because they felt confident enough to achieve their later goals independently. Alternatively, the older persons goals may have shifted or changed over the course of the intervention, thus their later goals were no longer relevant, and did not need to be achieved.

Table 23. Number and percentage of goals by goal completion status.

Goal completion status:	Number of goals:	Percentage of goals:
1. Not achieved	175	40.2%
2. Partially achieved	30	6.9%
3. Fully achieved	187	43.0%
Unknown	43	9.9%
TOTAL	435	

Table 24. Number and percentage of goals by goal completion status and goal number.

Goal completion status:	Goal 1 Number and percentage of goals:		Goal 2 Number and percentage of goals:		Goal 3 Number and percentage of goals:	
1. Not achieved	46	25.0%	59	42.4%	70	62.5%
2. Partially achieved	16	8.7%	10	7.2%	4	3.6%
3. Fully achieved	109	59.2%	52	37.4%	26	23.2%
Unknown	13	7.1%	18	12.9%	12	10.7%
TOTAL	184		139		112	

Outcome Data

At stage 2 and stage 5 of the client journey (figure 1), service users were asked to complete a survey which assessed their experiences of loneliness and social isolation, and their feelings around getting out and about and making journeys. Older people were asked questions before completing any sessions (stage 2), and after sessions ceased (stage 5), to evaluate whether changes had occurred over the course of the support.

A total of 320 participants (table 1) engaged with the Travelling Companions programme, however the outcome data analysis was carried out on the participants who took part in at least one session, those who provided responses to both surveys, and those aged 50+ years old- a total of 159 participants (49.8% of participants). Table 25 shows a breakdown of the participants, both from the overall sample and the outcome data analysis sample.

Table 25. Comparison of sample between all participants, and those used for outcome data analysis.

	Overall sample	Analysis sample
All	320	159
Gender:		
Male	62 (19.4%)	34 (21.4%)
Female	214 (66.9%)	124 (78.0%)
Unknown	42 (13.1%)	1 (0.6%)
Non-binary	1 (0.3%)	0 (0.0%)
Prefer not to say	1 (0.3%)	0 (0.0%)
Physical or mental health problems or disabilities:		
Yes, one or more	226 (70.6%)	130 (81.8%)
No	49 (15.3%)	29 (18.2%)
Unknown	43 (13.4%)	0 (0.0%)
Prefer not to say	2 (0.6%)	0 (0.0%)
Number of sessions:		
0	111 (34.7%)	0 (0.0%)
1	68 (21.3%)	40 (25.2%)
2	30 (9.4%)	27 (17.0%)
3	30 (9.4%)	21 (13.2%)
4	34 (10.6%)	33 (20.8%)
5	23 (7.2%)	19 (11.9%)
6 or more	24 (7.5%)	19 (11.9%)

Age:		
Less than 50	1 (0.3%)	0 (0.0%)
50-59	12 (3.8%)	4 (2.5%)
60-69	33 (10.3%)	22 (13.8%)
70-79	80 (25.0%)	45 (28.3%)
80-89	132 (41.3%)	69 (43.4%)
90+	33 (10.3%)	18 (11.3%)
Unknown	29 (9.1%)	1 (0.6%)
IMD decile:		
1 & 2	38 (11.9%)	17 (10.7%)
3 & 4	50 (15.6%)	25 (15.7%)
5 & 6	81 (25.3%)	37 (23.3%)
7 & 8	81 (25.3%)	48 (30.2%)
9 & 10	61 (19.1%)	31 (19.5%)
Unknown	9 (2.8%)	1 (0.6%)

Timeframe

We captured the date each client completed the pre- and post-survey, and calculated the number of weeks between these dates, as shown in figure 9.

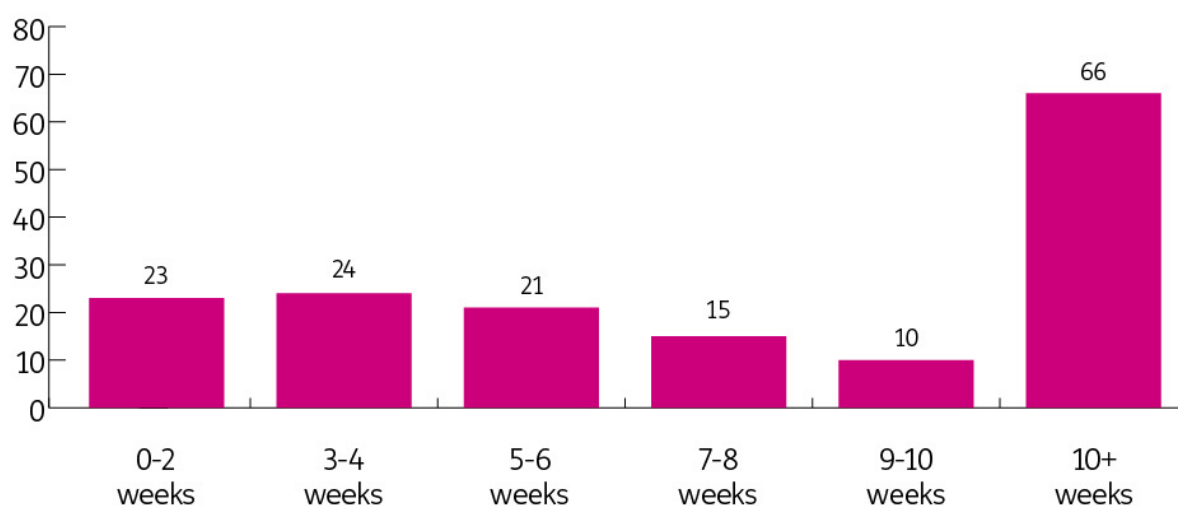


Figure 9: Number of weeks between pre- and post-survey completion date.

As reviewed above in this report, on average, each client received 3.6 sessions (table 14) and local Age UKs reported delivering sessions on average once a fortnight to clients, suggesting the average intervention length was between 6-8 weeks. However, figure 9 suggests that this time frame may have been longer for many clients, with the most common length of time between pre- and post-survey completion being 10+ weeks (41.3%).

A simple explanation for this skew is that the 6–8-week period only includes sessions, whereas figure 9 indicates the length of time between the survey completion. The pre-survey was administered at the initial one-to-one appointment between older person and local partner staff member (stage 2 in figure 1), and the post-survey was administered after the project close (stage 5 in figure 1). Therefore, the additional stages, may add time to the 6-8-week period. However, with 35% of the clients that reached stage 4 in the client journey only completing one journey, this does not explain the large skew towards 10+ weeks in figure 9.

Another explanation for this skew is that throughout the delivery period, local Age UKs reported that older people were requesting to pause their support and resume it at a later date. One reason for this was due to the bad winter weather, which resulted in older people wanting to pause and continue sessions with their Travelling Companion in the spring. Additionally, many clients had to pause sessions due to medical reasons; issues such as long-term health conditions, frailty and hospitalisation meant that it was not possible for them to travel, and they wanted to continue when they began feeling better.

A final possible explanation is that between stage 2 and stage 4 of the client journey (figure 1), there may have been a delay in pairing older people with a Travelling Companion. Local Age UKs reported that finding local volunteers with matching availability to clients was difficult from an administrative point of view. Also, Travelling Companions often only supported one client at any given time, so volunteer availability acted as a limiting factor, and may have led to long waiting-times for older people to be matched.

On the contrary, figure 9 demonstrates that one-third of clients had less than 4 weeks between completing their pre- and post-surveys, which is less than the expected 6-8 weeks. Age UK's reported that for some individuals, it took only 1-2 sessions for them to feel confident enough to begin travelling independently. As a result, they cancelled the rest of their planned support sessions and exited the programme.

The following analysis in this section will compare the pre- and post- survey responses of the analysis sample (table 25), to draw conclusions about the outcomes of the intervention.

Social Interaction

As an indirect measure of social isolation, we asked clients in the pre- and post-survey 'On average, how often do you meet up (including both arranged and chance meetings) with people you are not living with?'. The responses to this question are displayed in table 26.

Table 26. Breakdown of pre- and post-survey responses to social interaction question.

Social Interaction Post-Project						
Social Interaction at Project Start		Less than once a month	Once a month	Several times a month	Once a week	Several times a week
	Less than once a month	4	1	5	4	3
	Once a month	1	1	7	7	2
	Several times a month		1	14	9	15
	Once a week	2		4	32	18
	Several times a week			2	4	23

In table 26, cells filled grey represent older people whose responses indicate that their level of social interaction decreased over the course of the service. These grey cells represent 8.8% of the sample. In contrast, the cells filled plum represent older people whose responses indicate that their level of social interaction increased between completing the pre- and post-survey. This group represents 44.6% of the sample and could be due to the intervention introducing older people to services and social activities that helped them to increase the number of interactions they were having per week.

Active Travel

A number of the survey questions were linked to either public transportation (bus, train, tram, taxi, tube, etc) or active travel (walking or cycling). We will first analyse the questions related to active travel.

Respondents were asked ‘In the last week, on how many occasions did you leave your home to make a journey on foot or by bicycle?’ before the intervention and after. The responses are presented in figure 10.

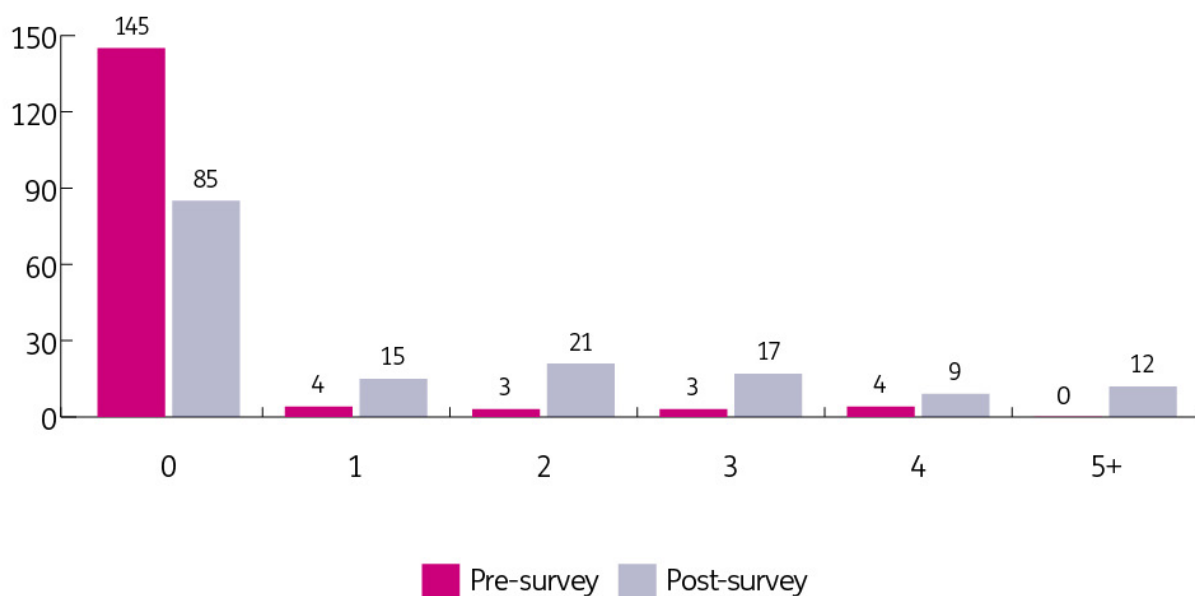


Figure 10: The number of journeys completed by respondents through active travel in the previous week.

Figure 10 demonstrates that the number of older people completing no journeys by active travel decreased by 41.3% between pre- and post-survey completion. The number of individuals completing one or more journeys by active transport increases from 17 people at pre-survey to 74 post-survey. There is a relatively even distribution at post-survey between all categories from one journey upwards, suggesting that walking and cycling can be used as a frequent form of transport for older people, and there is seemingly no limit to its use.

Overall, the average number of journeys by active travel per person increased from 0.22 to 1.46 between pre- and post-survey completion. This suggests that the intervention was successful at increasing the number of journeys completed by active transport per week for the service users.

Figures 11 and 12 attempt to explore the link between the service and the observed increase in the number of active travel journeys completed, by asking clients the following:

1. ‘How confident are you in walking or cycling to get out and about in your local area?’ (Figure 11)
2. ‘How anxious are you in walking or cycling to get out and about in your local area?’ (Figure 12)

Figure 11 demonstrates that at pre-survey 34.0% of the sample indicated they felt at a one on the scale ('not at all confident' using active travel to get out and about). This decreased by 44.4% at post-survey, to just 30 individuals. By comparison, those indicating a four or five on the scale more than doubled between pre- and post-project, from 11.9% of the sample to 27.0%. Therefore, a possible explanation for why older people were able to complete more journeys by active travel after the intervention, was due to an increase in confidence.

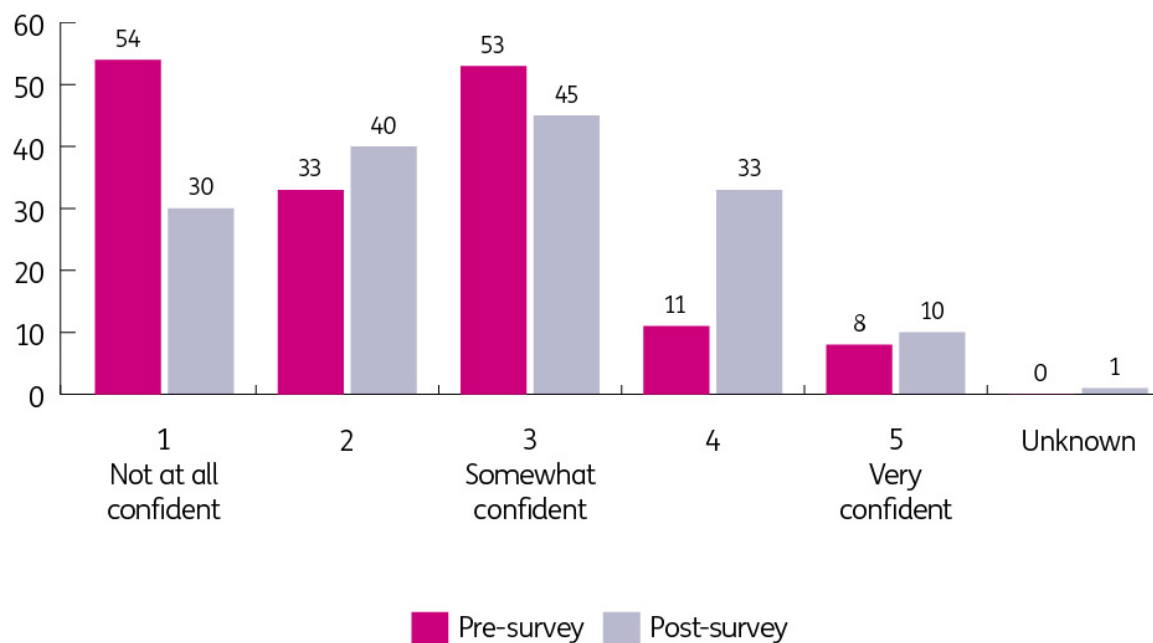


Figure 11: Confidence rating on using active travel to get out and about.

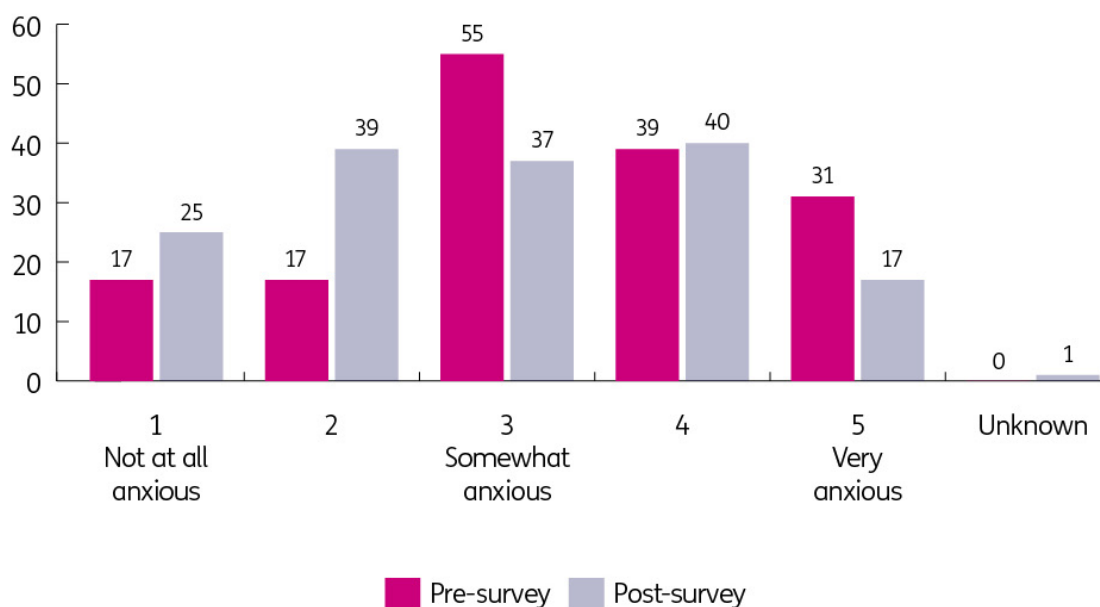


Figure 12: Anxiety rating on using active travel to get out and about.

Figure 12 demonstrates the difference in anxiety ratings between pre- and post-survey, in relation to active travel. A rating of five on the scale refers to feeling 'very anxious' using active travel; pre-project this represented 19.5% of the sample, decreasing to 10.7% at post-survey. The 'somewhat anxious' rating of three reduced by 32.7%, from 55 people to 37. The more positive ratings of one and two, nearly doubled between pre- and post-survey, from 21.4% of the sample, to 40.3%. Again, this suggests that lowering anxiety was one of the key reasons why the service was able to increase the number of journeys by active travel that older people completed after the support.

Public Transport

We will now look to explore the effect of the intervention in relation to public transportation. Figure 13 presents the findings to the following question: ‘In the last week, on how many occasions did you leave your home to make a journey on public transport [including bus, train, tram, taxi, tube, etc.]?’

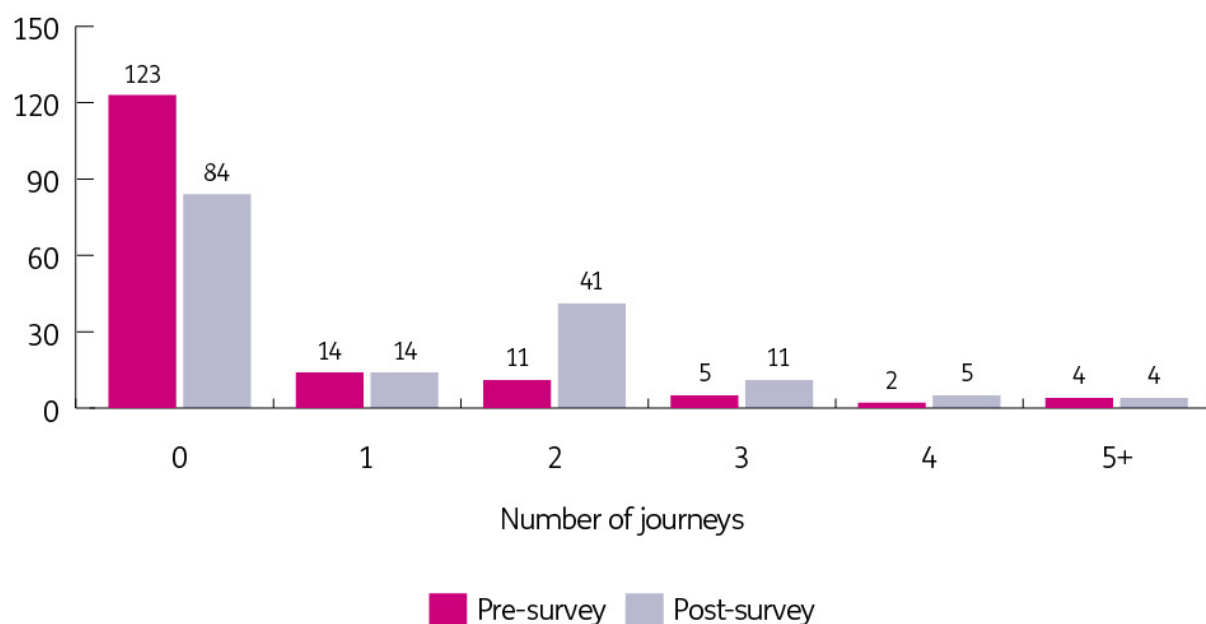


Figure 13: The number of journeys completed by respondents through public transport in the previous week.

The key differences between pre- and post-survey responses in figure 13 are in the categories of zero and two journeys. The percentage of people making no journeys by public transport decreased from 77.4% of the sample to 52.8% once they had received support from the Travelling Companions service. This is very similar finding to that of the journeys by active transport. When analysing the category of two journeys, there is a spike post-survey from 6.9% of the sample to 25.8%. However, beyond two journeys there is minimal change in the distribution between pre- and post-survey. This suggests that although public transport can be a useful modality of getting out and about, there may be a limit on how often older people need to use it on a weekly basis, when compared to walking and cycling, for example.

Overall, the average number of journeys completed via public transport by older people supported by the intervention increased from 0.5 to 1.08 between pre- and post-survey completion. Therefore, there is evidence to suggest that the service can increase public transport engagement amongst older people. Similarly to active travel, we utilised the following questions to explore the cause of this change:

1. How confident are you in using public transport to get out and about in your local area?’ (Figure 14)
2. ‘How anxious are you in using public transport to get out and about in your local area?’ (Figure 15)

Analysing the distribution of responses in figure 14, pre-survey responses follow primarily a negative distribution with the highest response being for a one on the scale (feeling ‘not at all confident’ using public transport), and the lowest response being for a five on the scale (feeling ‘very confident’). Following the intervention, individuals feeling ‘not at all confident’ almost halved (53.5% pre-survey, 28.3% post-survey). All other response categories increased post-project, with the greatest increase observed for a rating of four on the scale (8.18% pre-project, 20.8% post-project). This positive shift in public transport-related confidence may explain the increase in the number of journeys observed after the intervention.

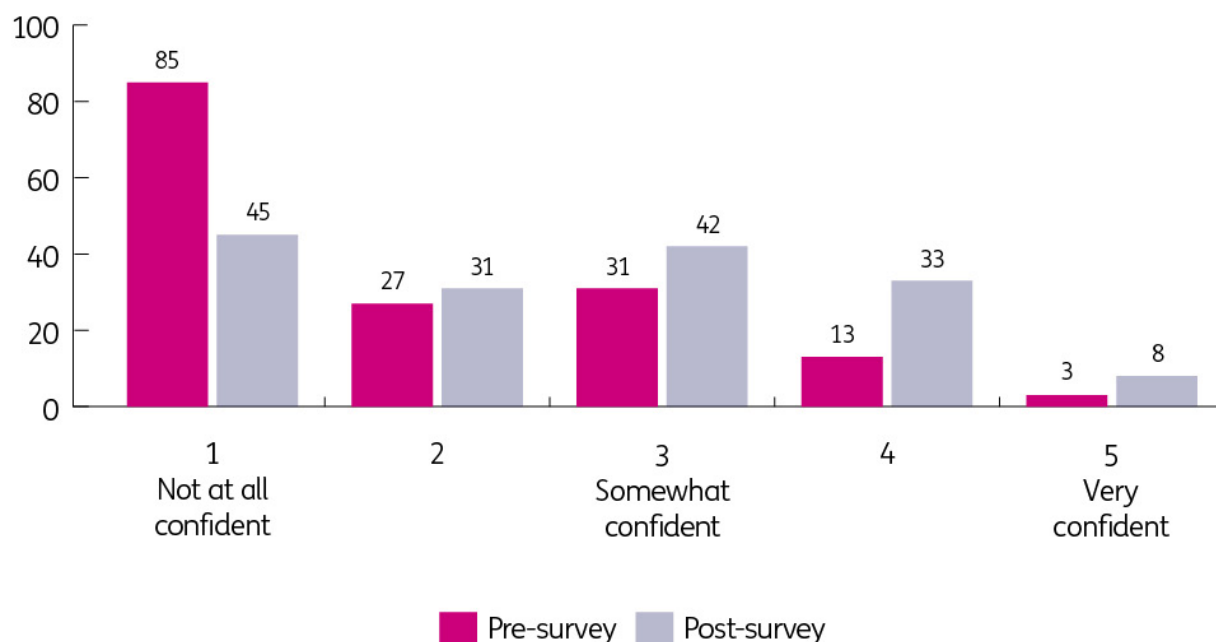


Figure 14: Confidence rating on using public transport to get out and about.

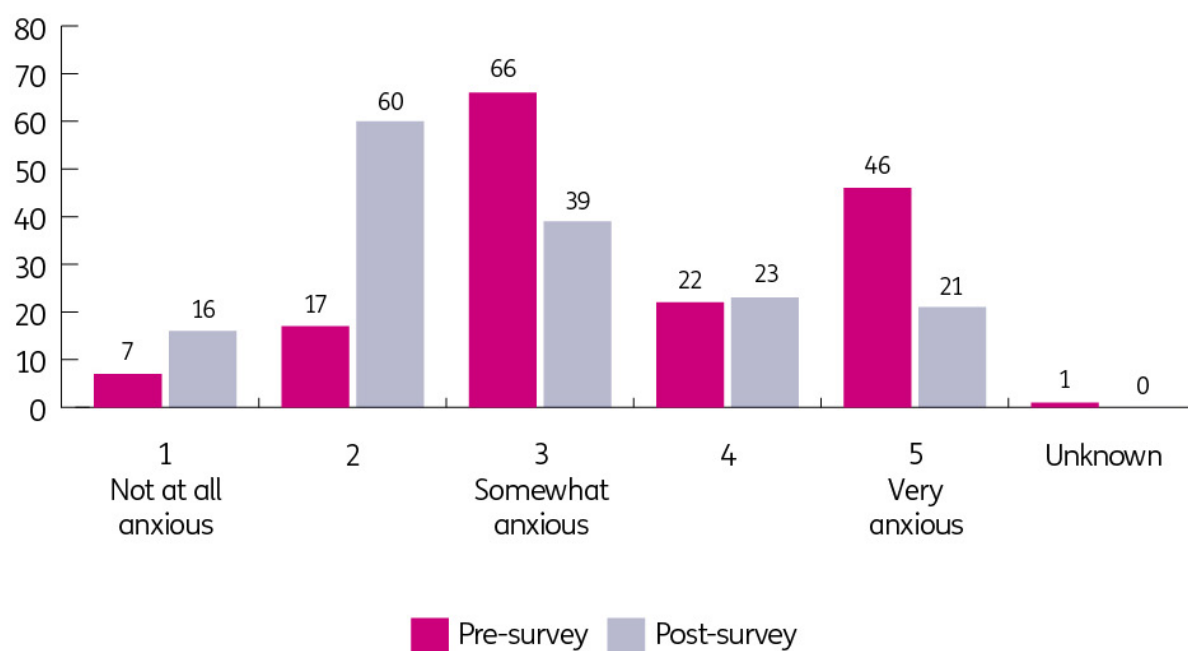


Figure 15: Anxiety rating on using public transport to get out and about.

Figure 15 demonstrates that public transport-related anxiety significantly differed between pre- and post-survey completion. The least anxious ratings of one and two on the scale more than tripled from 15.1% of the sample before the intervention, to 47.8% after. Responses three (somewhat anxious) and five (very anxious) decreased by 40.9% and 54.3% respectively. This shift towards lower rankings on the anxiety scale also offer an explanation for the increase in the number of journeys observed after the intervention.

Figures 11, 12, 14 and 15 demonstrate that the Travelling Companions service was moderately successful at engaging clients that were struggling with their confidence and experiencing high anxiety regarding getting out and about (between 42%-70% scored one of the two lowest ratings). From our findings, it can be assumed that if an intervention is able to influence anxiety and confidence in relation to specific transport modalities, then older people are likely to increase the number of weekly journeys they complete by this modality.

Comfort in leaving the house

Respondents were asked to categorise how they felt, based on question: ‘How comfortable or uncomfortable do you feel about leaving your home to get out and about in your local area?’. Responses are displayed in figure 16. Similar to the confidence and anxiety findings, there is a general shift towards feeling more comfortable in the post-survey responses. Importantly, only 2.5% of the sample felt ‘not at all comfortable’, and 19.5% felt ‘very comfortable’ after receiving the service.

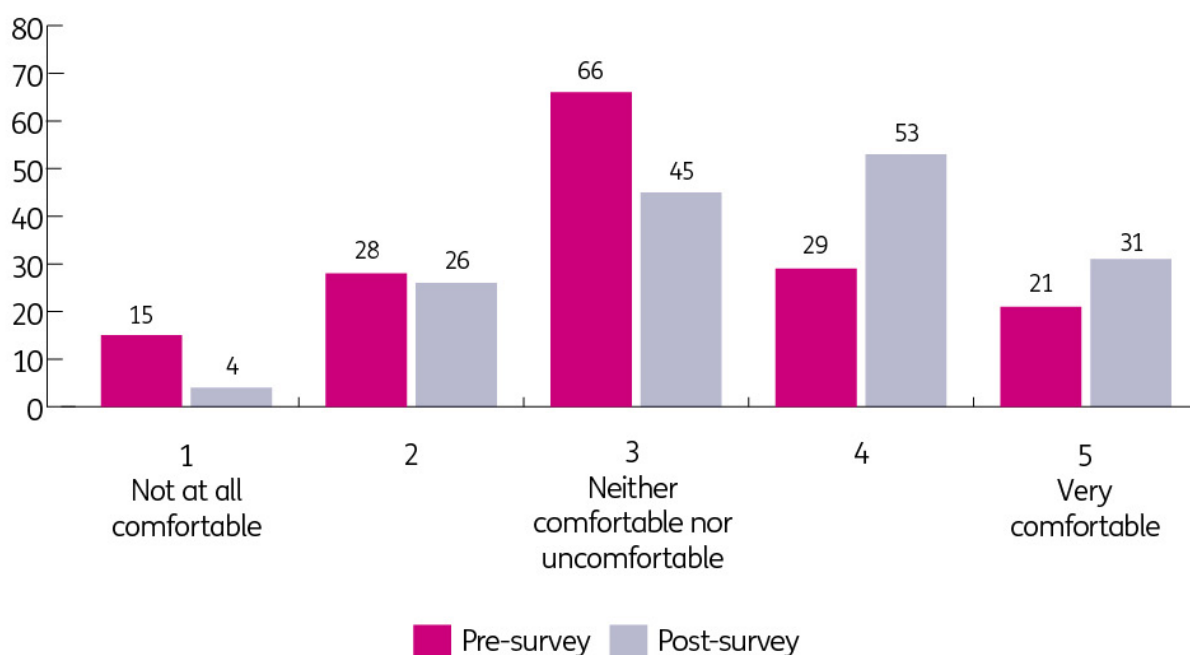


Figure 16: Comfort rating on leaving the home to get out and about.

Loneliness

To measure loneliness, a single-item loneliness question “How often do you feel lonely?” from the Office of National Statistics was asked⁵. Analysing the responses to the single-item loneliness scale in figure 17, it is evident that the skew of data changes between pre- and post-survey. The pre-survey data regression line is steeply positively correlated, with the majority of older people reporting that they feel lonely ‘often’, and the least respondents reporting that they feel lonely ‘never’. The regression line for the post-survey data is also positively correlated, but much flatter. The majority of older people post-project reported feeling lonely ‘occasionally’ and ‘some of the time’. This is an initial indication that the intervention may have been successful at helping clients reduce their feelings of loneliness.

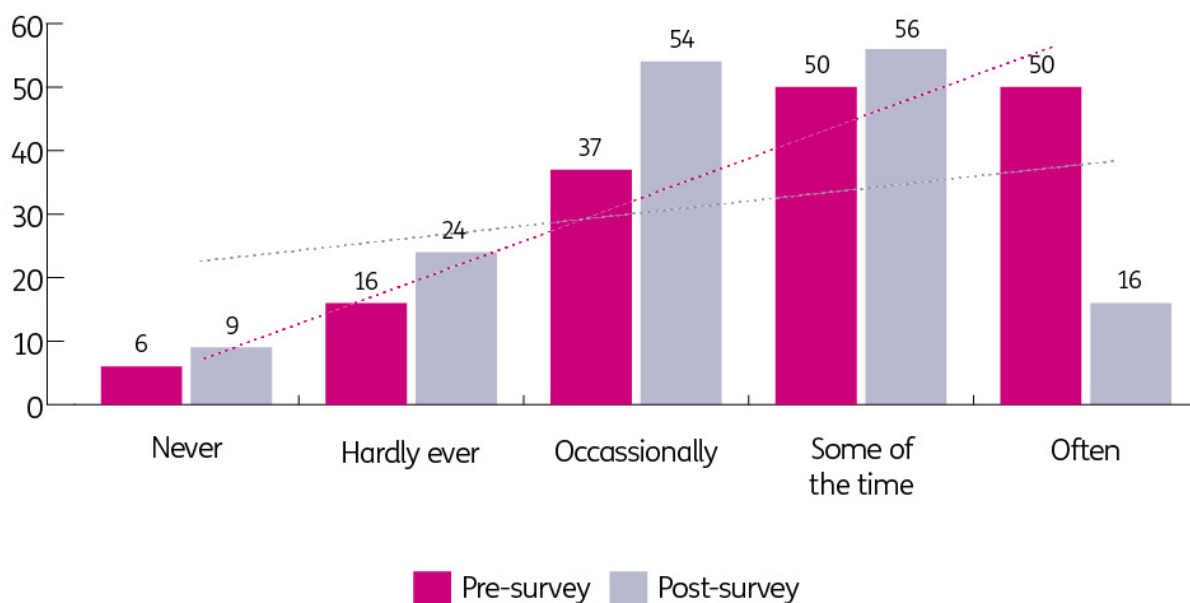


Figure 17: Client response to single-item loneliness question, pre- and post-survey.

Table 27 demonstrates the link between the pre- and post-survey responses, to further analyse the effect of the intervention. In the table, cells filled grey represent older people whose responses indicate that their feelings of loneliness worsened between completing the pre- and post-survey. This represents 12.5% of the older people in the sample. A potential explanation for this, is that the removal of the interaction between the older person and their Travelling Companion could have exacerbated their feelings of loneliness. On the contrary, the cells filled plum represent older people whose responses indicate that their feelings of loneliness reduced between completing the pre- and post-survey. This represents the majority of the sample (46.9%), demonstrating that over the course of the service nearly half of the clients experienced lessened feelings of loneliness. This could be as a result of building a relationship with their Travelling Companion, or because their increased independence helped them to engage with services or clubs that fostered new relationships, or this could be as a result of something outside of the service. The remaining older people in the sample reporting unchanged feelings of loneliness (40.6%) based on the single-item loneliness scale.

Table 27. Breakdown of pre- and post-survey responses to single-item loneliness question.

Loneliness Post-Project						
Loneliness at Project Start		Often	Some of the time	Occasionally	Hardly ever	Never
	Often	14	20	11	4	1
	Some of the time		23	23	3	1
	Occasionally	1	10	15	10	1
	Hardly ever	1	3	4	7	1
	Never			1		5

To further analyse the impact the service had on loneliness, we analysed the responses to the University of California, Los Angeles (UCLA) 3-item scale⁵. The scale asks the following three questions:

- How often do you feel you lack companionship?
- How often do you feel left out?
- How often do you feel isolated from others?

Each question has three responses “Hardly ever or never”, which is scored as 1, “Some of the time”, which is scored as 2, and “Often” which is scored as 3. The scores from the three questions are added together to give a combined score from 3 to 9. A score of 3 or 4 represents someone who is “hardly ever or never” lonely; a score of 5, 6 or 7 represents someone who is lonely “some of the time”; and a score of 8 or 9 represents someone who is lonely “Often”.

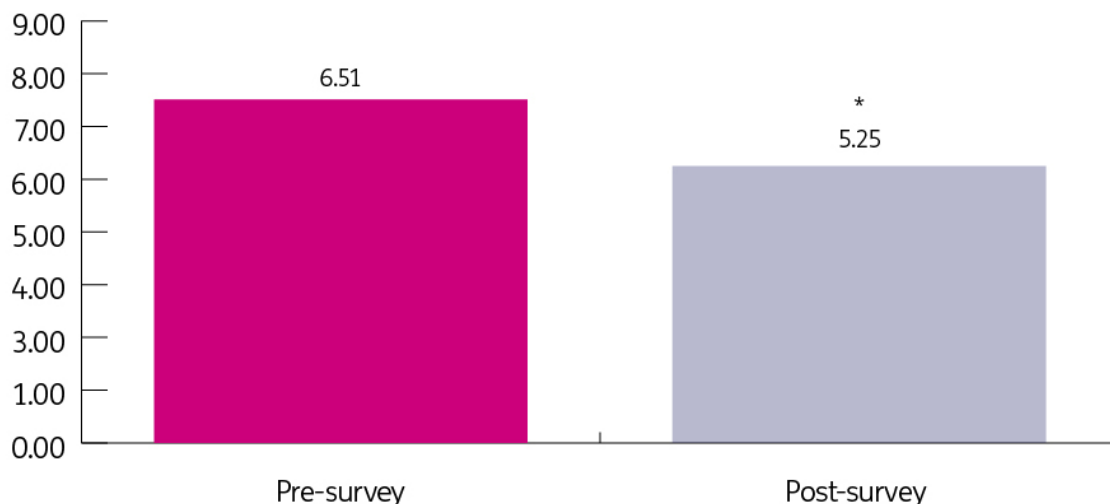


Figure 18: Mean combined scores to the UCLA 3-item scale $\pm$ standard deviation.

*Denotes significance between the pre- and post-survey responses ($P < 0.05$).

Figure 18 demonstrates the change in mean combined score, over the course of the service. The scores of 6.51 and 5.25 are both categorised as feeling lonely ‘some of the time’. However, the change in mean score is 1.25, which represents a significant difference (see appendix), and suggests that we can be 95% confident that the intervention supported older people to reduce their feelings of loneliness.

We tested the difference in means between different sub-sets of the sample (see appendix):

- Male vs. female
 - Mean combined score for males was slightly higher than females pre-survey, but slightly lower post-survey, suggesting that the intervention was more successful at reducing loneliness in men. However, there is not enough evidence to suggest this difference is significant.
- One or more physical or mental health problem or disability vs. none
 - The difference in mean combined score between pre- and post-survey for individuals with a disability is 1.43, compared to 0.48 for individuals without a disability. Participants with a disability showed a greater decrease in loneliness levels and this difference is of statistical significance.
- Number of sessions
 - There is a significant difference in loneliness outcomes when comparing the number of sessions an older person completed. The greatest difference in mean combined score between pre- and post-survey was seen in those that completed six or more sessions.
- Age group
 - There was a significant difference between the mean combined scores of the age categories ‘50-59’ and ‘80-89’, but there is not enough evidence to suggest there is a significant relationship between age group and service outcomes.

Overall, the pre- and post-survey responses suggest a small positive change was observed in levels of loneliness. This suggests that the service model was successful at reducing feelings of loneliness, to some extent. More evidence would need to be captured to understand which elements of the intervention were most successful at alleviating feelings of loneliness, and how we can extend the positive effect to all older people that engage with this form of support.



Conclusion

In conclusion, this report has presented compelling evidence towards the effectiveness of the Travelling Companions service model. However, the report suffers from a relatively small sample size throughout, exacerbated by the volume of 'Unknown' fields. Additionally, the sample was further limited by the number of individuals marked as unsuitable for the project and referred out of the service at stage 3 (figure 1). In future iterations of this project, we would focus on quality of data collection and endeavour to eliminate data gaps. We may need to reduce the breadth of data collected to do this, with the hope of collecting a stronger dataset for a bigger sample.

This report demonstrates that the service model is very effective when offered to the target audience: older people who are physically capable of independent travel and who want to get out and about but are not currently doing so. Now we have evidence on what this target group looks like (including referral routes and demographic information), we can better focus engagement on these individuals in future. Additionally, we will be able to avoid using local Age UK time focussing on dealing with inappropriate enquiries and identifying more relevant onward referrals. This would mean more staff time could be allocated to moving clients through the service and would result in larger client numbers. This means that for the same staff time, more clients could be supported, lowering the cost-per-person of the service and making it a more attractive funding opportunity.

It is important to acknowledge the gaps in the sample, specifically around ethnic minorities, areas of high deprivation and carers. In future iterations of this service, we will endeavour to focus a proportion of client recruitment to these demographic groups. This will allow us firstly to test the intervention on a new group of individuals, and potentially understand why it might not be an attractive offer for them. This will help us to identify any changes needed to the service model to make it more accessible and inclusive. Additionally, it is important to work towards reducing inequalities for these groups as we know they can be at higher risk of experiencing poverty and in-turn loneliness.

With the present sample, we were able to demonstrate that a short-term intervention can be effective at delivering behaviour change (for example, increasing the number of journeys an individual completes per week). In future iterations of this service model, we would be interested in exploring the permanency of this behaviour change, and tracking clients progress without their Travelling Companions for support. It would be important to capture any regression and how the service can endeavour to avoid this.

Overall, the findings of the Travelling Companions pilot programme suggest that lack of access to transport can be a key barrier to making and maintaining meaningful relationships. Therefore, transport can be seen as an important factor in tackling loneliness. Additionally, our findings suggest that older people want to get out and about to allow them to access services, clubs and activities. Therefore, community and Age UK services, especially those that aim to alleviate loneliness, may be better attended if transport to the service is considered a priority. Finally, we know that some local Age UKs struggled with finding appropriate transport options for older people to access, therefore local authorities should focus on the provision of better public transport if they are looking to alleviate loneliness and improve community engagement amongst the older population.

References

1. Age UK. 2021. Same as it ever was: 'Life during the pandemic was no different to normal...I'm always lonely'. Loneliness and Covid-19.
2. Age UK. 2018. All the Lonely People: Loneliness in Later Life.
3. Carers UK. 2015. Alone and caring: isolation, loneliness and the impact of caring on relationships.
4. Campaign to End Loneliness and Age UK. 2015. Promising approaches to reducing loneliness and isolation in later life.
5. ONS. 2018. Measuring loneliness: guidance for use of the national indicators on surveys available [here](#).

Appendix

Table 25 shows a breakdown of the 159 participants used for the following analysis. The data is the combined score of the UCLA 3-item scale questions.

All Participants

A paired t-test was conducted with two paired measurements of the combined UCLA-3 questions, pre and post the Travelling Companions programme, for a total of 159 subjects (N = 159). Before the programme, the mean value of the combined UCLA-3 variable is 6.51. On completion of the programme, the mean value of the combined UCLA-3 variable is 5.25.

	Mean	N	Std. Deviation	Std. Error Mean
Pre-programme	6.51	159	1.786	0.142
Post-programme	5.25	159	1.526	0.121

There was a significant difference in the UCLA-3 combined scores for pre-programme (M=6.51, SD=1.786) and post-programme (M=5.25, SD=1.526) levels of loneliness, $t(158)=9.700$, $p=0.000$.

	Paired Differences					t	df	Significance	
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
				Lower	Upper				
Pre-programme - post-programme combined UCLA-3	1.258	1.635	0.130	1.002	1.514	9.700	158	0.000	0.000

The responses from the participants at the start of the programme and end of the programme suggest that there was a statistically significant reduction in levels of loneliness. With a p-value of 0.000 (less than the typical significance level of 0.05), the results of the paired t-test are highly significant. This indicates strong evidence to reject the null hypothesis, suggesting that there is a significant difference between the pre-programme and post-programme measurements. The positive mean difference (1.258) and the 95% confidence interval (1.002 to 1.514) also confirm that the post-programme values are significantly lower than the pre-programme values.

Gender

Gender		N	Mean	Std. Deviation	Std. Error Mean
Pre-programme	Male	34	6.59	2.017	0.346
	Female	124	6.47	1.718	0.154
Post-programme	Male	34	5.06	1.496	0.257
	Female	124	5.30	1.541	0.138

A total of 34 males and 124 females completed the programme and made up the analysis sample.

A paired samples t-test was conducted to compare the pre-programme and post-programme scores, by gender. The mean pre-programme score for males (6.59) is slightly higher than that for females (6.47). The mean post-programme score for males (5.06) is lower than that for females (5.30).

		Levene's Test		t-test for Equality of Means							
		F	Sig.	t	df	Significance		Mean Difference	Std. Error Difference	95% Confidence	
						One - Sided p	Two - Sided p			Lower	Upper
Pre-programme	Equal variances assumed	1.632	0.203	0.349	156	0.364	0.728	0.120	0.346	-0.562	0.803
	Equal variances not assumed			0.318	46.932	0.376	0.752	0.120	0.379	-0.641	0.882
Post-programme	Equal variances assumed	0.034	0.855	-0.808	156	0.210	0.420	-0.240	0.296	-0.825	0.346
	Equal variances not assumed			-0.822	53.756	0.207	0.415	-0.240	0.292	-0.824	0.345

For equal variances assumed, the t-test for equality of means has a t-value of 0.349 and a p-value of 0.728. With $p > 0.05$, there is not enough evidence to reject the null hypothesis of equal means. This suggests that there is no statistically significant difference between the means of the pre-programme value for the two groups of male and female.

Similarly for the post-programme analysis, the t-test for equality of means has a t-value of -0.808 and a p-value of 0.210. With $p > 0.05$, there is no statistically significant difference between the means of post-programme for the two groups.

Disability

Disability		N	Mean	Std. Deviation	Std. Error Mean
Pre_combined	Yes	130	6.71	1.767	0.155
	No	29	5.62	1.613	0.299
Post_combined	Yes	130	5.28	1.499	0.132
	No	29	5.14	1.663	0.309

Based on the provided descriptive statistics for the Pre-programme and Post-programme measurements, broken down by disability status (Yes and No), we can interpret the results as follows:

For pre-programme, individuals with a disability (Mean = 6.71) have higher scores compared to those without a disability (Mean = 5.62). For post-programme, individuals with a disability (Mean = 5.28) have slightly higher scores than those without a disability (Mean = 5.14).

		Levene's Test		t-test for Equality of Means							
		F	Sig.	t	df	Significance		Mean Difference	Std. Error Difference	95% Confidence	
						One - Sided p	Two - Sided p			Lower	Upper
Pre-programme	Equal variances assumed	1.543	0.216	3.041	157	0.001	0.003	1.087	0.357	0.381	1.793
	Equal variances not assumed			3.223	44.319	0.001	0.002	1.087	0.337	0.408	1.766
Post-programme	Equal variances assumed	0.894	0.346	0.442	157	0.329	0.659	0.139	0.314	-0.482	0.760
	Equal variances not assumed			0.414	38.798	0.341	0.681	0.139	0.336	-0.540	0.818

The t-test for equality of means has a t-value of 3.041 and a p-value of 0.001. With $p < 0.05$, we have enough evidence to reject the null hypothesis of equal means. This suggests that there is a statistically significant difference between the means of pre-programme for the two groups (e.g., individuals with and without a disability). The participants with a disability showed a greater decrease in loneliness levels than those without a disability.

Number of Sessions

Descriptives								
Difference								
	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
1 session	40	1.13	1.181	0.187	0.75	1.50	0	3
2 sessions	27	1.70	1.918	0.369	0.95	2.46	-2	5
3 sessions	21	0.57	1.207	0.263	0.02	1.12	-2	3
4 sessions	33	1.00	1.820	0.317	0.35	1.65	-3	4
5 sessions	19	1.26	1.968	0.451	0.31	2.21	-3	5
6+ sessions	19	2.11	1.410	0.323	1.43	2.78	0	5
Total	159	1.26	1.635	0.130	1.00	1.51	-3	5

A one-way between subjects ANOVA was conducted to compare the effect of the number of sessions on the Travelling Companions participants.

ANOVA					
Difference					
	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	31.807	5	6.361	2.492	0.034
Within Groups	390.621	153	2.553		
Total	422.428	158			

With Sig.=0.034 this shows that there is a significant difference between the groups.

Multiple Comparisons						
Dependent Variable:						
Tukey HSD						
(I) Sessions Grouped		Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
1 session	2 sessions	-0.579	0.398	0.694	-1.73	0.57
	3 sessions	0.554	0.431	0.792	-0.69	1.80
	4 sessions	0.125	0.376	0.999	-0.96	1.21
	5 sessions	-0.138	0.445	1.000	-1.42	1.15
	6+ sessions	-0.980	0.445	0.243	-2.27	0.30
2 sessions	1 session	0.579	0.398	0.694	-0.57	1.73
	3 sessions	1.132	0.465	0.151	-0.21	2.47
	4 sessions	0.704	0.415	0.536	-0.49	1.90
	5 sessions	0.441	0.478	0.941	-0.94	1.82
	6+ sessions	-0.402	0.478	0.960	-1.78	0.98
3 sessions	1 session	-0.554	0.431	0.792	-1.80	0.69
	2 sessions	-1.132	0.465	0.151	-2.47	0.21
	4 sessions	-0.429	0.446	0.929	-1.72	0.86
	5 sessions	-0.692	0.506	0.746	-2.15	0.77
	6+ sessions	-1.534*	0.506	0.033	-2.99	-0.07
4 sessions	1 session	-0.125	0.376	0.999	-1.21	0.96
	2 sessions	-0.704	0.415	0.536	-1.90	0.49
	3 sessions	0.429	0.446	0.929	-0.86	1.72
	5 sessions	-0.263	0.460	0.993	-1.59	1.06
	6+ sessions	-1.105	0.460	0.162	-2.43	0.22
5 sessions	1 session	0.138	0.445	1.000	-1.15	1.42
	2 sessions	-0.441	0.478	0.941	-1.82	0.94
	3 sessions	0.692	0.506	0.746	-0.77	2.15
	4 sessions	0.263	0.460	0.993	-1.06	1.59
	6+ sessions	-0.842	0.518	0.584	-2.34	0.65

6+ sessions	1 session	0.980	0.445	0.243	-0.30	2.27
	2 sessions	0.402	0.478	0.960	-0.98	1.78
	3 sessions	1.534*	0.506	0.033	0.07	2.99
	4 sessions	1.105	0.460	0.162	-0.22	2.43
	5 sessions	0.842	0.518	0.584	-0.65	2.34

There is a significant difference in levels of loneliness between the groups, but post hoc tests show it is only between those who had three sessions and 6 or more sessions. Those participants who took part in 3 sessions had a relatively low decrease in loneliness at 0.57, and those who took part in 6 sessions or more were relatively high at 2.11. However, the small sample sizes should be taken into consideration.

Age Groups

Descriptives								
Difference								
	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
50-59	4	3.50	1.000	0.500	1.91	5.09	3	5
60-69	22	1.18	1.943	0.414	0.32	2.04	-3	5
70-79	45	1.31	1.459	0.217	0.87	1.75	-3	4
80-89	69	1.09	1.606	0.193	0.70	1.47	-2	5
90+	18	1.28	1.638	0.386	0.46	2.09	-3	4
Total	158	1.25	1.634	0.130	0.99	1.50	-3	5

A one-way between subjects ANOVA was conducted to compare the age groups on the Travelling Companions participants and whether age group affected reduction in loneliness levels.

ANOVA					
Difference					
	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	22.367	4	5.592	2.155	0.077
Within Groups	397.007	153	2.595		
Total	419.373	157			

A p-value of Sig.=0.077 suggests that there is some evidence against the null hypothesis, but it's not strong enough to claim statistical significance at a conventional significance level (e.g., 0.05).

Multiple Comparisons						
Dependent Variable:						
Tukey HSD						
(I) Age group	Mean Difference (I-J)		Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
50-59	60-69	2.318	0.876	0.067	-0.10	4.74
	70-79	2.189	0.840	0.075	-0.13	4.51
	80-89	2.413*	0.828	0.033	0.13	4.70
	90+	2.222	0.890	0.097	-0.24	4.68
60-69	50-59	-2.318	0.876	0.067	-4.74	0.10
	70-79	-0.129	0.419	0.998	-1.29	1.03
	80-89	0.095	0.394	0.999	-0.99	1.18
	90+	-0.096	0.512	1.000	-1.51	1.32
70-79	50-59	-2.189	0.840	0.075	-4.51	0.13
	60-69	0.129	0.419	0.998	-1.03	1.29
	80-89	0.224	0.309	0.950	-0.63	1.08
	90+	0.033	0.449	1.000	-1.21	1.27
80-89	50-59	-2.413*	0.828	0.033	-4.70	-0.13
	60-69	-0.095	0.394	0.999	-1.18	0.99
	70-79	-0.224	0.309	0.950	-1.08	0.63
	90+	-0.191	0.426	0.992	-1.37	0.99
90+	50-59	-2.222	0.890	0.097	-4.68	0.24
	60-69	0.096	0.512	1.000	-1.32	1.51
	70-79	-0.033	0.449	1.000	-1.27	1.21
	80-89	0.191	0.426	0.992	-0.99	1.37

The mean difference between age group 50-59 and age group 80-89 is 2.413. Since the significance level is less than 0.05, the difference is considered statistically significant. Additionally, the 95% confidence interval suggests that we can be 95% confident that the true population mean difference falls between 0.13 and 4.70. However, there was a total of just 4 participants in the 50-59 age group, so these results may not be fully representative.