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Putting Life in Years (PLINY): a randomised controlled trial and mixed-methods process evaluation of a telephone friendship intervention to improve mental well-being in independently living older people

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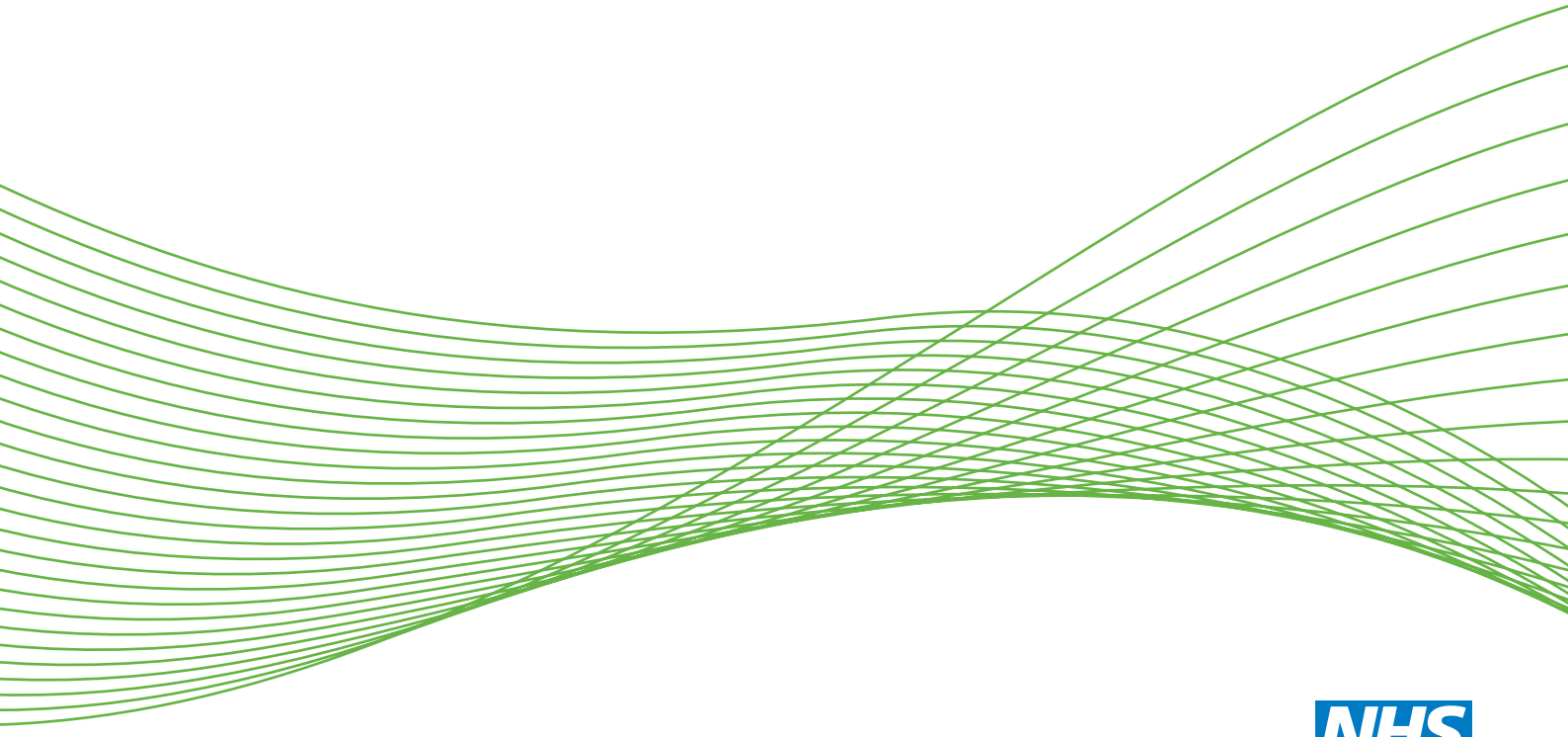

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Putting Life in Years (PLINY): a randomised controlled trial and mixed-methods process evaluation of a telephone friendship intervention to improve mental well-being in independently living older people

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Abstract

Putting Life in Years (PLINY): a randomised controlled trial and mixed-methods process evaluation of a telephone friendship intervention to improve mental well-being in independently living older people

Daniel Hind,[1] Gail Mountain,[2] Rebecca Gossage-Worrall,[1]* Stephen J Walters,[2] Rosie Duncan,[2] Louise Newbould,[2] Saleema Rex,[1] Carys Jones,[3] Ann Bowling,[4] Mima Cattan,[5] Angela Cairns,[6] Cindy Cooper,[1] Elizabeth Goyder[2] and Rhiannon Tudor Edwards[3]

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Background: Social isolation in older adults is associated with morbidity. Evaluating interventions to promote social engagement is a research priority.

Methods: A parallel-group randomised controlled trial was planned to evaluate whether telephone friendship (TF) improves the well-being of independently living older people. An internal pilot aimed to recruit 68 participants by 30 September 2012, with 80% retained at 6 months. Randomisation was web based and only analysts were blind to allocation. A service provider was contracted to train 10 volunteer facilitators by 1 April 2012 and 10 more by 1 September 2012. Participants were aged > 74 years with good cognitive function and living independently in an urban community. The intervention arm of the trial consisted of manualised TF with standardised training: (1) one-to-one befriending (10- to 20-minute calls once per week for up to 6 weeks made by volunteer facilitators) followed by (2) TF groups of six participants (1-hour teleconferences once per week for 12 weeks facilitated by the same volunteer). Friendship groups aimed to enhance social support and increase opportunities for social interaction to maintain well-being. This was compared with usual health and social care provision. The primary clinical outcome was the Short Form questionnaire-36 items (SF-36) mental health dimension score at 6 months post randomisation. Qualitative research assessing intervention acceptability (participants) and implementation issues (facilitators) and an intervention fidelity assessment were also carried out. Intervention implementation was documented through e-mails, meeting minutes and field notes. Acceptability was assessed through framework analysis of semistructured interviews. Two researchers coded audio recordings of telephone discussions for fidelity using a specially designed checklist.

Results: In total, 157 people were randomised to the TF group ($n = 78$) or the control group ($n = 79$). Pilot recruitment and retention targets were met. Ten volunteers were trained by 1 September 2012; after volunteer attrition, three out of the 10 volunteers delivered the group intervention. In total, 50 out of the 78 TF participants did not receive the intervention and the trial was closed early. A total of 56 people contributed primary outcome data from the TF ($n = 26$) and control ($n = 30$) arms. The mean difference in

SF-36 mental health score was 9.5 (95% confidence interval 4.5 to 14.5) after adjusting for age, sex and baseline score. Participants who were interviewed ($n = 19$) generally declared that the intervention was acceptable. Participant dissatisfaction with closure of the groups was reported ($n = 4$). Dissatisfaction focused on lack of face-to-face contact and shared interests or attitudes. Larger groups experienced better cohesion. Interviewed volunteers ($n = 3$) expressed a lack of clarity about procedures, anxieties about managing group dynamics and a lack of confidence in the training and in their management and found scheduling calls challenging. Training was 91–95% adherent with the checklist (39 items; three groups). Intervention fidelity ranged from 30.2% to 52.1% (28–41 items; three groups, three time points), indicating that groups were not facilitated in line with training, namely with regard to the setting of ground rules, the maintenance of confidentiality and facilitating contact between participants.

Conclusions: Although the trial was unsuccessful for a range of logistical reasons, the experience gained is of value for the design and conduct of future trials. Participant recruitment and retention were feasible. Small voluntary sector organisations may be unable to recruit, train and retain adequate numbers of volunteers to implement new services at scale over a short time scale. Such risks might be mitigated by multicentre trials using multiple providers and specialists to recruit and manage volunteers.

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Glossary

de Jong Gierveld Loneliness Scale This multidimensional scale uses self-reported characteristics such as social networks and levels of social contact to assess loneliness and is based on the assumption that feelings of loneliness result when there is a discrepancy between what an individual wants from interpersonal relationships and what they actually have.

Intervention fidelity An examination of whether the intervention was delivered as intended. In this study, this included examining whether the trainer delivered training to volunteers as stated and whether volunteers followed the training provided to them when they facilitated group calls.

Research assistant In this study, research assistants were employed to conduct research activities (screening candidates for study eligibility and collecting baseline and follow-up data).

Self-efficacy theory Defined by Albert Bandura as an individual's belief in his or her own capabilities to carry out actions that are required to manage future situations.

List of abbreviations

6CIT	six-item Cognitive Impairment Test
BECCA	Befriending and Cost of Caring
CI	confidence interval
CONSORT	Consolidated Standards of Reporting Trials
CTRU	Clinical Trials Research Unit
DMEC	Data Monitoring and Ethics Committee
EQ-5D	European Quality of Life-5 Dimensions
GEE	generalised estimating equation
GLM	general linear model
GP	general practitioner
GSE	General Perceived Self-Efficacy Scale
ICC	intracluster correlation
IQR	interquartile range
ITT	intention to treat
LOCF	last observation carried forward
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
PHQ-9	Patient Health Questionnaire – nine questions
PLINY	Putting Life in Years
QALY	quality-adjusted life-year
RCT	randomised controlled trial
REC	Research Ethics Committee
RNIB	Royal National Institute for the Blind
SD	standard deviation
SF-36	Short Form questionnaire-36 items
SMD	standardised mean difference
TF	telephone friendship
TMG	trial management group
TSC	trial steering committee

Plain English summary

Older people can become isolated as a result of factors such as access to transport, illness, disability or bereavement.

This study aimed to answer the question, 'Can telephone friendship (TF) improve the well-being of older people living in their own homes?' The first part of the study was a pilot. This pilot aimed to recruit ≥ 68 participants in 95 days and see whether a voluntary sector organisation could recruit enough volunteers to deliver a TF service. Only when these aims were achieved would we carry out the full study, which would require us to recruit 248 participants in a year.

General practitioners in one UK city informed people aged ≥ 75 years about the study. Participants had a 50% chance of being in the TF group and a 50% chance of being in the control group. TF consisted of short one-to-one telephone calls for 6 weeks followed by 12 weeks of 1-hour calls in groups of up to six participants. Calls were facilitated by trained volunteers. Participants were asked about their quality of life at the beginning of the study and 6 months later.

The pilot study met its recruitment targets but an insufficient number of volunteers was recruited to deliver the service. The trial closed early.

Small voluntary sector organisations may be unable to recruit, train and retain adequate numbers of volunteers to implement services for the numbers of people who might benefit. For research, these risks might be managed by using several geographical sites and by using multiple providers to recruit and manage volunteers.

Scientific summary

Background

Social isolation in older adults is relatively common and is associated with increased morbidity. Systematic reviews of randomised controlled trials (RCTs) evaluating interventions to promote socialisation and alleviate loneliness reported shortcomings in the available evidence. In 2008, the UK National Institute for Health and Care Excellence (NICE) concluded that further research on home-based interventions that could improve or successfully maintain the mental well-being of vulnerable, older people living in the community was a priority.

Objectives

The primary objective was a RCT [the Putting Life in Years (PLINY) trial] to determine whether mental well-being, as measured by the Short Form questionnaire-36 items (SF-36) health instrument mental health dimension, 6 months after randomisation, is significantly improved in participants allocated to receive the telephone friendship (TF) group intervention compared with participants allocated to a control group. A necessary precondition for the RCT was pilot work to determine whether the main RCT was feasible, based on objective targets for recruitment and retention of research participants by the study team and the capacity of volunteers working with a voluntary sector service provider to deliver the intervention. Secondary objectives included a process evaluation using qualitative methods to identify the psychosocial and environmental factors as well as implementation issues that may mediate or modify the effectiveness of the intervention. This included examining voluntary sector readiness to take forward new forms of services and the extent to which the fidelity of the intervention was maintained.

Design

This was a two-arm, parallel-group, pragmatic, superiority RCT using web-based randomisation and with only the principal investigator and the analysts blind to allocation until after the final analysis. An internal pilot was carried out to assess study and intervention feasibility. Nested qualitative research and intervention fidelity substudies were also carried out.

Setting

The study setting was one urban centre in the UK.

Participants

Between June 2011 and December 2012, 528 participants from a longitudinal cohort study and 9051 people registered with general practices were invited to take part in the trial. Information packs were also distributed across services in the city. The eligibility criteria included being aged ≥ 75 years, living independently and having reasonable cognition [attaining a score of < 8 on the six-item Cognitive Impairment Test (6CIT)]. In total, 157 participants were recruited, consented and randomised to the intervention group ($n = 78$) or the control group ($n = 79$).

Interventions

1. Manualised TF with standardised training: (a) one-to-one befriending – 10- to 20-minute calls once per week for up to 6 weeks made by a volunteer befriender – followed by (b) TF groups of six participants – 1-hour teleconferences once per week for 12 weeks facilitated by the same volunteer.
2. Control: usual health and social care provision.

Volunteers, who had no previous experience of befriending or group facilitation, were recruited by a voluntary sector service provider. Friendship groups aimed to maintain or enhance social support and increase opportunities for social interaction to maintain well-being. All volunteers were trained in group facilitation using standardised manualised content delivered by the same trainer. Volunteers modelled facilitation scenarios to learn how to provide a suitable environment for TF, manage conflict and maintain ground rules and confidentiality.

Main outcome measures

Success criteria for progression to the main trial were the recruitment of 68 participants in the first 95 days, the retention of 80% of the participants at 6 months and the successful delivery of TF by a local franchise of a national charity (not defined).

The primary clinical outcome was the SF-36 mental health dimension score at 6 months. The developers of the SF-36 have suggested that differences between treatment groups of between 5 and 10 points on the 100-point scale can be regarded as 'clinically and socially relevant'. For the original sample size calculation we assumed that a mean difference in SF-36 mental health dimension score of ≥ 8 points at 6 months post randomisation between the intervention group and the control group is the smallest difference that can be regarded as clinically and practically important. Secondary clinical outcomes included other dimensions of the SF-36 for functional health and well-being; the European Quality of Life-5 Dimensions (EQ-5D) for health status; the Patient Health Questionnaire – nine questions (PHQ-9) for self-reported depression; the General Perceived Self-Efficacy Scale (GSE) for optimistic self-beliefs about ability to cope with difficult life events; the De Jong Gierveld Loneliness Scale for overall, emotional and social loneliness; and health and social care resource use.

Barriers to implementation of the intervention were assessed using e-mail communication, trial management group meeting minutes and field notes. Views on the acceptability, accessibility and effectiveness of the intervention were obtained through semistructured interviews with older people and volunteer facilitators. Interviews were audio recorded and transcribed verbatim, with transcripts coded using NVivo 9 (QSR International, Warrington, UK) (participants) and manually (volunteers) and analysed using framework analysis.

Researchers recorded volunteer training sessions and group TF sessions in which volunteers delivered the intervention to assess the fidelity of each. The fidelity of training delivered to the volunteer facilitators was assessed in three out of the four training groups using a specially designed checklist of prescribed content. Audio recordings of 11 separate facilitated telephone discussions were sampled from four groups at three time points: weeks 1, 6 and 12 (22% of all relevant sessions). Sessions were coded independently by two researchers using a specially designed checklist of prescribed and proscribed content, with median scores calculated afterwards. Participant fidelity was assessed using a checklist of four fidelity items that assessed group members' participation in calls in terms of observing ground rules, introducing topics, showing support and showing commitment. Samples were taken from all four groups at weeks 1, 6 and 12 (three groups only).

Results

In total, 157 people were randomised to the TF group ($n = 78$) or the control group ($n = 79$). Two (out of three) success criteria for progression to the main trial were met: 70 participants were randomised in the first 95 days and 56 out of the 70 (80%) contributed valid primary outcome data 6 months later. The third criterion, successful delivery of TF, was deemed not to have been met as only 50 out of the 78 (64%) participants randomised to the intervention group received the intervention because the service provider could not recruit and retain a sufficient number of volunteer facilitators. Only 10 out of 42 (24%) potential volunteers completed training, of whom three out of 10 (30%) adhered long enough to deliver the group intervention. As a result, the trial closed early.

In the internal pilot trial, 35 people were randomised to the control group and 35 to the intervention group. Fourteen participants were excluded from the analysis because of incomplete primary outcome data, leaving 56 participants (control $n = 30$, intervention $n = 26$) in the intention-to-treat analysis.

At study closure, none of the remaining 101 participants had been followed up for long enough to contribute primary outcome data; the 56 participants from the internal pilot phase became the final intention-to-treat analysis set. The mean difference in SF-36 mental health score was 6.5 [95% confidence interval (CI) –3.0 to 16.0]; after adjusting for age, sex and baseline score the mean difference was 9.5 (95% CI 4.5 to 14.5).

During the interviews, participants mostly acknowledged that the groups were enjoyable but were beneficial for others rather than for themselves. Few technical issues with befriending were identified by participants; a minority experienced lines cutting out and confusion over who to contact when experiencing such incidents. Nine participants made positive comments about finding the groups acceptable and enjoyable, although three were frustrated that they could not see other members of the group face to face while they were speaking. Four expressed dissatisfaction with the input from other group members because of a lack of shared interests or attitudes. The remainder made fairly neutral comments, describing the intervention as useful, interesting or 'not too technical'. The groups varied in size, with members of larger groups reporting better group cohesion. Participants of groups whose numbers fell below five reported struggling to keep up a conversation for the 1-hour duration of a session. The three volunteer facilitators who completed the facilitation of the 12-week group intervention all expressed satisfaction with the role. In contrast, one volunteer who dropped out before commencing a befriending group was dissatisfied with the lack of face-to-face contact with participants. Volunteer facilitators who delivered the intervention expressed some lack of clarity about intervention procedures (e.g. procedures for closing groups) and occasional anxieties about managing group dynamics (especially conflict management), despite the training that they had received. They all reported experiencing few technical difficulties but found arranging times to make one-to-one and group calls challenging and frustrating at times. They thought that scheduling evening calls (prohibited by the teleconference provider, Community Network) would have been more successful. They reported that group calls were often interrupted by members receiving visitors while on the line. Two volunteers expressed a lack of confidence in the training and in the willingness or ability of the host charity to support them to deliver the intervention.

Training content was delivered faithfully, with > 95% of all fidelity checklist items present in two groups and > 91% present in the third group. The minimum duration of group telephone discussions sampled was 23 minutes and the maximum was 69 minutes, with a median of 55 minutes. The median intervention fidelity score of volunteer facilitators ranged from 30.2% to 52.1%, indicating that the volunteers did not facilitate the group discussions in line with the training content delivered. Two groups also showed a decline in fidelity score over the time points sampled. The most salient failings in intervention fidelity across volunteer facilitators relate to the setting of ground rules, the maintenance of participant confidentiality and the ending of each group programme, with regard to facilitating further contact between participants when desired. Three participants reported distress when the programme of

sessions was ended abruptly without proper arrangements for desired post-intervention contact between participants being properly facilitated:

> *I'm sad, I'm sad that it's stopped. Not . . . that the telephoning group stopped even, sad that that stopped I suppose but I'm sad that I'd, I'd been cut off.*
>
> *006, female*

> *Awful because I'd nothing to look forward to . . . And that was quite, quite . . . yeah I missed talking to them.*
>
> *008, female*

> *I would have liked to have stayed in touch with somebody just to ring up and say 'How are you today?'*
>
> *019, male*

> *Well, I enjoyed doing it but as I say, I was so upset when they came to a full stop.*
>
> *019, male*

Two volunteers admitted participating in, rather than facilitating, group calls and saw the training material as guidelines rather than protocol, reflecting that the technical content was more useful than that intended to help them manage group dynamics. Median fidelity scores for participants ranged from 49% to 71%.

Conclusions

The point estimates for the primary outcome and associated CIs suggest that the likely effect of the telephone befriending intervention is within a clinically relevant range and that it may be worth progressing to a full trial. However, there was no change in SF-36 mental health dimension score in the intervention group whereas the control group experienced a decline or deterioration in SF-36 mental health dimension score over the 6-month follow-up period.

The study design and protocol were found to be acceptable to participants and general practitioners; we observed no adverse events, although three participants voiced dissatisfaction with how the intervention was terminated, and the intervention seems to be safe. We were able to recruit our target sample and the attrition rate was within an acceptable range. However, we were not able to deliver the intervention as specified in the protocol, to the majority of the participants, which led to early termination of the study. Although the definitive RCT seems feasible in terms of acceptability to participants, safety and recruitment and retention, the delivery of the actual telephone befriending intervention was not feasible. Small voluntary sector organisations may not be in a position to recruit, train and retain adequate numbers of volunteers to implement new services at scale over a short time scale. A definitive trial may have to be run in more than one major population centre and include a number of voluntary sector providers and/or involve volunteer recruitment and management by specialists.

Trial registration

This trial is registered as ISRCTN28645428.

Funding

Funding for this study was provided by the Public Health Research programme of the National Institute for Health Research.

Chapter 1 Introduction

Scientific background

There is increasing evidence of a direct association between loneliness and ill health. Loneliness is a strong risk factor for depression and increases mortality rates significantly in older people with depression.[1] Research has shown that loneliness predicts all-cause mortality in older people.[2] Loneliness is associated with poor self-rated health,[3] increased blood pressure,[4] higher levels of some vascular biomarkers,[5] poor sleep quality[6] and greater likelihood of health risk behaviours.[7] Greater cognitive decline and an increased risk of Alzheimer's disease are also associated with loneliness.[1,2] Although previous reviews have considered the effectiveness of loneliness interventions in alleviating loneliness, they have not considered the link between loneliness and the wider public health factors associated with loneliness and ill health, for example health inequalities. With such major impacts on health, an understanding of what, how and why public health interventions prevent or alleviate loneliness in older people is critical. Overall, health and life expectancy are linked to social circumstances. Older people are socially excluded when they experience economic and material deprivation and/or lack access to social networks, services and activities.[7] Therefore, social exclusion can impact on loneliness, which in turn can impact on mental and physical health. Thus, loneliness may mediate the pathway between social inequalities and health inequalities.

The number of older people is increasing globally. In the UK, > 17% of the population is aged ≥ 65 years and this is predicted to rise to 20% by 2024. Life expectancy is also increasing and now stands at 78.1 years for men and 82.1 years for women. The number of older people living alone is currently rising. Among women aged ≥ 75 years, 60% live alone.[8] One of the risk factors for loneliness is living alone, although this may be linked to the time spent alone and the size of an individual's social network.[9] Loneliness is frequently reported by people living in rented accommodation and in single dwellings, particularly if they have been forced into the situation as a result of widowhood or divorce.[10] Social breakdown, inadequate systems to support older people and lack of infrastructure to maintain social networks can lead to loneliness and social exclusion.[11] Older people are at greater risk of enduring loneliness, because of a reduction in personal and external resources available to them. Between 30% and 40% of older people are sometimes or often lonely,[12] and this figure has remained fairly constant for the past 40 years. With the increase in the number of older people, the actual number experiencing loneliness is therefore increasing. Loneliness can occur as a result of one or more event or it can be chronic and made worse by transition into old age. Events that can cause loneliness include loss and bereavement, widowhood, migration and perceived and actual poor health, whereas other risk factors for loneliness include lack of resources, living alone and time spent alone.[12] Physical limitation through loss of mobility and/or sensory impairment is the largest single predictor of loneliness.[13] The prevalence of visual impairment increases exponentially with age, with > 50% of visually impaired older people feeling lonely.[14] With such overwhelming evidence of the societal costs of loneliness, a wide range of interventions has been developed to prevent and/or alleviate loneliness in later life.

Social isolation and loneliness have long been identified as being problems associated with later life. According to Age Concern England,[15] many of Britain's older people are living in isolation, with those aged > 65 years being twice as likely as other age groups to spend > 21 hours of the day alone. Mental illness, low morale, poor rehabilitation and admission to residential care have all been found to be correlated with either social isolation or loneliness or both.[16] Six independent vulnerability factors for loneliness have been identified: marital status, increases in loneliness and time alone over the previous decade, elevated mental morbidity, poor current health and poorer health in old age than expected.[17] In response to research gaps highlighted in National Institute for Health and Care Excellence (NICE) guidance on interventions to promote mental well-being in older people,[18] this study was funded to provide evidence of population benefit of one home-based intervention that aims to improve the mental well-being of community-living older people who may be vulnerable.

Over the last decade there has been a continued focus on the value of providing health-promoting interventions to older people with the aim of compressing morbidity in the later stages of the life course and promoting quality of life.[7,15,18–21] This is supported by robust evidence that has demonstrated the relationship between extent of social activity and morbidity and mortality.[22] The NICE guidance on interventions to promote mental well-being[18] was underpinned by a systematic review of the evidence of effectiveness and cost-effectiveness of interventions.[21] However, the evidence to support the introduction of many interventions in practice, and particularly those that aim to promote socialisation and alleviate loneliness, is lacking.[8,10] A systematic review[23] of research into interventions that aim to promote socialisation identified 11 studies with sufficiently robust findings out of 30 that met the review inclusion criteria, with the majority of studies originating from North America. Despite the methodological challenges that this review posed, the review was able to identify that the most effective interventions were those conducted in a group with educational and/or supportive input. Only one study showed that benefit could be derived from one-to-one interventions. Further to this, Cattan *et al.*[24,25] conducted an evaluation of eight schemes that participated in the Call in Time initiative, promoted through Help the Aged (later to merge with Age Concern to become Age UK), a national charity, and Zurich Community Trust. The results of the evaluation found that telephone befriending can provide a vital lifeline in helping older people who spend a lot of time in their home to regain confidence and increase their levels of engagement and participation. However, older people in the study also emphasised a desire for choice in the types of support services on offer, including face-to-face contact and peer support. A recommendation from the study was therefore for a model that, in addition to one-to-one telephone support, included scope for developing peer support through telephone clubs. This recommendation echoes that given in earlier work conducted in North America.[26] The Foresight report[27] also notes that there is a strong case for giving priority to research that assesses the potential use of technologies through the life course, and their impact on individuals; an example cited is social networking for older adults (p. 248).

Rationale

The Putting Life in Years (PLINY) trial was designed to evaluate the effectiveness and cost-effectiveness of a 12-week, telephone-delivered, group intervention based on de Jong Gierveld's loneliness model[28] and Bandura's theory of self-efficacy,[29] and delivered by the voluntary sector. The intervention was designed to include a number of short one-to-one telephone calls with a trained volunteer with the purpose of introducing participants to the concept of group telephone calls. Participants received all calls in their own home using their existing equipment and were connected to their volunteer and group participants via the Community Network's teleconferencing system. The intervention was based on recommendations in the work by Cattan *et al.*[24,25] All interventions were delivered by trained volunteer facilitators whose competence was assessed using a treatment fidelity framework to evaluate whether delivery was consistent.[17]

Funding for intervention delivery was provided by Age UK (national), the national charity formed from Age Concern and Help the Aged in 2009. There is a network of independent Age UK and Age Concern branches across England. One of these, hereafter the service provider, agreed to recruit and manage the volunteers necessary to deliver the intervention. Community Network provided the infrastructure to enable participants and their volunteer to be joined together by telephone. Community Network is a national charity working with local, regional and other national charities to help connect people who may experience social isolation.

Chapter 2 Methods

Methods for the implementation of the intervention

To understand the course of this study and its outcomes it is necessary for the reader to have a clear sense of how the intervention was implemented. For this reason, before presenting the main trial results (see *Chapter 3*), we provide a narrative summary of the barriers to intervention implementation. Statements are supported, when possible, by e-mail communication, trial management group (TMG) meeting minutes and field notes.

Methods for the main trial

This report is concordant with the extension of the Consolidated Standards of Reporting Trials (CONSORT) statement to improve the reporting of pragmatic trials.[30] This is a pragmatic two-arm parallel-group randomised controlled trial (RCT) with a feasibility phase. Formal stop–go criteria were established to assess the feasibility of the trial: (1) sufficient participants willing to enter the trial and (2) retention of sufficient participants to assess the primary outcome measure. The final study protocol can be found in *Appendix 1*, along with a table of changes made to the protocol over the course of the project, which were approved by South Yorkshire Research Ethics Committee (REC).

Participants

Two main methods were used to identify potentially eligible study candidates. We worked with an existing research cohort that is following the lives of 20,000 adults in the area over a period of 10 years and includes individuals who have signalled a willingness to be contacted about further research. Between June 2011 and July 2011 we sent letters with a postage-paid response card and a candidate leaflet to 528 participants in the cohort aged ≥ 75 years. We also invited general practices to help identify potentially eligible study candidates. Between June 2011 and December 2012, 18 general practices sent letters to 9051 patients. The letters included the same candidate leaflet and an invitation to complete a postage-paid response card to express an interest in the study. Response cards were returned to the recruiting site (University of Sheffield, Sheffield, UK).

A pack containing the same candidate leaflet and postage-paid response card was also given to workers in services across the city that were likely to come into contact with older people with the aim of asking them to identify potential participants. In many instances, researchers personally delivered packs and spent time with workers explaining the aims of the study and what it entailed. The Community Intermediate Care Service (NHS) was provided with 500 packs, the city council's main library received 50 packs and the mobile library service received 200 packs. In addition, two A3 and 30 A4 posters were provided for display. The Community Access and Reablement Service (CARS) was given 100 packs and the local Meals on Wheels service received 120 packs. In addition, 200 packs were given to an extra care scheme (housing with care services available if or when required), a local housing association and the local churches council for community care. Research assistants distributed 200 packs at community events in the locality including a Lifewise event, Regenerate RISE (Reaching the ISolated Elderly) and a local well-being festival (150 packs). Two referrer information sheets and 100 packs were sent to the Allied Healthcare Group; one referrer information sheet and a study leaflet were sent to the Older People's Partnership Board and distributed to its network (22 May 2012); and five packs each were given to nine Healthy Living Pharmacies.

An unknown number of packs was also sent to relevant public and voluntary sector outlets: the local Expert Elders Network, the local Pensioners Action Group, the local Wellbeing Consortium, Age Well, a victim support group, an older adults community mental health team and a black and minority ethnic community mental health development worker.

Information about the study was circulated to local community and media outlets including the city council's Help Yourself web page and the local newspaper.

Research assistants telephoned all potential candidates who had returned a response card. A number of candidates telephoned the research team directly. Research assistants checked initial eligibility during the telephone call, for example age and living situation. Research assistants arranged to visit those who were identified as being potentially eligible and interested in finding out more about the study. Appointments were arranged approximately 5 days after the telephone call to allow sufficient time for the candidates to receive and read the Participant Information Sheet, which was posted out (or e-mailed on request) by the research assistants. The Participant Information Sheet was reviewed by the lay representative on the TMG as part of the submission of essential documents to the REC. Research assistants visited potentially eligible candidates in their own home to conduct a screening visit. Those eligible to join the study were aged ≥ 75 years; had good cognitive function, defined as having a six-item Cognitive Impairment Test (6CIT) score of ≤ 7; were living independently (including those who were co-resident with others) or in sheltered extra care housing; and were able to understand and converse in English. The exclusion criteria were (1) the inability to use a telephone effectively with appropriate assistive technology; (2) living in a residential/nursing care home; and (3) already receiving a telephone intervention.

Written informed consent was obtained by research assistants either at the screening visit or at a separate visit if additional time was required to make a decision whether or not to participate. Research assistants administered the 6CIT and calculated the score during the visit. Candidates who were ineligible because of a 6CIT score > 7 were subsequently contacted by a clinically qualified member of the research team and told that they were not eligible to be involved and advised to contact their doctor. A letter containing the score was sent to the candidate. For candidates who were eligible, the research assistant taking consent and administering the baseline questionnaires informed another member of the research team (research assistant or trial manager) of the screening identifier so that they could randomise and inform participants of their allocation. On allocation, and before they were contacted by a volunteer, participants allocated to receive telephone friendship (TF) were sent a 'question and answer' document about TF groups by the research team (see *Appendix 2*) and were advised that the service provider's volunteer would contact them. The research assistants or the study manager informed the service provider of intervention participants by letter. Initially, this was carried out each time a participant was allocated to receive TF. However, the research team and the service provider subsequently agreed to wait until six participants (sufficient to make a group) had been allocated before forwarding details to the service provider.

Participants were able to withdraw from active participation in the study on request. Individuals who withdrew from the intervention were not replaced. Written consent was obtained to share information with the NHS Health and Social Care Information Centre and other central UK NHS bodies to check participants' health status and help minimise the risk of telephoning or writing to participants who died before follow-up. Both study arms received postal updates on the study at 2 and 4 months after randomisation.

Interventions

The intervention design is detailed in *Appendix 3*.

Candidates were screened as described in the previous section. Those who consented were randomly allocated to one of two groups (see *Randomisaton and blinding*):

1. TF group calls provided through the voluntary (charitable) sector
2. a control group who received usual health and social care following randomisation.

The aim of the intervention was to increase contact between individuals with the intention of forming new acquaintances and friendships. By improving perceptions of companionship and support the aim was to reduce perceived isolation and improve participants' sense of confidence and mental well-being.

The intervention was designed by MC and built on the findings of a previous study which suggested that group calls, following one-to-one befriending, may help older adults to share interests.[24,25]

The interventions were delivered by trained volunteer facilitators. Volunteers were recruited by the service provider. Volunteers had no previous experience of protocolised befriending or facilitating conversations, either face to face or by telephone.

The one-to-one individual intervention consisted of up to six calls between each participant and a volunteer befriender. The purpose of the one-to-one calls was to support the participant and prepare him or her for the group conversations. One-to-one calls were brief (10–20 minute) friendly conversations that were held each week for a duration of 6 weeks, beginning with familiarisation and everyday conversation and moving towards a focus on the group calls including topics of interest and supporting the participants with concerns about starting group sessions. Volunteer befrienders telephoned participants using the Community Network's teleconferencing system. Although not designed for one-to-one calls, the use of the system enabled cost-free calls for participants and volunteers. A detailed description of the training is provided in *Appendix 4*.

Roles and remit of the service provider and Community Network

Implementation meetings of between 1 and 2 hours were held with the service provider or its delegates (the volunteer co-ordinators) every 2–4 weeks between 20 October 2011 and 16 January 2013. The same individuals from the service provider and representatives of Community Network also attended the monthly TMG meetings, at which the perspectives of members of the public about process and documentation were also elicited. At implementation meetings the trial manager provided advice, guidance and additional documentation as required to the volunteer co-ordinators. E-mail and telephone communication was also frequent, including reminders about training date cut-offs and suggestions for promoting the volunteer opportunity to charities and community groups in the city and within the university. The trial manager attended all but one volunteer induction session and all one-to-one training sessions. The chief investigator initiated the meetings with the service provider and attended implementation meetings on request.

A worker from the service provider was responsible for recruiting all volunteers and provided an induction to the organisation, including the provision of information on issues facing older people and shadowing paid workers in day centres. Those who were deemed to be appropriate for the telephone befriending role were then trained by the same member of staff to make the one-to-one calls in accordance with the training manual (see *Appendix 4*) before progressing to the group training. Volunteers received group facilitation skills training by telephone. The training lasted 4 hours in total and was delivered in 1-hour sessions over the telephone by a professional trainer who delivers training on behalf of Community Network. Training groups were designed to consist of a maximum of five trainee facilitators and the trainer. However, this was difficult to fulfil for this study (see *Chapter 3*, *The contract with the service provider*). Group training included how to run groups in a style conducive to creating group cohesion and promoting a safe environment for participants. Volunteers were told that assisting the group to be self-sustaining if possible was an important goal. The trainer from the service provider also committed to offer volunteers ongoing mentoring. The contract with the service provider subsequently included an agreement for volunteer mentoring but did not specify its type and frequency.

Table 1 summarises the facilitation skills training content. Detailed information is provided in *Appendix 4*.

The group intervention consisted of 12 weekly telephone calls facilitated by the trained volunteer at a prearranged time each week, as agreed between members and the volunteer facilitator. Community Network provided the teleconferencing facility, which involved the volunteer facilitator booking the time/date of group calls in advance. The operator called the volunteer facilitator first and then each participant in turn at the prearranged time. TF groups ideally involved six participants and one volunteer facilitator. Group telephone discussions were designed to last about 1 hour to allow sufficient time for sharing

TABLE 1 Telephone facilitation skills training and session structure

Session 1	Session 2	Session 3	Session 4

• Role of the facilitator
  ○ change from directive to monitoring the group
• Listening
  ○ attention
  ○ assumptions
	• Groups – how they work
	  ○ level of need (task, group, individual)
	  ○ group maintenance practice (e.g. creating a safe environment)
	• Groups – how they develop
	  ○ stages of development
	  ○ signs the group is performing well
	• Using questions
	  ○ types of questions
	  ○ when to use questions
		• Handling conflict
		  ○ signs of conflict
		  ○ when to intervene (e.g. triggers)
		  ○ ways to intervene
			• Professional and ethical practice
			  ○ data protection
			  ○ confidentiality
			  ○ equal opportunities
			  ○ record keeping and note taking
			  ○ time keeping

experiences and interests and talking about everyday life. Participants were able to contact Community Network and/or the TF group service provider if they would not be taking part in a call. The purpose of the group discussions on the telephone was to increase social contact and reduce perceived isolation. The intervention was not designed to actively instil major behaviour change. Technical and procedural strategies covered by the facilitation skills training were based on psychological models for how groups develop and how facilitators should run groups in a style conducive to creating group cohesion that provides a safe environment for achieving underlying quality of life goals of the intervention, such as to 'review life experiences'.[31] Volunteer facilitators were instructed about circumstances in which they should intervene to retain a safe environment, for instance if there was conflict or if the ground rules of the group were broken. Volunteer facilitators were present to make the work of the group 'easy' and to allow the group to be self-sustaining if possible.

Participants randomised to the control arm did not receive any study intervention. However, they did participate in the baseline and outcome measurements and the extent of their health and social care service usage was assessed (as for all participants).

Objectives

The primary objective of the main study, a parallel-group RCT, was to determine whether mental well-being, as measured by the Short Form questionnaire-36 items (SF-36) (mental health dimension) 6 months after randomisation, is significantly increased in participants allocated to receive the TF group intervention compared with participants allocated to a control group (receiving only contact by card/letter at months 2, 4, 8 and 10 with no further contact other than follow-up assessment).

Secondary objectives were to:

1. Identify, using qualitative methods, the psychosocial and environmental factors, as well as implementation issues, that may mediate or modify the effectiveness of the intervention, specifically voluntary sector readiness to take forward new forms of services, the best modes of delivery of telephone support/friendship, how volunteers (facilitators) can be supported and retained, and the extent to which fidelity of the intervention is maintained within and across the participating organisations.
2. To determine any lasting impact on mental well-being by repeat measurement with all participants 12 months after baseline assessment.

3. To examine whether there is any significant improvement in the intervention arm compared with the standard care arm in the physical dimension of the SF-36 at 6 months and 12 months following baseline assessment.
4. To measure the extent of use of health and social care and community facilities by participants over time to determine whether the intervention is cost-effective compared with standard care.

Outcomes

Table 2 shows the timing of the assessments and interventions. All baseline assessments and interventions were carried out in participants' homes using the case report form (see *Appendix 5*). Follow-up assessment at 6 months post randomisation was carried out by telephone (unless a home visit was indicated).
The primary end point was the level of mental well-being at 6 months post randomisation using the SF-36 mental health dimension. Secondary end points were:

1. other dimensions of the SF-36 to measure all aspects of health including physical health[32]
2. the Patient Health Questionnaire – nine questions (PHQ-9)[33]
3. the European Quality of Life-5 Dimensions (EQ-5D) score (for health economic analysis)[34]
4. the General Perceived Self-Efficacy Scale (GSE) score[35]
5. the de Jong Gierveld Loneliness Scale score[36]
6. Office for National Statistics (ONS) well-being measure[37]
7. a health and social care resource use questionnaire to collect participants' use of health, social care and community services (for health economic analysis).[38]

All primary and secondary outcomes were measured at 6 months post randomisation.

TABLE 2 Timing of assessments and interventions

Assessment/ intervention	≈Minus 2 weeks	≈Minus 1 week	Baseline	2 months	4 months	6 months	8 months	10 months	12 months
Study promotion text/referrer information sheet	✓								
Invitation letter		✓							
Response card/first contact form		✓							
Initial screening		✓							
Participant information sheet		✓							
Screening visit		✓							
Cognitive impairment test (6CIT)		✓							
Consent form			✓						
Baseline questionnaires			✓						
Randomisation			✓						
TF group questions and answers (intervention)			✓						
Contact card/letter				✓	✓		✓	✓	
Follow-up questionnaires						✓			✓

Sample size

For the purposes of sample size estimation the primary outcome was the mean SF-36 mental health dimension score at 6 months post randomisation. The SF-36 mental health dimension is scored on a scale from 0 (poor) to 100 (good health). A previous general population survey of residents demonstrated that the SF-36 can successfully be used as an outcome measure for community-dwelling residents aged ≥ 75 years, with a response rate of 82% being achieved.[39] From this general population survey of 3084 community residents, the mean SF-36 mental health score was 68.3, with a standard deviation (SD) of 19.9.[39]

The developers of the SF-36 have suggested that differences between treatment groups of between 5 and 10 points on the 100-point scale can be regarded as 'clinically and socially relevant'.[40] We assumed a SD of 20 points for the SF-36 mental health dimension at 6 months post randomisation and that a mean difference in mental health score of ≥ 8 points between the intervention group and the control group is the smallest difference that can be regarded as clinically and practically important.

Assuming that a mean difference of ≥ 8 points on the SF-36 mental health dimension between the intervention group and the control group is the smallest difference of clinical and practical importance that is worth detecting, then with 248 subjects (124 intervention, 124 control) the trial was originally determined to have 90% power to detect this mean difference or greater as statistically significant at the 5% (two-sided) significance level using a two independent samples *t*-test. We assumed a correlation of 0.50 between the baseline and the 6-month SF-36 mental health scores. However, the telephone befriending intervention is a group or facilitator-led intervention. Therefore, the success of the intervention may depend on the volunteer facilitator delivering it so that the outcomes of the participants in the same group with the same volunteer facilitator may be clustered. We therefore assumed an average cluster size of six participants per telephone befriending group and an intracluster correlation (ICC) of 0.04 so the design effect is 1.28. With these assumptions and 99 participants per group, the power of the analysis was reduced to 80% to detect a mean difference of ≥ 8 points in the 6-month SF-36 mental health score. If 20% of the participants drop out and are lost to follow-up then we would have needed to recruit and randomise 124 participants per arm (248 in total).

Randomisation and blinding

Eligible participants were randomised to one of the two arms by the trial manager or a research assistant through a centralised web-based randomisation service provided through the Clinical Trials Research Unit (CTRU). The randomisation sequence was generated in advance by a CTRU statistician, not by the trial team. There were no stratification factors in the randomisation sequence. A sequence of treatment/intervention assignments was randomly permuted in blocks of varying size to ensure that enough participants were allocated evenly to each arm of the trial. Participants, outcome assessors and the trial manager were not blind to treatment allocation because of the practical nature of the intervention. All outcomes were self-reported using validated questionnaires (except for sociodemographics and health and social care resource use, which were assessed using bespoke instruments). Trial statisticians and the principal investigator were blinded to the treatment allocation codes until after the final analysis. Data presented to the trial steering committee (TSC) and the TMG did not identify treatment allocations.

Statistical methods

Analysis population

The intention-to-treat (ITT) data set included all participants who were randomised during the time period when participants were able to receive the intervention (ignoring any occurrences post randomisation such as protocol or treatment non-compliance and withdrawals). This included participants randomised on or before 30 September 2012, plus one participant (R1/081) randomised after this date (who received the intervention because another participant dropped out before receiving the intervention), and followed up for 6 months. Participants randomised to the intervention from October 2012 onwards (with the exception of R1/081) did not receive the intervention because there were not enough volunteers to deliver it. No attempt was made to follow up participants recruited in this time period and they did not form part of the outcome analyses.

The SF-36 mental health dimension data were defined as complete if at least half of the items that make up the mental health dimension score were available. The mental health dimension is made up of five items/questions from the SF-36 questionnaire; if at least three of these items were available then the participant was defined as having complete SF-36 mental health dimension data (see the following section for a description of missing data).

A per-protocol data set was defined as all participants in the control group and participants in the intervention group who completed ≥ 75% of the group telephone calls over the 12 weeks of the group intervention (the one-to-one telephone calls with a volunteer were not included in the definition of 'per protocol'). This means that, if a TF group completed 12 group telephone calls, individuals were part of the per-protocol data set if they were present for the duration of nine or more of the calls. Sensitivity analysis on the per-protocol data set was performed.

As a pilot study the main trial analysis was largely descriptive and focused on confidence interval (CI) estimation and not formal hypothesis testing. Rates of consent, recruitment, adherence and follow-up by randomised group are reported. Outcome measures are summarised by randomisation group. Data from the pilot study are used to estimate the variability of the continuous outcome (SF-36) in the trial population. As the intervention is volunteer led we also used the data to estimate the ICC. As part of the pilot analysis we estimated the effect size for the 6-month SF-36 mental health outcome with CIs to check whether or not the likely effect was within a clinically relevant range.

Handling incomplete telephone call data or missing measurements

Missing items in the SF-36 mental health dimension were imputed with the mean of the complete items in that dimension, given that at least half of the items in the mental health dimension are completed. If half or more of the items were missing (i.e. three or more) then the mental health dimension score was not calculated. For sensitivity analysis, imputation was used to obtain complete 6-month SF-36 mental health dimension data. Missing data were imputed using three methods: last observation carried forward (LOCF), regression and multiple imputation. The primary analysis was repeated for these imputed data sets and displayed alongside the ITT analysis results.

Statistical analysis

Baseline characteristics

The baseline and sociodemographic characteristics and person-reported outcome data (SF-36, PHQ-9, EQ-5D, GSE, de Jong Gierveld Loneliness Scale, 6CIT) were summarised and assessed for comparability between the TF group and the control group.[41–43] Age and SF-36, PHQ-9, EQ-5D, GSE, de Jong Loneliness Scale and 6CIT scores were presented on a continuous scale. For these continuous variables, summary statistics such as the minimum, maximum, mean, SD, median and interquartile range (IQR) were presented depending on the distribution of the data. Numbers of observations and number and percentage in each category are presented for categorical variables (e.g. sex and ethnicity). All of these summaries are presented by treatment group and overall and are assessed for comparability. No statistical significance testing has been carried out to test baseline imbalances between the arms but any noted differences are reported descriptively.[44,45]

Data completeness

Data completeness is summarised in a CONSORT flow chart, from participants' enrolment, during follow-up and at the close of the trial. Data completeness is based on the primary outcome (SF-36 mental health dimension score) and having a valid measurement at 6 months post randomisation.

Effectiveness analyses

The mean SF-36 mental health dimension score was compared between participants allocated to receive the TF group intervention and participants allocated to the control group using a marginal general linear model (GLM) with robust standard errors, and an exchangeable correlation.[46] The marginal model

used generalised estimating equations (GEEs) to estimate the regression coefficients. The intervention is a group-based intervention with each group led by a single volunteer facilitator. The statistical analysis allows for the possibility that there may be clustering or correlation of the participants' outcomes within the same telephone befriending group. Participants in each telephone befriending group were regarded as a cluster in the analysis. Participants in the control group were treated as a cluster of size one in the analysis. The exchangeable correlation assumes that individual outcomes in the same cluster (TF group) have the same correlation. A 95% CI for the difference in SF-36 mental health dimension scores between the intervention group and the control group is also reported. An adjusted analysis was performed alongside this unadjusted analysis, which included the potential baseline prognostic covariates of age, sex and baseline SF-36 mental health dimension score in the marginal GLM. The inclusion of baseline covariates was informed by the investigation of baseline imbalance and previous research, which suggested that health-related quality of life varies by age and sex.[39] The mean (SD) SF-36 mental health dimension scores for the treatment and control groups and the number in each group were displayed. This was accompanied by the adjusted and unadjusted mean difference between the intervention group and the control group with the associated CIs (see *Table 2*).

Analysis of secondary outcomes

The remaining SF-36 dimensions (physical functioning, role – physical, bodily pain, general health, vitality, social functioning and role – emotional) were computed and rescaled in the same manner as the mental health scale described in the previous section. The two component scores (physical component summary and mental component summary) were also computed and normalised using data from US norms.[32] The PHQ-9 is calculated as the total score of the nine questions; each is scored from 0 to 3, giving a total score in the range 0–27. The total was calculated only if all nine questions were answered. Two measures for the EQ-5D were analysed:

1. The EQ-5D tariff, derived from five three-level questions using UK norms.[34] The tariff was calculated only if all five questions were answered.
2. The single-item EQ-5D 'thermometer' scale.

Three measures from the de Jong Gierveld Loneliness Scale were analysed:

1. Emotional loneliness: this is calculated from questions 2, 3, 5, 6, 9 and 10 and is the number of items scored 'yes' or 'more or less'. It is scored from 0 to 6 and is defined only when all six questions are answered.
2. Social loneliness: this is calculated from questions 1, 4, 7, 8 and 11 and is the number of items scored 'no' or 'more or less'. It is scored from 0 to 5 and is defined only when all five questions are answered.
3. Overall loneliness: this is the sum of the emotional and social loneliness scores. It is defined when 10 or 11 of the questions are answered.

The GSE is the sum of 10 questions, each of which is scored from 1 to 5, giving a total score in the range 10–50. It is defined when at least seven of the 10 questions are answered; if < 10 are answered, the revised total is given by GSE = total × (10/number of questions answered).

Secondary outcomes (other dimensions of the SF-36, PHQ-9, EQ-5D, de Jong Gierveld Loneliness Scale, GSE) at 6 month post randomisation were compared between the intervention group and the control group using a marginal GLM with robust standard errors and exchangeable correlation with and without adjustment for baseline covariates. The means and SDs (and numbers used for each calculation) for the treatment and control groups with adjusted and unadjusted mean differences and associated CIs are reported.

Estimates of the critical parameters that would be used for a sample size calculation (SD, correlation between baseline and 6-month outcomes and the ICC) are also reported.

Economic analysis

The case report form (see *Appendix 5*) included questions about the use of primary and secondary care health services, social care services and voluntary and private sector services.

The following elements were planned for the health economics analysis:

1. Costing of the TF service.
2. Costing of participants' health, social care and voluntary service use during the trial.
3. Cost-effectiveness analysis using a range of outcome measures and a cost–utility analysis using the EQ-5D. The resulting cost per quality-adjusted life-year (QALY) would be compared with the NICE threshold of £20,000–30,000 per QALY gained.
4. An exploratory analysis of participants' willingness to pay for a TF scheme.

Because of the early closure of the trial for reasons outlined in *Chapter 4* (see *Assessment of study feasibility*), a high proportion of participants allocated to the intervention arm did not receive the intervention and it was therefore not appropriate to conduct the planned health economics analysis. Frequency tables for participants' service use are presented in *Chapter 4* (see *Health and social care resource use*); differences between the intervention group and the control group at follow-up should be interpreted with caution.

Methods for the qualitative research

Background

This report is concordant with Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines for reporting qualitative research.[47] The purpose of the qualitative research was to evaluate the impact of TF groups on older people as well as their perceived advantages and disadvantages in terms of well-being. The objective was an assessment of the acceptability and appropriateness of the intervention for preventing loneliness and maintaining good mental health. Some aspects of the fidelity assessment (e.g. views on the receipt and enactment of the intervention) were also informed by the qualitative research (see *Methods for the fidelity assessment*).

Methods for the participant interviews

The aim of the qualitative research was to explore to what extent older people considered TF groups to have made an impact on their well-being. A topic guide (see *Appendix 6*) was used to undertake semistructured interviews. This was based on a previous study[25] and was tailored by MC and RG-W in line with the secondary end points for the trial. The topic guide was not piloted but was reviewed by the lay representative on the TMG as part of the review of essential documents submitted for ethical approval.

The topic guide covered questions regarding participants' needs and expectations of telephone befriending, its impact on their health and well-being and accessibility and acceptability of the telephone discussion. It also inquired after participants' experiences of the volunteer facilitator and whether they felt that the telephone discussions were or were not a good way to give them the support that they needed.

All participants allocated to the telephone befriending intervention and provided with a volunteer facilitator were invited (by telephone) to participate in a semistructured interview (24 individuals). We interviewed all 19 participants who volunteered to take part. Reasons for declining a research interview were not elicited but were recorded if volunteered by the participant. One female research associate (RG-W) and one female research assistant (RD) performed the interviews in April 2013. RG-W had studied qualitative research techniques as part of her MA in Research Methods and had experience of in-depth and semistructured interviews. RD had experience of qualitative interviews but was a novice in terms of qualitative analysis. Neither of the interviewers delivered the intervention to the interviewees. RD visited some interviewees to collect baseline data and/or collected 6-month follow-up data by telephone for the

main trial. Interviewees would have known that the interviewers were on the research team and were from the University of Sheffield and may have associated them with the volunteers delivering the intervention and/or with delivery of the intervention. The interviewers were asked to withhold their own opinions, personal goals and characteristics and to reiterate the purpose of the research and that this interview was separate from the intervention. No repeat interviews were undertaken or field notes taken.

The interviews lasted between 14 and 63 minutes (median 29 minutes) and were conducted face to face in a place selected by the participants. All were conducted in participants' homes. Written consent for audio recording was obtained when participants entered the study. For all but three interviews no one was present except for the participant and the researcher. Three interviews were interrupted by (1) a participant's daughter (bringing a drink), (2) a participant's cleaner and (3) a visitor. Sociodemographic data were collected from participants as part of the main trial and are reported in *Chapter 4*. Interviews were digitally recorded and transcribed verbatim. Transcripts were not returned to the participants for comment or correction.

Data analysis commenced during the data collection period using a constant comparative method to identify themes and where interviews and analysis each informed the other. Data analysis of the transcripts was conducted using NVivo 9 (QSR International, Warrington, UK). We used a 'framework' approach to analysis in which a priori and emergent themes were identified using the following stages: familiarisation, identifying a thematic framework, indexing, mapping and interpretation (charting was not undertaken).[48] A priori themes of interest were acceptability and accessibility of the group telephone discussion; subthemes were derived inductively through familiarisation with the transcripts.[48,49] Results were used to explore factors that may have mediated and moderated the intervention and contributed towards the findings of the trial and to identify any other emerging issues or factors that may have influenced the uptake of the intervention and which had not previously been documented.[50] It is unlikely that data saturation was achieved.[51] Participants were not asked to provide feedback on the identified themes.

Initially, we indexed transcripts using our own thematic framework (see *Appendix 7*); this was later supplemented with codes based on concepts from the group dynamics literature, relating to characteristics of functioning groups, specifically group cohesion and disclosure.[31]

Methods for the volunteer interviews

The aim of the qualitative research was also to explore the experiences of volunteer facilitators in delivering the intervention. A semistructured topic guide was used with themes including the accessibility and acceptability of delivering befriending by telephone and the motivations of volunteers to take part and their experiences of facilitating group discussions, including their perceptions of participant benefit. All volunteers who remained in contact with the service provider were invited to take part in a semistructured interview. This included volunteers who dropped out before, mid and post completion of facilitator training, resulting in a sample of three. Two had completed the one-to-one and group telephone call phases of the intervention and one dropped out during the group facilitator training. We did not elicit reasons for declining an interview. RG-W performed the interviews in April 2013 and had a previous relationship with all volunteers having attended volunteer induction and one-to-one training sessions to support the service provider (by request). Interviewed volunteers knew that the interviewer was on the research team and from the University of Sheffield and not from the service provider. The interviewer was asked to withhold her own opinions and to reiterate the purpose of the research and that the interview was separate from the intervention and the service provider. No repeat interviews were undertaken or field notes taken.

The interviews lasted between 18 and 59 minutes (median 43 minutes) and were conducted face to face in a place selected by participants. Two interviews were conducted at the home of the volunteers and one was conducted at the University of Sheffield. For all interviews no one was present except for the participant and the researcher. Sociodemographic data were not collected for volunteers. A topic guide (see *Appendix 6*) was used. This was based on the secondary end points of the study and was informed by some elements of the fidelity framework, for instance whether the group experienced conflict or followed ground rules (see *Methods for the fidelity assessment*). The topic guide was not piloted.

Interviews were digitally recorded and transcribed verbatim. Transcripts were not returned to the participants for comment or correction. Data analysis of transcripts was conducted by RG-W by hand using a constant comparative method to identify themes. Analysis and interpretation followed relevant themes from the qualitative research framework developed from the participant interviews (see *Chapter 5*, *Results of the participant interviews*). Results were used to explore potential explanations for the quantitative findings and identify other emerging issues or factors influencing volunteer-led interventions. The final outcome was a synthesis of coded data and subthemes including those relevant to the fidelity assessment.

Methods for the fidelity assessment

The importance of describing complex interventions and actual content delivered is well established.[52,53] The fidelity substudy assessed how well the TF intervention was delivered according to the intervention protocol. An intervention fidelity framework based on that identified by the Behaviour Change Consortium[54] was developed (see *Appendix 1*). The framework sets out the parameters by which quality and fidelity would be measured, under the headings of study design, training, delivery, receipt and enactment.

Telephone befriending design

To assess comparable 'treatment dose', the number, frequency and duration of one-to-one and group telephone contacts were established. The minimum number of one-to-one contacts was recommended as three on the basis that some participants would need more one-to-one contacts to be sufficiently confident to join the group discussions. A maximum of six one-to-one contacts was set. A maximum of 12 group telephone contacts was established and a minimum (in terms of treatment dose) was set at nine (of 12) group calls. The frequency of all telephone contact was weekly.

Telephone befriending training content assessment and methods

Volunteers were trained by Community Network's group facilitation skills trainer. Attendance at training sessions was monitored by register taken by the single trainer who trained all volunteer facilitators. The training was delivered over the telephone to a number of trainees (maximum five) over four 1-hour sessions. The session content focused on providing skills and techniques to enable the facilitator to support the group to work well as a group and fulfil its purpose (see *Methods for the main trial*, *Interventions*).

The trial manager (RG-W) developed a fidelity checklist based on the standard training delivered to all volunteers who facilitate telephone discussion via the Community Networks' teleconferencing system. This was reviewed by the content expert (MC) and the Community Network trainer to ensure that core components were included and that materials and practice delivered by the trainer could be assessed for consistency across groups. The checklist also included components to assess volunteer facilitator skill acquisition. The checklist was piloted by RG-W and MC using a sample of audio recordings, with modifications made where necessary (see *Appendix 8*, *Training content checklist*).

A purposive sample of training sessions was audio recorded across and within the training groups. RG-W and a research assistant (LN) used the training content checklist to assess the content and delivery techniques conveyed to trainee (volunteer) facilitators and facilitator skill acquisition. Checklists were completed and scored separately by the two coders and scores were compared. All scores were reviewed to ensure consistency in interpretation of the checklist items, with areas of dispute discussed and agreement reached by consensus. When agreement could not be reached the original observations, and therefore scores, remained the same. Median scores were calculated to provide an overall fidelity score for each training group and show the degree of consistency in the content delivered to trainee facilitators.

Treatment fidelity assessment and methods

To ensure that the criteria for treatment fidelity were met, those delivering the group befriending intervention (volunteer facilitators) were assessed for adherence to the intervention protocol across the 12 weeks. The assessment of treatment fidelity by volunteer facilitators used an intervention delivery

checklist developed by RG-W based on the techniques delivered in the facilitator skills training and on a one-to-one training manual provided to volunteers (see *Appendix 4*). The training fidelity checklist was reviewed by MC and the Community Network trainer with modifications made where appropriate (see *Appendix 8*, *Intervention delivery checklist*).

According to the facilitation skills training, as groups develop, the level of input required from the volunteer facilitator should diminish over time. Therefore, the sample of audio recordings included three time points (weeks 1, 6 and 12) to assess the degree to which volunteers used their acquired skills and adhered to the intervention protocol during delivery. The checklists were designed to take into account variation in the content of sessions and the fact that, if some scenarios did not arise, volunteer facilitators could not be expected to demonstrate the appropriate response.

Telephone befriending delivery

Attendance at all planned sessions was recorded through call registers completed by volunteer facilitators at every session during both the one-to-one phase and the group phase. Volunteer facilitators recorded any difficulties with the delivery of the intervention protocol on the call registers. Issues arising during delivery of the intervention were noted by the service provider and forwarded to the research team. The challenges of implementation and barriers to uptake were examined with a convenience sample of volunteer facilitators (see *Methods for the qualitative research* and *Chapter 5*, *Results of the volunteer interviews*).

A purposive sample of audio recordings of group sessions was used to assess the match with the intervention protocol in terms of the content and techniques delivered and the extent to which volunteer facilitators enabled choice and decision-making. Note that the protocol (see *Appendix 1*) also incorrectly refers to the concept of intervention 'drift', which implies a trend away from intervention fidelity known to exist at baseline, something not established in this study. Samples were taken at three time points – weeks 1, 6 and 12 – to examine intervention delivery and volunteer facilitator skills and receipt of the intervention and enactment by participants. Checklists were completed and scored separately by the two observers and scores were compared. Coders reviewed scores to ensure consistency in interpretation of checklist items, with areas of dispute discussed and agreement reached by consensus. When agreement could not be reached the original observations, and therefore scores, remained the same. Median scores were calculated to provide an overall percentage score for each facilitated group.

Telephone befriending receipt and enactment

Unlike formal behaviour change interventions, such as cognitive–behavioural therapy or motivational interviewing, the PLINY intervention does not attempt to tightly regulate behaviour outside the delivery setting. The intervention attempts to reduce the discrepancy or (mis-)match between the quality and quantity of existing relationships and relationship expectations.[55] The intervention, through facilitated dialogue between participants, is intended to create a safe environment in which social contact can improve perceptions of available companionship and support (see *Appendix 3*). It follows that, if the volunteer facilitators are delivering the intervention per protocol, then the group is 'working' well and participants should not be exhibiting problem behaviours known to inhibit successful group experiences. For this reason, we limit our assessment of participant receipt and enactment to evidence of their performance as part of a friendship group. To try and identify whether participants found the group intervention to be appropriate, acceptable and beneficial (see *Methods for the qualitative research* and *Chapter 5*, *Results of the participant interviews*), we specifically reviewed interview transcripts with participants and volunteer facilitators for evidence of characteristics which indicated that the groups were in a transitional phase, towards functioning well as a group:[31]

- defensiveness and resistance
- conflict
- confrontation.

Other characteristics – anxiety, the struggle for control, challenges to the group leader and the leader's reactions to resistance – were not seen as relevant in this intervention, as the level of disclosure, anxiety and resistance within befriending groups was anticipated to be lower than in a therapeutic group.

Interview transcripts and audio recordings were also reviewed for the following problem behaviours that are counterproductive to group functioning:[31]

- silence and lack of participation
- monopolistic behaviour
- hostile behaviour
- dependency
- acting superior
- socialising (before the end of the programme)
- 'band-aiding' (e.g. try to sooth/lessen pain when someone is upset).

Other behaviours – storytelling, questioning, giving advice, intellectualising, emotionalising (dwelling on getting in touch with their feelings) – were not seen as problematic in this intervention.

Chapter 3 Results of the implementation of the intervention

Interaction with the service funder and service provider

Conditional funding

It was originally intended to use multiple service providers to deliver the intervention. This was not possible for the following reasons. We considered it likely that the delivery at scale of a manualised intervention by volunteers would need the stable base offered by formal training and monitoring by experienced volunteer co-ordinators. For this, it was essential to secure funding. The funding was secured from a national charity on condition that we would use the money to deliver the intervention through one or more of its local branches only; we were unable to use other organisations to deliver the intervention. We looked at the viability of recruiting other branches of the charity to deliver the intervention. Other branches did express an interest but were unable to provide the intervention to participants recruited in the urban centre where the study was ongoing. Each branch of the charity was restricted through its constitution to serve the needs of its (bounded) local population. No branch could provide volunteers to work outside its geographical area. The research team was not adequately resourced to work in other geographical areas, which, in participant recruitment terms, was unnecessary in a conurbation with an estimated population of over half a million people.

An overview of the funding made available by the national charity is provided in *Table 3*. Detailed breakdowns follow of the resource for (1) the service provider, the local branch of the national charity, to recruit, train and mentor volunteer befriending facilitators (*Table 4*) and (2) a specialist trainer in group facilitation to support the manualisation of the intervention, provide advice on assessing its fidelity and train the volunteer facilitators (*Table 5*).

TABLE 3 Overall cost specification for the research intervention

Item	Cost (£)	Assumptions/notes
Service provider costs		
Staffing and resources (three recruitment waves)	6078.60	See *Table 4*
Overheads	1215.72	
Subtotal	7294.32	Excluding VAT (service provider confirmed that it would not charge VAT)
Group facilitation trainer costs		
Training content	3300.00	Assume 5.5 days' work @ £600 per day
Volunteer training	4200.00	Based on 30 volunteers retained by the service provider for facilitator training. Training provider – four 1-hour sessions for five people at £700
Manuals/materials	117.60	See *Table 5*
Participant – facilitator training	700.00	Assume that five participants will start their own group
Fidelity advice	1200.00	Advice to content expert and study manager on fidelity – approximately 2 days at £600 per day
Subtotal	9517.60	
VAT @ 20%	1903.52	
Total	11,421.12	

TABLE 4 Detailed breakdown of the service provider's costs

Item	Unit	Number of units	Cost per unit (£)	Total cost (£)	Notes/assumptions
Advertising					
Website	Updates	1	30	30.00	External costs incurred for website support
Mail-outs	Mail-outs	100	0.85	85.00	Second-class post and stationary plus return envelopes
E-mail-outs	Hours	2	12	24.00	Internal staff time – BDA (includes staff time for postal mail-outs)
Window advertisement	Posters		0	0.00	Internal printing only
VAS			0	0.00	Assumes no charge for VAS
Press advertising	Press adverts	2	300	600.00	Estimated costs of local 'freebies'
Radio				0.00	
Subtotal				739.00	
Initial day course orientation to working with older people and training in one-to-one befriending (assumes 15 volunteers per day)					
Preparatory work	Hours	4	0	0.00	Induction to working with older people plus summary of the trial
Introductory day	Days	2	150	300.00	Assumes 10 volunteers per day can be accommodated in the venue
Venue	Days	2	50	100.00	
Refreshments	Volunteers	20	3.5	70.00	Includes lunch, tea/coffee/water, biscuits
Equipment				0.00	Own equipment used
Handouts		20	2.5	50.00	Handouts printed internally
Subtotal				520.00	
Administration					
Collate applications	Hours	3	12	36.00	Internal staff time – BDA
Invitations to applicants	Invitations	20	0.46	9.20	Second-class post and stationary
CRB checks	Volunteers	10	0	0.00	External costs to process – no charge for volunteers
CRB checks administration	Hours	5	12	60.00	Internal staff time – BDA
Vetting administration	Hours	5	12	60.00	Internal staff time – BDA
Subtotal				165.20	
Interim – mentoring and review per wave					
Mentor and review sessions	Half-days	4	75	300.00	Assumes five volunteers per half-day
Venue	Half-days	4	30	120.00	
Refreshments	Volunteers × half-days	20	1.5	30.00	Includes tea/coffee/water, biscuits
Equipment				0.00	Own equipment used
Handouts	Handouts × sessions	20	1	20.00	Handouts printed internally
Follow-up	Hours	6	22	132.00	Internal staff time – CEM
Subtotal				602.00	
Total per wave of 20 inducted, 10 retained (excluding overheads)				2026.20	
Overheads					
Contribution to service provider overheads (20%)				405.24	
Total per wave of 20 inducted, 10 retained (including overheads)				*2431.44*	
Total across three waves (including overheads)				*7294.32*	

BDA, business development assistant; CEM, customer engagement manager; CRB, Criminal Records Bureau; VAS, visual analogue scale.

TABLE 5 Detailed breakdown of group facilitation trainer's costs

Item	Cost (£)	Notes/assumptions
Training content development	3300	Assumed 5.5 days' work @ £600 per day
Training		
Four × 1-hour course	4200	Based on £700 per four volunteers ($n = 30$)
Subtotal	7500	
Manual and materials (estimate)		
Cover letter ($n = 30$)	3	
Confidentiality sheet ($n = 30$)	3	
Facilitator handbook (25 pages; $n = 30$)	75	
Facilitator recording sheet ($n = 252$)	3	
Certificates ($n = 30$)	3	
Content/session sheets ($n = 252$)	3	
Postage ($n = 30$)	28	
Subtotal	118	
Fidelity advice		
Advice to content expert on fidelity	1200	e.g. Facilitator adherence to intervention protocol
Subtotal	1200	
Volunteer facilitator training		
Train four volunteers as facilitators	700	
Subtotal	700	
Total	9518	

The contract with the service provider

Contractual negotiations with the service provider ran between 20 October 2011 and 14 June 2012 when the contract was signed. The service provider was contracted to:

1. Identify and recruit suitable volunteers for the role of volunteer/facilitator for the delivery of the PLINY research intervention, including carrying out Criminal Records Bureau (CRB) checks.
2. Ensure that volunteers are oriented to working with older people and willing to deliver telephone befriending, are trained to carry out one-to-one calls in line with the PLINY research intervention and are ready to receive training in telephone befriending facilitation (to be delivered by a third party) in the numbers and by the dates shown in *Table 6*.
3. Ensure that volunteers take responsibility for scheduling and (subject to participant adherence) delivery of up to six one-to-one and 12 group telephone sessions for each person recruited to the PLINY research study and randomised to the TF group.

TABLE 6 Contract-specified deliverables for the service provider

Deadline	Recommended number of volunteers recruited and trained	Minimum number of volunteers recruited and trained
1 May 2012	20	10
1 September 2012	20	10
1 January 2013	20	10

4. Ensure that there are sufficient volunteers to provide cover in the event of volunteer facilitator absence or discontinuation.
5. Provide ongoing 'mentoring' to volunteers, in line with the service provider's policies and procedures and the PLINY research intervention, to ensure a point of contact and support.
6. Provide regular (at least monthly) updates to the research team on levels of volunteer recruitment and retention and feed back information, including the one-to-one and group call registers, to inform the research.
7. Alert the research team at the earliest opportunity if a participant wishes to withdraw or is unable to participate in the intervention (TF groups), with reasons recorded (if provided by the participant).

Item (3), the delegation of first contact and scheduling of calls, might not be considered best practice for sustaining a volunteer befriending service. For instance, a Delphi survey of volunteer co-ordinators managing befriending services found general agreement that they should be managed either by a full-time or a part-time project co-ordinator.[25] The volunteer co-ordinators also agreed that it was essential to have a monitoring system in place (p. 51).[24] We were unable to broker such an arrangement within the available finances.

Recruitment and retention of volunteers

Recruitment and retention of volunteers was an important criterion for the feasibility of the study (see *Chapter 4*, *Assessment of study feasibility*) and for the continuity of the service for individual participants and their groups. Matching service demand (participant recruitment) with the capacity of the service provider was part of the study design. Participant recruitment was intended to be conducted over three waves. It was estimated that a minimum of 10 and a maximum of 20 volunteers would be required in each wave. Therefore, a minimum of 30 (maximum of 60) volunteers was agreed with the service provider as being necessary to facilitate approximately 20 friendship groups over the life of the study. This would ensure capacity to continue the service in the event of dropout or planned and unplanned absences.

The service provider experienced difficulties with recruiting and retaining a sufficient number of volunteers. These difficulties were explored within the four categories of marketing, training, monitoring and boundaries. *Figure 1* shows the flow of volunteers throughout the study. Ten (24%) out of 42 volunteers who expressed an interest in the study completed the training of whom three (33%) delivered the intervention. Reasons for dropping out were captured when possible to provide an indication of the acceptability and accessibility of the volunteer role to those expressing an interest in the role.

Marketing

Activity by the service provider to promote the volunteer opportunity included its website (news archive, 25 September 2012; accessed 10 May 2013), the Northern Community Assembly website (field note, 21 November 2012), the local Wellbeing Consortium (field note, 20 November 2012), a local newspaper and a range of community and voluntary networks and organisations available in the locality, which we have not named to preserve the anonymity of the service provider (field note, 14 June 2012; TMG, 15 November 2013). The service provider reported that potential volunteers referred to them by other agencies (e.g. Jobcentre Plus) were often not suitable for the facilitator role (TMG, 19 September 2012).

Suggestions for additional strategies to promote the volunteer role in the locality were made by the study team (e.g. TMG, 15 November 2013).

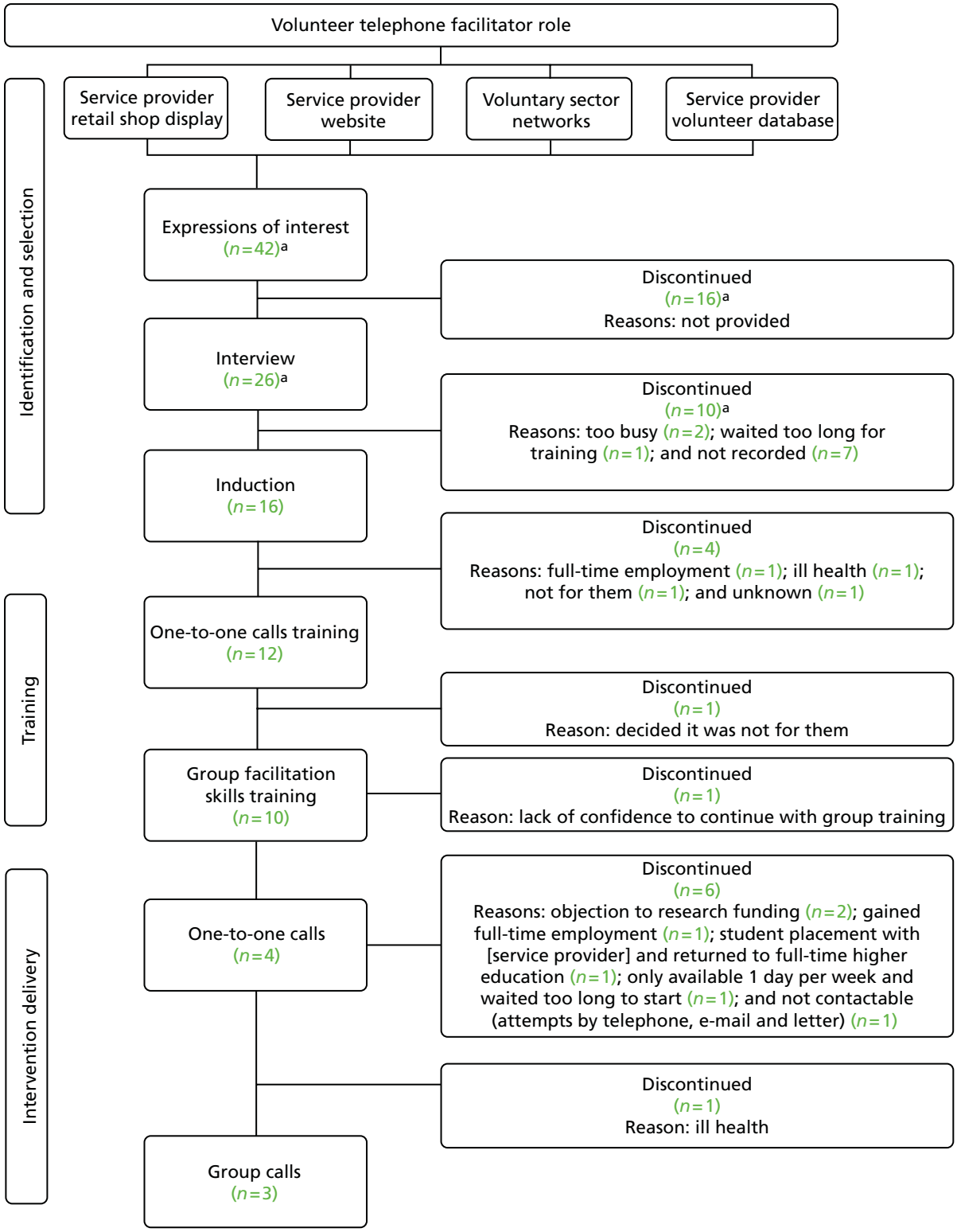

FIGURE 1 Flow of service provider's volunteers. a, Information supplied by the service provider (field note, 13 November 2012). Detailed information was not captured for all expressions of interest/referrals to the service provider (including agencies, e.g. Jobcentre Plus). The service provider reported that all candidates were screened for suitability for a number of volunteer opportunities, including the telephone group facilitator role.

Training

Training sessions for the group intervention required a minimum of four volunteers for the training group to be feasible. The service provider identified an initial group of six volunteers early in the project (TMG, 20 February 2012) and scheduled one-to-one training for them in March 2012. The charity reported a number of implementation issues including matching the availability of volunteers to training dates (TMG, 20 February 2012). They also found that retaining volunteers between recruitment and training was difficult and required more resources than anticipated (TMG, 20 August 2012). It should be noted that the first group of volunteers ($n = 4$ in two groups) received induction and one-to-one calls training from the service provider in March 2012, 2 months before the scheduled start of participant recruitment. In fact, participant recruitment did not commence until June 2012, 1 month late, because of delays in contracting. A lower than anticipated response to the initial recruitment strategy (direct mail out to participants of a population cohort) meant a further delay before the research team had recruited and randomised the six intervention-arm participants needed for a group. According to the service provider, this delay caused the attrition of several existing volunteers (see *Figure 1*). At a time when the rate of participant recruitment was starting to increase, the service provider advised the study team that it was not actively recruiting volunteers (TMG, 19 September 2012) because there was an insufficient number of randomised participants. Instead, the service provider was waiting for candidate volunteers to approach them in response to advertisements.

Once the research team had managed to increase the rate of participant recruitment through general practice mail-outs, the service provider experienced repeated difficulties identifying volunteers to fill facilitator training groups. As a result, the first two training sessions (May 2012) contained only two genuine volunteers; to make the training viable, the service provider's staff and members of the study team – who did not intend to deliver the intervention – made up the places to make the training viable. A finite training budget meant that running sessions with insufficient numbers of genuine volunteers was not sustainable. As a result, we agreed that the four (ideally five) places on training sessions scheduled for some time in the future had to be filled by a certain date – the 'book by' date – or they would be cancelled. 'Book by' dates were arranged with the group facilitator trainer to assist the service provider as it reported (TMG, 14 June 2012) practical difficulties in co-ordinating volunteers at the times and pace required by (1) the trial, which had a window of 1 year to recruit 248 participants to test the effectiveness of a public health intervention, which had to be rolled out at scale, and (2) the group training (four 1-hour telephone sessions on different days). The service provider did not always confirm whether sufficient volunteers had been identified by the 'book by' date despite reminders from the trainer/study manager (e-mail and telephone, 16 November 2012).

The total number of volunteers group trained between 17 May 2012 and 22 October 2012 was 11, instead of the 20 who should have been trained. Two trained volunteers were not available to take on a group; one was on a student placement with the service provider and needed to return to full-time education and one was available for only 1 day per week, having assumed that they could make befriending calls in the evening. Three training sessions (during which 15 more volunteers should have been trained) were cancelled between August 2012 and January 2013 because of a lack of take-up. Three volunteers facilitated four groups ($n = 24$) to completion between September 2012 and May 2013 (with up to 6 weeks one-to-one befriending beforehand). One group received one-to-one befriending from a fourth volunteer facilitator who dropped out before the group stage. An existing volunteer took over for the group calls stage (see *Monitoring volunteers*). The number of days that volunteers 'survived' in the project (from completing group training to the day that they dropped out) ranged from 12 to 118 (mean 62 days).

Monitoring volunteers

Feedback from volunteers was collected by the service provider and reported to the TMG and, when relevant, to other volunteers delivering the service. The study team also captured implantation issues during set-up and recruitment in field notes.

The service provider was responsible for providing ongoing 'mentoring' to volunteers, in line with its existing policies and procedures relating to volunteers and the intervention protocol, to ensure a point of contact and support for the volunteers whilst they were delivering the TF service. The charity provided a summary of the project in its induction pack together with copies of the one-to-one training manual (field notes, 20 March 2012, 15 June 2012, 9 October 2012). Volunteers often contacted the study team with enquiries about what to do in certain circumstances, for instance if participants missed calls and the facilitator had been only able to contact one (of six) participants in the first week (field note, 30 October 2012), they were going on holiday (field note, 17 September 2012) or if they experienced technical difficulties with audio recording calls (field note, 29 September 12) (see also *Boundaries between research and service delivery*). The reasons why volunteers contacted the study team rather than the service provider are considered in *Boundaries between research and service delivery* and *Chapter 5* (see *Results of the volunteer interviews*).

Volunteers reported difficulties in contacting participants to arrange the initial and subsequent one-to-one telephone calls (see *Chapter 5*, *Results of the volunteer interviews*). Volunteers reported that it would be better to make calls in the early evening and that some participants had also reported this. however, to safeguard participants using the service the provider did not permit volunteers to make calls before 0900 or after 1700 from Monday to Friday. This resulted in one volunteer dropping out (see *Figure 1*).

In reviewing volunteer identification and recruitment (field note, 5 December 2012), the service provider identified three issues that it felt were impacting on the recruitment and retention of volunteers: (1) existing volunteers found it difficult to contact participants for the one-to-one calls as they were 'socially active', resulting in the volunteers being reluctant to take on another group; (2) there was a time delay between volunteers being trained and actually delivering the service; and (3) there was a lack of introductions by the service provider between the volunteers and the 'participants'. The service provider decided that volunteers would introduce themselves to study participants at the first contact (one-to-one call) and be responsible for scheduling one-to-one and group calls (field note, 22 March 2012). One of the volunteer co-ordinators stated that, for their face-to-face visiting service, volunteers often want to be introduced to clients by the service provider staff and felt that this may have contributed to the difficulty in recruiting or retaining volunteers (field note, 2 January 2012).

One volunteer (out of 10) who completed all training dropped out during intervention delivery (between completion of the one-to-one calls and the start of the group calls) because of ill-health. Attempts by the service provider to contact two trained volunteers failed and, because of the already limited pool of volunteers, the only facilitators available were those already running a friendship group. The service provider reported contacting participants of the group to let them know and asked the existing volunteers ($n = 2$) if they would be willing to take on the group (field note, 5 December 2012). One volunteer agreed but did not run the groups concurrently, which resulted in a delay in the group calls starting. Some participants were difficult to contact (field note, 14 February 2012) and at least one member of the group was not contacted (see *Chapter 5*, *Results of the volunteer interviews*).

In accordance with the intervention design, the service provider asked volunteer facilitators to discuss with participants in their groups whether they would like to volunteer to run their own group when they had finished their own involvement, thereby contributing to the notion of older people helping other older people. Feedback on responses was not provided.

Boundaries between research and service delivery

Boundaries between the research and the service being investigated were blurred in some instances. Participants called the study team to advise that they would miss the week's call; volunteers called the study team directly if they were unsure about what to do (see *Monitoring volunteers*). For instance, one volunteer enquired about what information participants had received about 'how it all works' (field note, 26 September 2012). Another enquired about how the group could exchange contact details so that members could meet up (field note, 25 March 2013). The service provider also referred volunteers to the study team for information, for example one volunteer enquired about the Christmas period (VF03, female, field note, 3 December 2012) and one volunteer (not interviewed, female) contacted the team because she lacked confidence in making the calls via the Community Network system (field note, 2 November 2013). Additional training was provided to this volunteer by the study team (field note, 8 November 2012).

Chapter 4 Results of the main trial

Assessment of study feasibility

The criteria used to assess the feasibility of the trial as part of the internal pilot were (1) sufficient participants willing to enter the trial; (2) retention of sufficient participants to assess the primary outcome measure; and (3) recruitment and retention of adequate volunteers to deliver TF to trial participants. Criteria (1) and (2) formed the basis of formal stop–go criteria agreed with the funders for the primary outcome assessment time point of 6 months.

Assessment of feasibility was made at 6 months from the start of participant recruitment. The review found that two criteria were satisfactorily met, with participant recruitment and retention by the trial team being feasible. However, the recruitment and retention of volunteer facilitators by the service provider was not adequate to deliver the intervention to the participants randomly allocated to receive the TF intervention. Training courses were not filled to capacity and, although implementation issues were reported by the service provider and addressed when possible, recruitment and retention were not adequate (see *Chapter 3*, *Recruitment and retention of volunteers*).

Participant recruitment was stopped, with the last participant randomised on 11 January 2013. The main consideration contemplated by the TMG at the point of suspension was that 50 out of the 78 participants allocated to the research arm had not been allocated a volunteer facilitator, that is, had not been treated per protocol.

Attempts were made to identify an alternative service provider. This included potential service providers in neighbouring districts; however, they were restricted by charitable aims preventing service delivery to a population outside their geographical area. After clarifying that no other service provider was capable of recruiting and retaining volunteer facilitators in the numbers required, the TMG took the decision on 17 January 2013 to close the trial early. The TSC and Public Health Research programme were advised of the TMG's decision and recommended action. This included ensuring that participants were informed about how the decision would impact on them. Following approval from the NHS REC, participants still receiving the intervention were advised that they would continue to receive calls for 12 weeks. Participants in the intervention arm were advised whether or not they would be invited to take part in an interview about their experiences in the groups. Participants in both arms were also informed whether they would be followed up at the 6-month primary outcome assessment time point (by the end of March).

Recruitment of trial participants

Main results

Figure 2 shows the participant flow diagram; 157 participants were consented and randomised to the intervention group ($n = 78$) or the control group ($n = 79$).

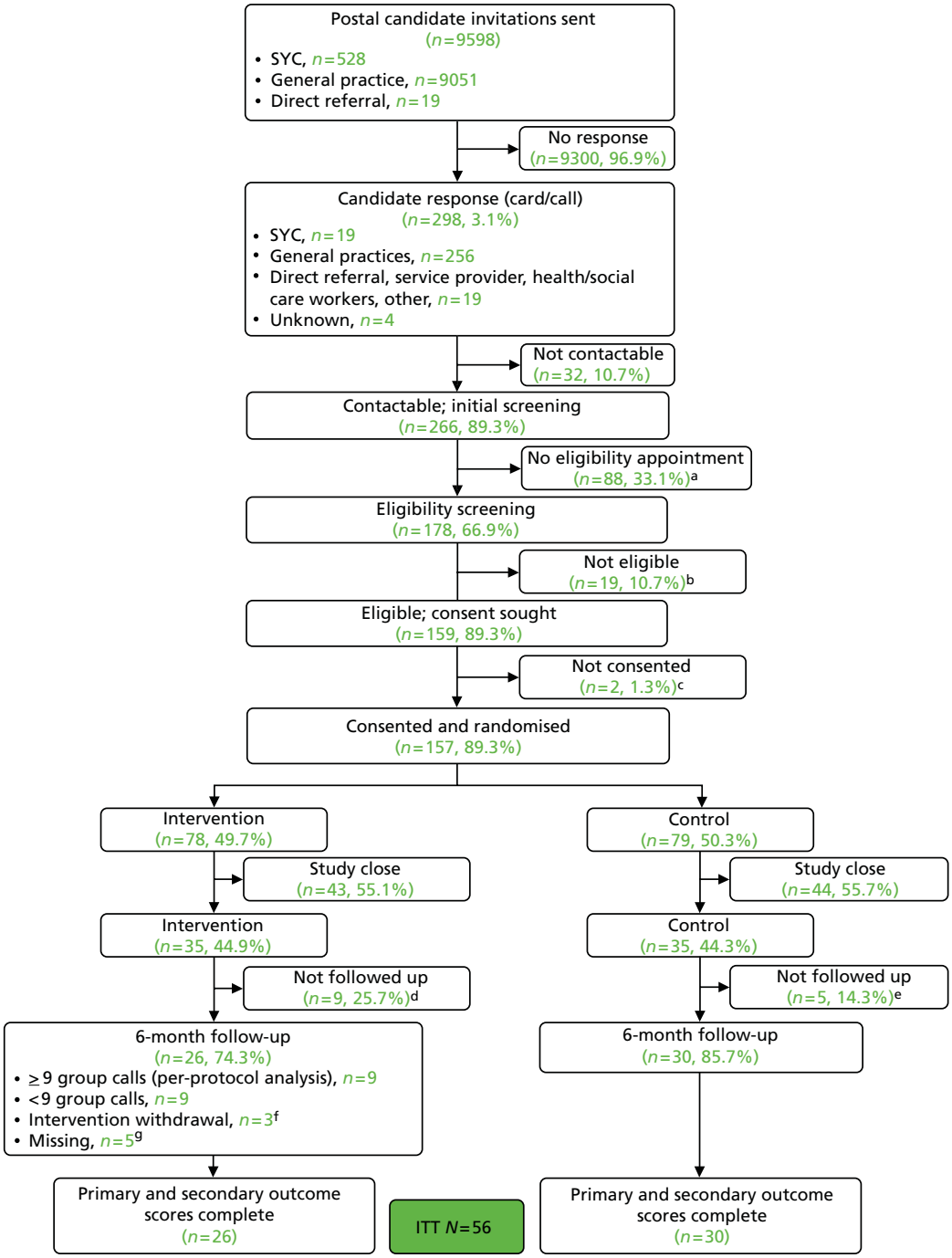

FIGURE 2 Participant flow diagram. SYC, South Yorkshire cohort. a, Three were ineligible, 21 were not interested in the intervention, 11 did not have enough time to participate, two were not willing to complete the questionnaires, two needed more information, one was not willing to take part if they did not receive the intervention, one preferred not to give a reason and 47 stated other reasons. b, 17 failed the 6CIT, one was already receiving telephone services and one was unable to use the telephone. c, One did not want to take part and one wanted to discuss the study with a family member. d, One was withdrawn by the chief investigator because of a protocol violation relating to eligibility, two withdrew consent shortly after allocation [one was unhappy with the involvement of (service provider) and one did not feel the study was for them], five withdrew consent at the point of arranging the 6-month follow-up (one because of ill-health, one was no longer unhappy and so did not want to take part, one was unhappy with the intervention – at this point they had not received any calls, one was unhappy with being left uninformed about the lack of intervention and one withdrew because of personal or family issues) and one was not contactable (at least six attempts were made by telephone and a reminder letter was sent). e, One withdrew consent at the point of arranging the 6-month follow-up (unhappy with allocation to the study arm), one was not contactable (no dial tone; letter and e-mail reminders sent), one was on holiday for 4 weeks and two refused (one did not want to answer the same questions as they did not feel any different and one felt too ill to answer any questions). f, Two no longer wanted the intervention (one was too busy and one thought that the intervention was not for them) and one did not give any reason for withdrawal from the intervention. g, Assigned to TF group 5 but the intervention was not delivered because the volunteer facilitator dropped out.

Table 7 shows the baseline characteristics of the 157 randomised participants. Overall, the two randomised groups were well matched with respect to baseline demographic characteristics. *Tables 8* and *9* show the baseline participant-reported outcome scores for the SF-36, EQ-5D, PHQ-9, de Jong Gierveld Loneliness Scale, ONS well-being outcome and the GSE. Again, the two randomised groups were well matched with respect to baseline quality of life scores.

TABLE 7 Baseline demographics by randomised group (all randomised participants, $n = 157$)

Variable	Scoring	Control ($n = 79$)	Intervention ($n = 78$)	Total ($n = 157$)
Sex, *n* (%)	Female	51 (65)	54 (69)	105 (67)
	Male	28 (35)	24 (31)	52 (33)
Age (years)	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	80.3 (4.3)	81.4 (4.9)	80.8 (4.6)
	Median (IQR)	79 (77–83)	81 (78–84)	80 (77–84)
	Min. to max.	75 to 91	75 to 95	75 to 95
Ethnicity, *n* (%)	English/Welsh/Scottish/ Northern Irish/British	74 (94)	74 (95)	148 (94)
	Any other white background	4 (5)	1 (1)	5 (3)
	Caribbean	0 (0)	1 (1)	1 (1)
	Indian	1 (1)	0 (0)	1 (1)
	Irish	0 (0)	1 (1)	1 (1)
	Prefer not to say	0 (0)	1 (1)	1 (1)
Live with anyone?, *n* (%)	Yes	23 (29)	22 (28)	45 (29)
	No	56 (71)	56 (72)	112 (71)
Live with spouse/partner, *n* (%)	Ticked	20 (25)	19 (24)	39 (25)
Live with children, *n* (%)	Ticked	3 (4)	3 (4)	6 (4)
Live with others, *n* (%)	Ticked	0 (0)	1 (1)	1 (1)
Education, *n* (%)				
One to four O levels/GCSEs/CSEs	Ticked	4 (5)	3 (4)	7 (4)
Five or more O levels/GCSEs/CSEs	Ticked	8 (10)	11 (14)	19 (12)
One A level/two to three AS levels	Ticked	1 (1)	1 (1)	2 (1)
Two or more A levels/four or more AS levels	Ticked	5 (6)	1 (1)	6 (4)
Degree	Ticked	5 (6)	14 (18)	19 (12)
Higher degree	Ticked	3 (4)	3 (4)	6 (4)
Professional	Ticked	6 (8)	9 (12)	15 (10)
NVQ4	Ticked	0 (0)	1 (1)	1 (1)
Apprenticeship	Ticked	3 (4)	2 (3)	5 (3)
Other	Ticked	14 (18)	5 (6)	19 (12)
Occupation, *n* (%)	Employed or self-employed	1 (1)	0 (0)	1 (1)
	Looking after home/family	0 (0)	3 (4)	3 (2)
	Retired	78 (99)	75 (96)	153 (97)

TABLE 8 Baseline SF-36 scores by randomised group (all randomised participants, $n = 157$)

Variable	Scoring	Control ($n = 79$)	Intervention ($n = 78$)	Total ($n = 157$)
Mental health (baseline)	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	77.5 (17.9)	78.1 (14.4)	77.8 (16.2)
	Median (IQR)	80 (70–90)	80 (70–90)	80 (70–90)
	Min. to max.	5 to 100	15 to 100	5 to 100
Physical function (baseline)	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	61.4 (28.7)	63.6 (26.2)	62.5 (27.4)
	Median (IQR)	65 (40–90)	70 (50–85)	70 (40–85)
	Min. to max.	5 to 100	0 to 100	0 to 100
Role – physical (baseline)	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	66.7 (29.8)	65.6 (27.9)	66.2 (28.8)
	Median (IQR)	68.8 (43.8–93.8)	65.6 (43.8–100)	68.8 (43.8–93.8)
	Min. to max.	0 to 100	0 to 100	0 to 100
Bodily pain (baseline)	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	58.4 (27.2)	61.5 (27.2)	59.9 (27.1)
	Median (IQR)	52 (41–74)	62 (41–84)	61 (41–80)
	Min. to max.	0 to 100	0 to 100	0 to 100
General health (baseline)	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	57.8 (22.7)	61.7 (23.4)	59.7 (23.1)
	Median (IQR)	57 (42–77)	67 (45–77)	62 (45–77)
	Min. to max.	5 to 100	0 to 100	0 to 100
Vitality (baseline)	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	54.7 (21.4)	58.5 (21.6)	56.6 (21.5)
	Median (IQR)	56.3 (43.8–68.8)	62.5 (43.8–68.8)	56.3 (43.8–68.8)
	Min. to max.	0 to 100	0 to 100	0 to 100
Social function (baseline)	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	79.9 (26.8)	79.3 (26.6)	79.6 (26.6)
	Median (IQR)	100 (62.5–100)	87.5 (62.5–100)	100 (62.5–100)
	Min. to max.	12.5 to 100	12.5 to 100	12.5 to 100
Role – emotional (baseline)	*n* (%)	79 (100)	77 (98.7)	156 (99.4)
	Mean (SD)	86.7 (24.6)	86.9 (21.6)	86.8 (23.1)
	Median (IQR)	100 (83.3–100)	100 (83.3–100)	100 (83.3–100)
	Min. to max.	0 to 100	0 to 100	0 to 100
Physical component score (baseline)	*n* (%)	79 (100)	77 (98.7)	156 (99.4)
	Mean (SD)	40.3 (12.1)	41.5 (11.5)	40.9 (11.8)
	Median (IQR)	41.9 (29.8–49.6)	43.1 (32.7–50.5)	42.8 (30.8–50.5)
	Min. to max.	11.9 to 70.7	10.9 to 61.7	10.9 to 70.7
Mental component score (baseline)	*n* (%)	79 (100)	77 (98.7)	156 (99.4)
	Mean (SD)	53.1 (10.8)	53.5 (8.1)	53.3 (9.5)
	Median (IQR)	56.8 (49.5–59.5)	55.2 (49.0–58.8)	56.4 (49.2–59.5)
	Min. to max.	16.5 to 69.9	24.3 to 68.1	16.5 to 69.9

A level, Advanced level; AS level, Advanced Subsidiary level; CSE, Certificate of Secondary Education; GCSE, General Certificate of Secondary Education; max., maximum; min., minimum; NVQ4, National Vocational Qualification level 4; O level, Ordinary level. The SF-36 dimensions are scored on a scale from 0 (poor) to 100 (good).

TABLE 9 Other baseline participant-reported outcome scores by randomised group (all randomised participants, $n = 157$)

Variable	Scoring	Control ($n = 79$)	Intervention ($n = 78$)	Total ($n = 157$)
EQ-5D (baseline)[a]	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	0.7 (0.25)	0.72 (0.27)	0.71 (0.26)
	Median (IQR)	0.73 (0.62–0.85)	0.76 (0.66–0.85)	0.73 (0.66–0.85)
	Min. to max.	–0.07 to 1	–0.37 to 1	–0.37 to 1
EQ-5D VAS (baseline)[b]	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	70.7 (19.2)	72.8 (17)	71.7 (18.1)
	Median (IQR)	75 (59–85)	77.5 (62–85)	75 (60–85)
	Min. to max.	18 to 100	15 to 100	15 to 100
de Jong Gierveld emotional loneliness (baseline)[c]	*n* (%)	79 (100)	77 (98.7)	156 (99.4)
	Mean (SD)	2.1 (1.9)	2.1 (1.9)	2.1 (1.9)
	Median (IQR)	2 (0–4)	2 (0–3)	2 (0–4)
	Min. to max.	0 to 6	0 to 6	0 to 6
de Jong Gierveld social loneliness (baseline)[d]	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	1.5 (1.7)	1.5 (1.7)	1.5 (1.7)
	Median (IQR)	1 (0–2)	1 (0–3)	1 (0–3)
	Min. to max.	0 to 5	0 to 5	0 to 5
de Jong Gierveld overall loneliness (baseline)[e]	*n* (%)	79 (100)	77 (98.7)	156 (99.4)
	Mean (SD)	3.5 (3.2)	3.6 (3.2)	3.6 (3.2)
	Median (IQR)	2 (1–5)	3 (1–6)	3 (1–5)
	Min. to max.	0 to 11	0 to 11	0 to 11
PHQ-9 (baseline)[f]	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	3.2 (4)	3.1 (3.8)	3.1 (3.9)
	Median (IQR)	2 (0–5)	2 (0–4)	2 (0–4)
	Min. to max.	0 to 22	0 to 17	0 to 22
ONS well-being (baseline)[g]	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	7.6 (2.1)	7.8 (1.8)	7.7 (2)
	Median (IQR)	8 (7–9)	8 (7–9)	8 (7–9)
	Min. to max.	0 to 10	0 to 10	0 to 10
GSE (baseline)[h]	*n* (%)	79 (100)	78 (100)	157 (100)
	Mean (SD)	32.1 (5.5)	33.6 (4.7)	32.9 (5.1)
	Median (IQR)	32 (28–36)	34.5 (30–38)	34 (29–37)
	Min. to max.	10 to 40	22 to 40	10 to 40

Max., maximum; Min., minimum; VAS, visual analogue scale.
a The EQ-5D utility score is measured on a scale from –0.56 to 1.00 (good health).
b The EQ-5D VAS is measured on a scale from 0 (worst imaginable health state) to 100 (best imaginable health state).
c The de Jong Gierveld emotional loneliness scale is scored from 0 to 6, with higher scores indicating more loneliness.
d The de Jong Gierveld social loneliness scale is scored from 0 to 5, with higher scores indicating more loneliness.
e The de Jong Gierveld overall loneliness scale is scored from 0 to 11, with higher scores indicating more loneliness.
f The PHQ-9 is measured on a scale from 0 to 27, with higher scores indicating more severe depressive symptoms.
g The ONS well-being measure is scored on a 0 to 10 scale with a higher score indicating better well-being.
h The GSE is scored on a scale from 10 to 40, with higher scores indicating more perceived self-efficacy.

Only 70 out of the 157 randomised participants were followed up for 6 months post randomisation. These participants were part of the initial internal pilot study to assess the feasibility of the full RCT. *Table 10* shows the baseline demographic characteristics of these 70 randomised participants. The two groups were reasonably well matched with respect to baseline demographic characteristics, although there is some evidence that slightly more women were randomised to receive the intervention. *Tables 11* and *12* show the mean baseline participant-reported outcome scores for these 70 participants. The mean participant-reported outcome scores were broadly similar for both groups, although there is some evidence that the intervention group had a slightly better quality of life at baseline, as measured by the SF-36 mental health, general health and vitality dimensions.

TABLE 10 Baseline demographics by randomised group (participants included in the analysis, $n = 70$)

Variable	Scoring	Control ($n = 35$)	Intervention ($n = 35$)	Total ($n = 70$)
Sex, *n* (%)	Female	18 (51)	23 (66)	41 (59)
	Male	17 (49)	12 (34)	29 (41)
Age (years)	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	80.1 (3.7)	81.8 (5.8)	80.9 (4.9)
	Median (IQR)	80 (76–82)	80 (78–85)	80 (77–84)
	Min. to max.	75 to 90	75 to 95	75 to 95
Ethnicity, *n* (%)	English/Welsh/Scottish/ Northern Irish/British	33 (94)	34 (97)	67 (96)
	Any other white background	2 (6)	1 (3)	3 (4)
Live with anyone?, *n* (%)	Yes	8 (23)	10 (29)	18 (26)
	No	27 (77)	25 (71)	52 (74)
Live with spouse/partner, *n* (%)	Ticked	6 (17)	8 (23)	14 (20)
Live with children, *n* (%)	Ticked	2 (6)	1 (3)	3 (4)
Live with others, *n* (%)	Ticked	0 (0)	1 (3)	1 (1)
Education, *n* (%)				
One to four O levels/GCSEs/CSEs	Ticked	2 (6)	2 (6)	4 (6)
Five or more O levels/GCSEs/CSEs	Ticked	3 (9)	3 (9)	6 (9)
Two or more A levels/four or more AS levels	Ticked	1 (3)	0 (0)	1 (1)
Degree	Ticked	1 (3)	5 (14)	6 (9)
Higher degree	Ticked	1 (3)	1 (3)	2 (3)
Professional	Ticked	4 (11)	7 (20)	11 (16)
Apprenticeship	Ticked	1 (3)	0 (0)	1 (1)
Other	Ticked	6 (17)	2 (6)	8 (11)
Occupation, *n* (%)	Looking after home/family	0 (0)	1 (3)	1 (1)
	Retired	35 (100)	34 (97)	69 (99)

A level, Advanced level; AS level, Advanced Subsidiary level; CSE, Certificate of Secondary Education; GCSE, General Certificate of Secondary Education; max., maximum; min., minimum; O level, Ordinary level.

TABLE 11 Baseline SF-36 scores by randomised group (participants included in the analysis, $n = 70$)

Variable	Scoring	Control ($n = 35$)	Intervention ($n = 35$)	Total ($n = 70$)
Mental health (baseline)	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	74.7 (21.6)	77.9 (17.5)	76.3 (19.6)
	Median (IQR)	80 (65–90)	80 (70–90)	80 (70–90)
	Min. to max.	5 to 100	15 to 100	5 to 100
Physical function (Baseline)	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	67 (27.3)	65.6 (27.4)	66.3 (27.2)
	Median (IQR)	75 (40–90)	70 (55–90)	72.5 (45–90)
	Min. to max.	15 to 100	0 to 100	0 to 100
Role – physical (baseline)	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	73.6 (25.3)	71.3 (25.2)	72.4 (25.1)
	Median (IQR)	81.3 (56.3–100)	75 (50.0–100)	75 (50.0–100)
	Min. to max.	12.5 to 100	25 to 100	12.5 to 100
Bodily pain (baseline)	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	64 (26)	64.4 (29)	64.2 (27.4)
	Median (IQR)	62 (51–84)	72 (41–100)	62 (41–84)
	Min. to max.	12 to 100	0 to 100	0 to 100
General health (baseline)	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	60 (19.4)	69.2 (21.4)	64.6 (20.8)
	Median (IQR)	57 (45–77)	72 (57–82)	66 (47–82)
	Min. to max.	20 to 100	25 to 100	20 to 100
Vitality (baseline)	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	54.3 (21.4)	62.3 (20.3)	58.3 (21.1)
	Median (IQR)	56.3 (37.5–68.8)	68.8 (50.0–75.0)	62.5 (43.8–75.0)
	Min. to max.	0 to 93.8	6.3 to 100	0 to 100
Social function (baseline)	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	81.4 (26)	85 (22.6)	83.2 (24.3)
	Median (IQR)	100 (75–100)	100 (75–100)	100 (75–100)
	Min. to max.	12.5 to 100	25 to 100	12.5 to 100
Role – emotional (baseline)	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	86.4 (24)	88.6 (19.2)	87.5 (21.6)
	Median (IQR)	100 (66.7–100)	100 (83.3–100)	100 (83.3–100)
	Min. to max.	0 to 100	25 to 100	0 to 100
Physical component score (baseline)	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	43.7 (11)	43.8 (10.5)	43.7 (10.6)
	Median (IQR)	45.2 (36.9–52.8)	44.2 (34.0–53.7)	44.7 (35.6–53.0)
	Min. to max.	22.7 to 70.7	22.7 to 61.2	22.7 to 70.7
Mental component score (baseline)	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	51.3 (12.5)	54.1 (9.1)	52.7 (11)
	Median (IQR)	55.7 (49.5–59.8)	56.2 (50.9–59.3)	56.1 (49.5–59.3)
	Min. to max.	16.5 to 67.7	24.3 to 68.1	16.5 to 68.1

Max., maximum; min., minimum.
The SF-36 dimensions are scored on a scale from 0 (poor) to 100 (good).

TABLE 12 Other baseline person-reported outcome scores by randomised group (participants included in the analysis, $n = 70$)

Variable	Scoring	Control ($n = 35$)	Intervention ($n = 35$)	Total ($n = 70$)
EQ-5D (baseline)[a]	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	0.73 (0.24)	0.73 (0.29)	0.73 (0.27)
	Median (IQR)	0.73 (0.62–1)	0.8 (0.62–1)	0.76 (0.62–1)
	Min. to max.	0.08 to 1	–0.37 to 1	–0.37 to 1
EQ-5D VAS (baseline)[b]	*n* (%)	35 (100%)	35 (100%)	70 (100%)
	Mean (SD)	72.5 (18.8)	75.1 (18.6)	73.8 (18.6)
	Median (IQR)	75 (62–87)	80 (61–90)	79 (62–90)
	Min. to max.	18 to 100	26 to 100	18 to 100
de Jong Gierveld emotional loneliness (baseline)[c]	*n* (%)	35 (100)	34 (97.1)	69 (98.6)
	Mean (SD)	2.3 (2)	1.9 (1.8)	2.1 (1.9)
	Median (IQR)	2 (0–4)	1 (0–3)	2 (0–3)
	Min. to max.	0 to 6	0 to 6	0 to 6
de Jong Gierveld social loneliness (baseline)[d]	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	1.7 (1.8)	1.4 (1.7)	1.5 (1.8)
	Median (IQR)	1 (0–3)	1 (0–3)	1 (0–3)
	Min. to max.	0 to 5	0 to 5	0 to 5
de Jong Gierveld overall loneliness (baseline)[e]	*n* (%)	35 (100)	34 (97.1)	69 (98.6)
	Mean (SD)	4 (3.5)	3.3 (3.1)	3.7 (3.3)
	Median (IQR)	3 (1–6)	2 (1–6)	3 (1–6)
	Min. to max.	0 to 11	0 to 11	0 to 11
PHQ-9 (baseline)[f]	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	3.3 (4.8)	2.9 (3.6)	3.1 (4.2)
	Median (IQR)	2 (0–5)	2 (0–4)	2 (0–4)
	Min. to max.	0 to 22	0 to 16	0 to 22
ONS well-being (baseline)[g]	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	7.5 (2.5)	7.8 (2.4)	7.7 (2.5)
	Median (IQR)	8 (7–9)	8 (7–9)	8 (7–9)
	Min. to max.	0 to 10	0 to 10	0 to 10
GSE (baseline)[h]	*n* (%)	35 (100)	35 (100)	70 (100)
	Mean (SD)	31.3 (5.5)	33.7 (4.5)	32.5 (5.2)
	Median (IQR)	31 (28–35)	35 (29–38)	33 (29–37)
	Min. to max.	10 to 39	24 to 40	10 to 40

Max., maximum; min., minimum; VAS, visual analogue scale.
a The EQ-5D utility score is measured on a scale from –0.56 to 1.00 (good health).
b The EQ-5D VAS is measured on a scale from 0 (worst imaginable health state) to 100 (best imaginable health state).
c The de Jong Gierveld emotional loneliness scale is scored from 0 to 6, with higher scores indicating more loneliness.
d The de Jong Gierveld social loneliness scale is scored from 0 to 5, with higher scores indicating more loneliness.
e The de Jong Gierveld overall loneliness scale is scored from 0 to 11, with higher scores indicating more loneliness.
f The PHQ-9 is measured on a scale from 0 to 27, with higher scores indicating more severe depressive symptoms.
g The ONS well-being measure is scored on a 0 to 10 scale with a higher score indicating better well-being.
h The GSE is scored on a scale from 10 to 40, with higher scores indicating more perceived self-efficacy.

By 6 months post randomisation, 56 participants had valid primary outcome data (SF-36 mental health dimension). There were 30 responders and five non-responders at 6 months in the control group and 26 responders and nine non-responders in the intervention group. *Tables 13* and *14* show the baseline demographic and quality of life characteristics of these four groups of participants respectively.

At 6 months post randomisation, the SF-36 mental health mean (SD) scores were 77.5 (18.4) in the intervention group and 70.7 (21.2) in the control group, a mean difference of 6.5 (95% CI –3.0 to 16.0); after adjusting for age, sex and baseline score the mean difference was 9.5 (95% CI 4.5 to 14.5) (*Table 15*). The estimated ICC from the marginal model for the primary outcome was –0.06, indicating little if any clustering by facilitator; the correlation between baseline and 6-month mental health scores was 0.78.

TABLE 13 Baseline demographics by randomised group and 6-month primary outcome response status ($n = 70$)

Variable	Scoring	Control 6-month responder ($n = 30$)	Control 6-month non-responder ($n = 5$)	Intervention 6-month responder ($n = 26$)	Intervention 6-month non-responder ($n = 9$)
Sex, *n* (%)	Female	16 (53)	2 (40)	18 (69)	5 (56)
	Male	14 (47)	3 (60)	8 (31)	4 (44)
	Total	30 (100)	5 (100)	26 (100)	9 (100)
Ethnicity, *n* (%)	English/Welsh/Scottish/ Northern Irish/British	28 (93)	5 (100)	25 (96)	9 (100)
	Any other white background	2 (7)	0 (0)	1 (4)	0 (0)
	Total	30 (100)	5 (100)	26 (100)	9 (100)
Live with others?, *n* (%)	No	22 (73)	5 (100)	21 (81)	4 (44)
	Yes	8 (27)	0 (0)	5 (19)	5 (56)
	Total	30 (100)	5 (100)	26 (100)	9 (100)
Main activity, *n* (%)	Retired	30 (100)	5 (100)	25 (96)	9 (100)
	Looking after home/family	0 (0)	0 (0)	1 (4)	0 (0)
	Total	30 (100)	5 (100)	26 (100)	9 (100)
Occupation type, *n* (%)	Professional	8 (27)	0 (0)	10 (40)	3 (33)
	Managerial/technical	8 (27)	2 (40)	7 (28)	3 (33)
	Skilled (non-manual)	6 (20)	0 (0)	1 (4)	0 (0)
	Skilled (manual)	3 (10)	0 (0)	3 (12)	0 (0)
	Partly skilled	2 (7)	2 (40)	2 (8)	1 (11)
	Unskilled	3 (10)	1 (20)	2 (8)	2 (22)
	Total	30 (100)	5 (100)	25 (100)	9 (100)

TABLE 14 Mean age and baseline participant-reported outcome scores by randomised group and 6-month primary outcome response status ($n = 70$)

	Control 6-month responder ($n = 30$)			Control 6-month non-responder ($n = 5$)			Intervention 6-month responder ($n = 26$)			Intervention 6-month non-responder ($n = 9$)		
Baseline variable	*n*	Mean	SD	*n*	Mean	SD	*n*	Mean	SD	*n*	Mean	SD
Age (years)	30	80.2	3.8	5	79.2	3.7	26	83.2	6	9	77.7	2.4
SF-36[a]												
Physical function	30	65.8	27.7	5	74	26.1	26	64.3	27.2	9	69.4	29.5
Role – physical	30	72.9	26.2	5	77.5	21	26	68.3	25.8	9	79.9	22.7
Bodily pain	30	63.7	27.8	5	66.2	12.2	26	64.5	30	9	64.1	27.7
General health	30	60.6	18	5	56.2	28.8	26	70.1	20.2	9	66.6	25.8
Vitality	30	53.5	21.4	5	58.8	23.6	26	63	21.6	9	60.4	17.1
Social function	30	82.1	25.1	5	77.5	33.5	26	82.2	24.8	9	93.1	12.7
Role – emotional	30	87.5	24.2	5	80	24	26	87.5	21	9	91.7	13.2
Mental health	30	76.7	19.7	5	63	31.1	26	77.3	19.5	9	79.4	10.4
Physical component score	30	43	11.5	5	47.4	6.1	26	43.4	10.3	9	44.8	11.6
Mental component score	30	52.2	11.5	5	45.9	18.3	26	53.8	10.1	9	55.2	5.6
EQ-5D[b]	30	0.75	0.22	5	0.62	0.34	26	0.73	0.31	9	0.72	0.25
EQ-5D VAS[c]	30	73.1	17.1	5	68.8	29.2	26	75.1	17.7	9	75	22.4
de Jong Gierveld emotional loneliness[d]	30	2.2	2	5	3	2.4	25	2.1	1.8	9	1.2	1.6
de Jong Gierveld social loneliness[e]	30	1.6	1.8	5	2	2	26	1.3	1.6	9	1.7	2.1
de Jong Gierveld overall loneliness[f]	30	3.8	3.4	5	5	3.9	25	3.4	3.1	9	2.9	3.3
PHQ-9[g]	30	2.6	3.4	5	7.4	9	26	3.2	4	9	2.1	2.1
ONS well-being[h]	30	7.7	2.4	5	6.6	3.6	26	7.5	2.7	9	8.4	1.1
GSE (baseline)[i]	30	31.1	5.7	5	32.6	4	26	33	4.8	9	35.5	3.1

VAS, visual analogue scale.
a The SF-36 dimensions are scored on a scale from 0 (poor) to 100 (good).
b The EQ-5D utility score is measured on a scale from –0.56 to 1.00 (good health).
c The EQ-5D VAS is measured on a scale from 0 (worst imaginable health state) to 100 (best imaginable health state).
d The de Jong Gierveld emotional loneliness scale is scored from 0 to 6, with higher scores indicating more loneliness.
e The de Jong Gierveld social loneliness scale is scored from 0 to 5, with higher scores indicating more loneliness.
f The de Jong Gierveld overall loneliness scale is scored from 0 to 11, with higher scores indicating more loneliness.
g The PHQ-9 is measured on a scale from 0 to 27, with higher scores indicating more severe depressive symptoms.
h The ONS well-being measure is scored on a 0 to 10 scale with a higher score indicating better well-being.
i The GSE is scored on a scale from 10 to 40, with higher scores indicating more perceived self-efficacy.

TABLE 15 Mean 6-month post-randomisation participant-reported outcomes by randomised group ($n = 56$)

	Intervention			Control			Unadjusted[a]		Adjusted[b]	
Outcome	*n*	Mean	SD	*n*	Mean	SD	Mean difference	95% CI	Mean difference	95% CI
SF-36[c]										
Mental health	26	77.5	18.4	30	70.7	21.2	6.5	–3.0 to 16.0	9.5	4.5 to 14.5
Physical function	26	60.3	29.9	30	56	29.9	3.4	–10.8 to 17.5	5	–0.9 to 10.9
Role – physical	26	72.6	24.7	30	55.4	27.6	15.6	3.8 to 27.4	20.2	9.9 to 30.6
Bodily pain	26	71	26	30	53.9	29.8	17.1	2.5 to 31.7	16.6	8 to 25.3
General health	26	66.2	24.2	30	56.1	22.9	10.3	–1.2 to 21.9	2.5	–6.4 to 11.4
Vitality	26	59.4	19.8	30	49.6	25.5	9.8	–2.0 to 21.7	3.1	–2.8 to 9
Social function	26	84.1	22.8	30	70	31.1	13.4	1.4 to 25.4	18.1	7.9 to 28.3
Role – emotional	26	89.1	19.4	30	81.7	23.9	7.4	–3.1 to 17.9	8.6	–0.8 to 18
Physical component score	26	43.5	10.9	30	38.3	11.5	5.1	–0.4 to 10.7	4.5	1.4 to 7.5
Mental component score	26	53.9	9.8	30	49.7	11.5	4.1	–0.5 to 8.7	4.7	2 to 7.5
EQ-5D[d]	26	0.73	0.35	29	0.71	0.27	–0.04	–0.17 to 0.10	0.02	–0.05 to 0.09
EQ-5D VAS[e]	26	75.5	19.5	30	70.5	21.8	4.7	–4.6 to 14.0	5.1	–4.9 to 15.2
de Jong Gierveld emotional loneliness[f]	26	2.2	2	30	2.2	1.9	0.2	–0.5 to 0.9	0	–0.6 to 0.6
de Jong Gierveld social loneliness[g]	25	1.3	1.9	30	1.2	1.5	–0.1	–0.7 to 0.5	0.3	–0.2 to 0.8
de Jong Gierveld overall loneliness[h]	26	3.5	3.4	30	3.3	2.9	0.0	–1.0 to 1.0	0.6	–0.4 to 1.6
PHQ-9[i]	26	3.1	4	30	3.6	4.6	–0.4	–2.2 to 1.3	–1.3	–2.6 to 0.0
ONS well-being[j]	26	8	1.5	30	7.6	1.8	0.5	–0.2 to 1.2	0.8	0.2 to 1.4
GSE[k]	26	32.9	4.7	30	32.1	3.8	0.8	–1.5 to 3.2	1.2	–0.7 to 3.1

VAS, visual analogue scale.
a Unadjusted: fixed covariate is randomised group only.
b Adjusted: fixed covariates are randomised group, baseline score, age and sex.
c The SF-36 dimensions are scored on a scale from 0 (poor) to 100 (good).
d The EQ-5D utility score is measured on a scale from –0.56 to 1.00 (good health).
e The EQ-5D VAS is measured on a scale from 0 (worst imaginable health state) to 100 (best imaginable health state).
f The de Jong Gierveld emotional loneliness scale is scored from 0 to 6, with higher scores indicating more loneliness.
g The de Jong Gierveld social loneliness scale is scored from 0 to 5, with higher scores indicating more loneliness.
h The de Jong Gierveld overall loneliness scale is scored from 0 to 11, with higher scores indicating more loneliness.
i The PHQ-9 is measured on a scale from 0 to 27, with higher scores indicating more severe depressive symptoms.
j The ONS well-being measure is scored on a 0 to 10 scale with a higher score indicating better well-being.
k The GSE is scored on a scale from 10 to 40, with higher scores indicating more perceived self-efficacy.
Models are general linear mixed models with befriending group included as a random effect.

The developers of the SF-36 have suggested that differences between treatment groups of between 5 and 10 points on the 100-point scale can be regarded as 'clinically and socially relevant'.[40] For the original sample size calculation we assumed that a mean difference in SF-36 mental health dimension scores of ≥ 8 points at 6 months post randomisation between the intervention group and the control group is the smallest difference that can be regarded as clinically and practically important. The point estimates for the primary outcome and their associated CIs suggest that the likely effect of the telephone befriending intervention is within a clinically relevant range. However, *Figure 3* shows how the SF-36 mental health scores change over time in the two randomised groups; over the 6 month follow-up period there is no change in scores in the intervention group but there is a decline or deterioration in scores in the control group.

Table 15 also shows that for the secondary participant-reported outcomes, such as the other dimensions of the SF-36, the differences in quality of life favoured the intervention group. For five dimensions of the SF-36 (role – physical, bodily pain, social functioning, physical component score and mental component score), after adjustment for baseline score, age and sex, the CI excluded zero, suggesting a non-zero effect (*Figure 4*).

There were no differences in mean scores between the intervention group and the control group for the other participant-reported outcomes, except for the ONS well-being total score.

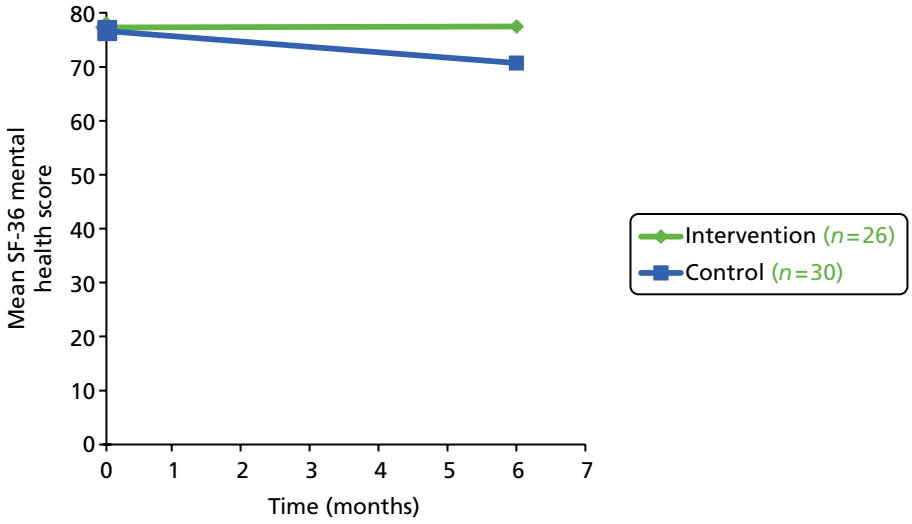

FIGURE 3 Mean SF-36 mental health dimension scores over time by randomised group.

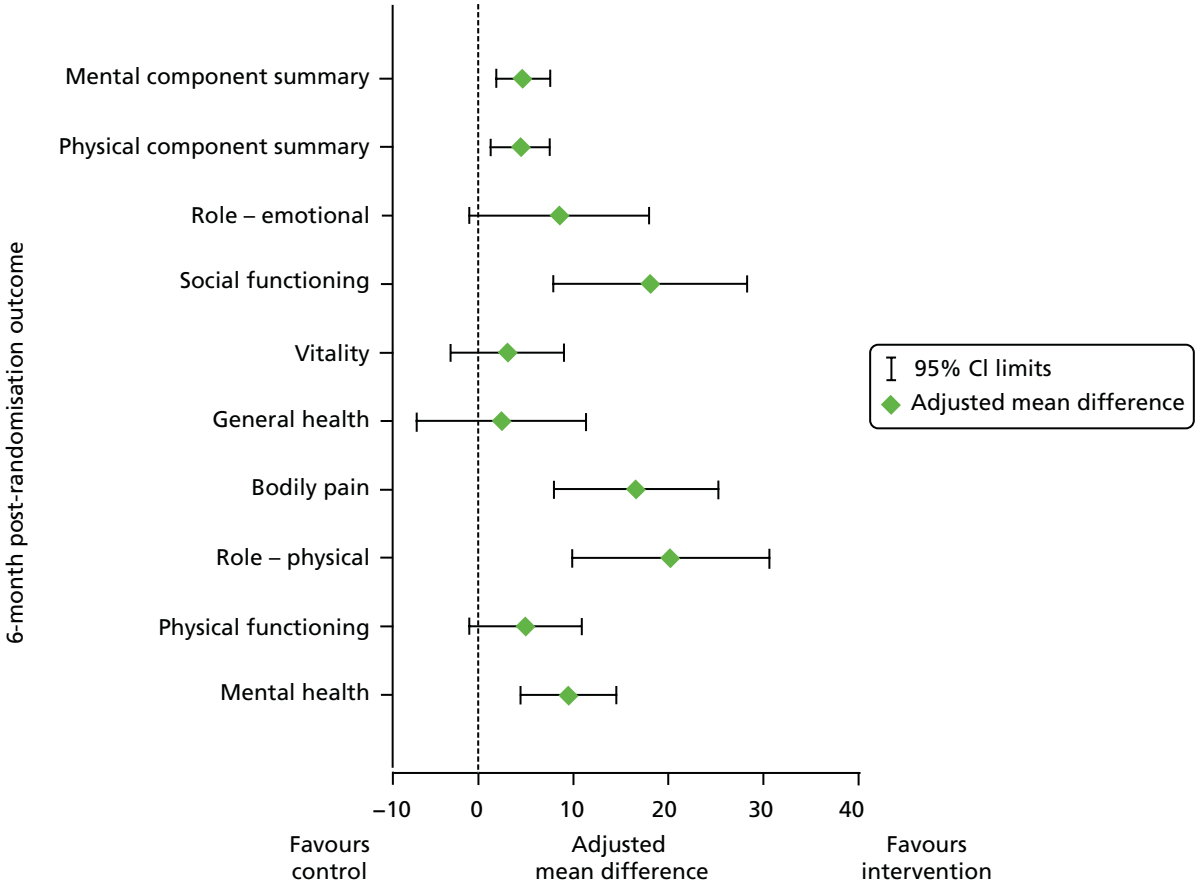

FIGURE 4 Forest plot of mean differences in 6-month post-randomisation SF-36 outcomes between groups, adjusted for age, sex and baseline score ($n = 56$).

The attrition rate at 6 months was 20%, with only 80% (56/70) of participants having valid primary outcome data; however, the results for the primary outcome were robust to missing data. *Table 16* shows the results of a sensitivity analysis of the primary outcome, the mean 6-month post-randomisation SF-36 mental health dimension score, using a variety of methods to impute missing primary outcome data. All imputation methods produced similar results (*Figures 5* and *6*). *Figure 5* shows the sensitivity analysis with adjustment for covariates (baseline score, age and sex) and *Figure 6* shows the results without adjustment for any covariates. The estimated treatment effects from the various sensitivity analyses performed produced broadly similar results, suggesting that the results are fairly robust.

A per-protocol data set was defined as all participants in the control group and participants in the intervention group who completed ≥ 75% of the group telephone calls over the 12 weeks of the group intervention (the one-to-one telephone calls with a volunteer were not included in the definition of 'per protocol'). This means that if a TF group completed 12 group telephone calls, individuals were part of the per-protocol data set if they were present for the duration of nine or more of the calls. Only 35% (9/26) of the participants in the intervention group who had valid 6-month outcome data had completed ≥ 75% of the group telephone calls over the 12 weeks of the group intervention. *Table 16* and *Figure 7* show the results for the per-protocol sample for the primary outcome only. At 6 months post randomisation, the mean (SD) SF-36 mental health dimension scores were 73.9 (17.5) for the nine participants in the intervention group and 70.7 (21.2) for the control group, a mean difference of 3.2 (95% CI –5.2 to 11.6); after adjusting for age, sex and baseline score, the mean difference was 8.0 (95% CI 3.3 to 12.7). The full results for the per-protocol population are reported in *Appendix 9*.

TABLE 16 Mean observed and imputed 6-month post-randomisation SF-36 mental health dimension scores[a] by randomised group ($n = 70$)

	Intervention			Control			Unadjusted		Adjusted[b]	
Outcome	*n*	Mean	SD[c]	*n*	Mean	SD[c]	Mean difference	95% CI	Mean difference	95% CI
Observed data ($n = 56$)	26	77.5	18.4	30	70.7	21.2	6.5	–3.0 to 16.0	9.5	4.5 to 14.5
LOCF imputed data ($n = 70$)	35	78	16.6	35	69.6	22.5	8.3	–0.5 to 17.2	7.7	3.7 to 11.8
Regression imputed data ($n = 70$)[d]	35	77.8	16.2	35	69.8	21.4	7.8	–0.6 to 16.2	7.6	3.6 to 11.6
Multiple imputation PMM ($n = 70$)[e]	35	78.9	3.7	35	70.6	3.7	8.3	–0.6 to 17.2	8.0	2.8 to 13.3
Multiple imputation regression ($n = 70$)[e]	35	77.3	3.2	35	69.7	3.9	7.6	–1.8 to 16.9	7.4	1.8 to 13.0
Per-protocol data ($n = 39$)	9	73.9	17.5	30	70.7	21.2	3.2	–5.2 to 11.6	8.0	3.3 to 12.7

PMM, predictive mean matching.
a The SF-36 mental health dimension is scored on a scale from 0 (poor) to 100 (good).
b Adjusted for randomised group, age, sex and baseline score.
c For the multiple imputation methods the SD is the standard error of the mean.
d Regression imputation based on a model with age, sex and baseline mental health score.
e Multiple imputation based on 20 imputed data sets, with age, sex and baseline score as covariates, using PMM or linear regression.
All analyses use a marginal GLM with regression coefficients estimated using a GEE, with robust standard errors.

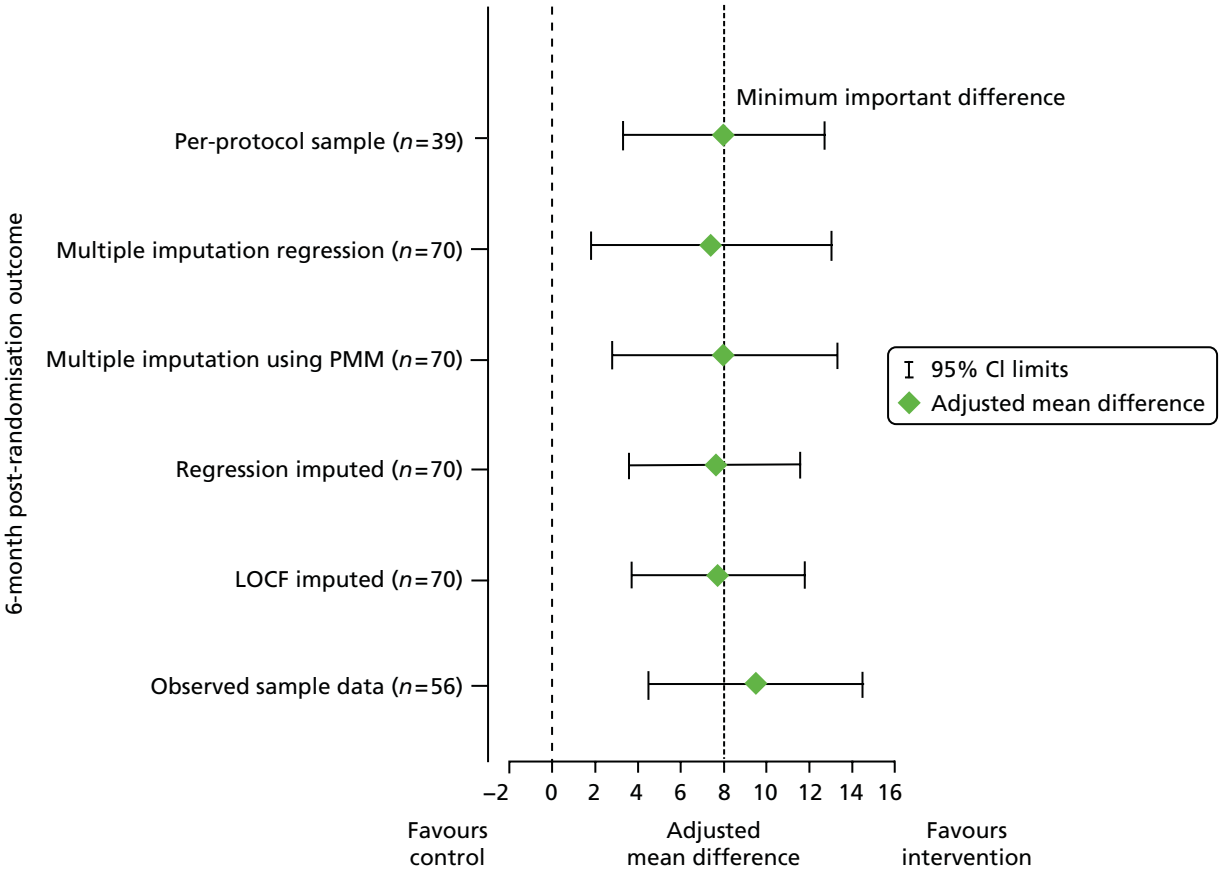

FIGURE 5 Forest plot of sensitivity analysis of mean difference in 6-month post-randomisation SF-36 mental health dimension scores between groups, adjusted for age, sex and baseline score. PMM, predictive mean matching.

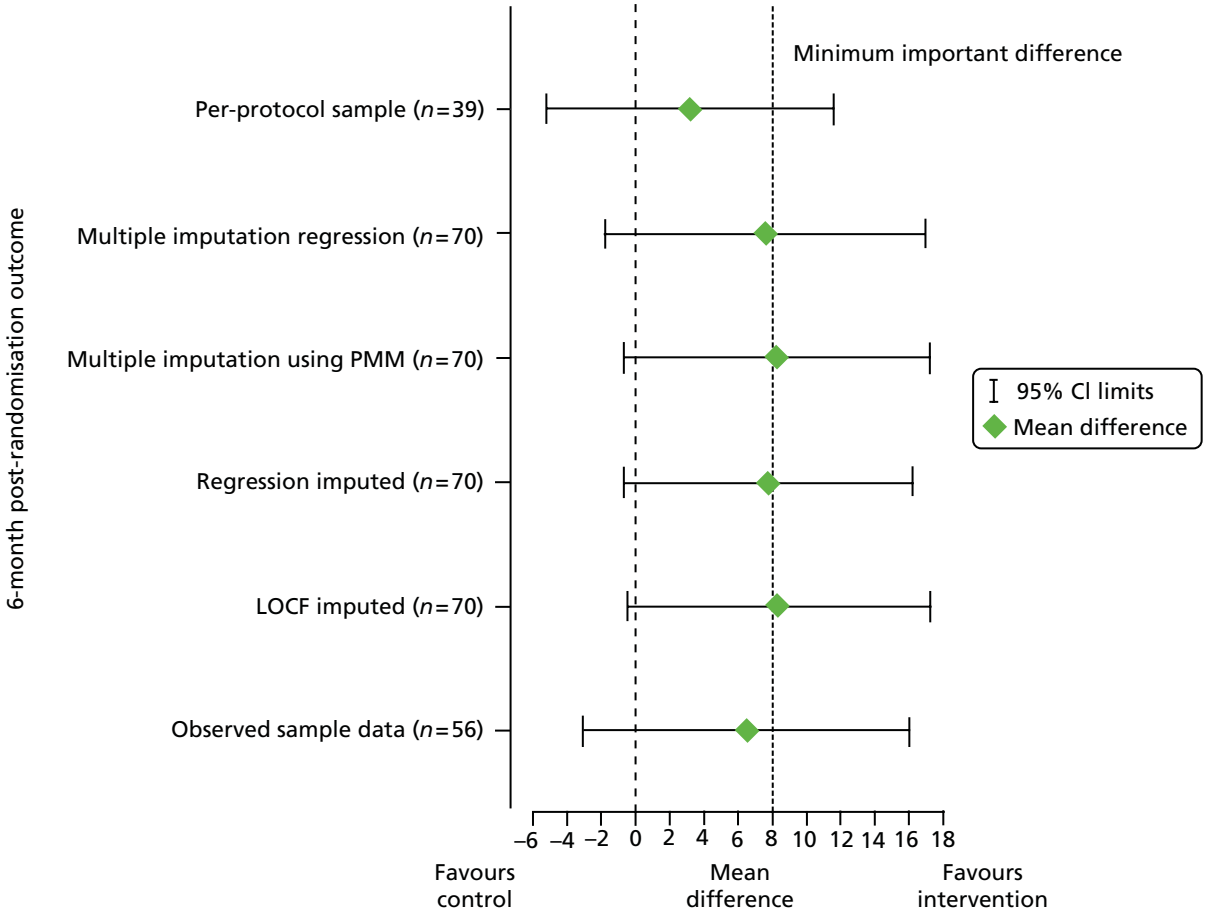

FIGURE 6 Forest plot of sensitivity analysis of mean difference in 6-month post-randomisation SF-36 mental health dimension scores between groups. PMM, predictive mean matching.

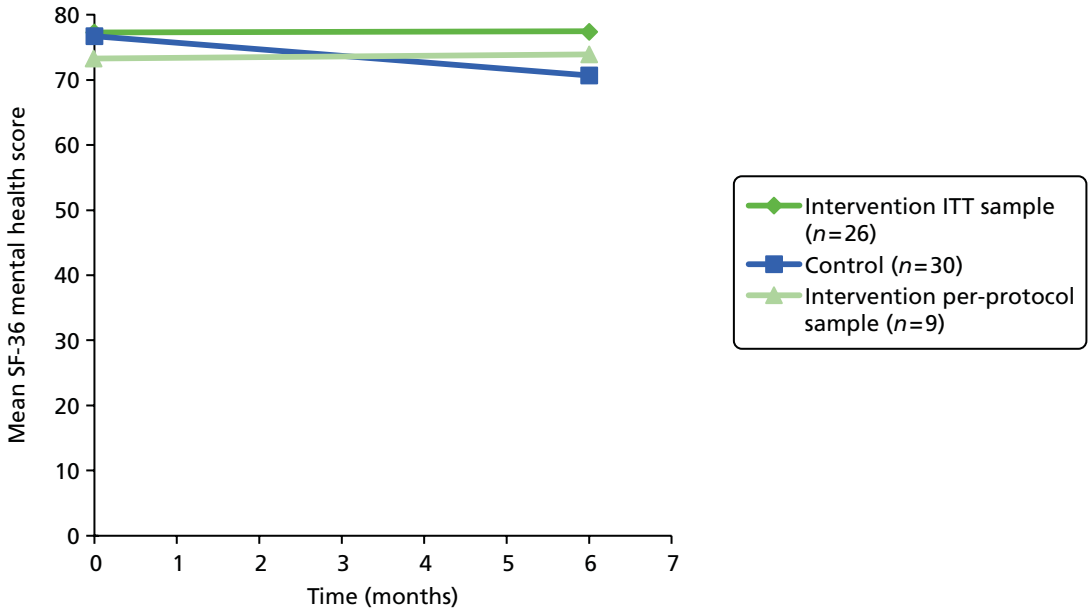

FIGURE 7 Mean SF-36 mental health dimension scores over time for the ITT and per-protocol samples.

Health and social care resource use

The health and social care resources recorded are presented for hospital use (*Tables 17–19*), medication (*Tables 20–22*), day services (*Tables 23–25*) and community services (*Tables 26–28*).

Hospital use

TABLE 17 Hospital use in the 3 months before baseline (whole sample, $n = 157$)

Resource	Intervention ($n = 78$), mean (SD), min. to max., *n* (%)	Control ($n = 79$), mean (SD), min. to max., *n* (%)
Outpatient appointment	1.37 (2.06), 0 to 10, 39 (50)	1.44 (2.92), 0 to 16, 40 (51)
A&E attendance	0.14 (0.35), 0 to 1, 11 (14)	0.05 (0.22), 0 to 1, 4 (5)
Hospital attendance – other	0.04 (0.19), 0 to 1, 3 (4)	0.04 (0.25), 0 to 2, 2 (3)
Medical inpatient nights	0.10 (0.69), 0 to 6, 3 (4)	0.08 (0.42), 0 to 3, 3 (4)
Assessment/rehabilitation inpatient nights	0.01 (0.11), 0 to 1, 1 (1)	0
Other inpatient nights	0.01 (0.11), 0 to 1, 1 (1)	0.03 (0.23), 0 to 2, 1 (1)

A&E, accident and emergency; max., maximum; min., minimum.

TABLE 18 Hospital use in the 3 months before baseline (reduced sample, $n = 70$)

Resource	Intervention ($n = 35$), mean (SD), min. to max., *n* (%)	Control ($n = 35$), mean (SD), min. to max., *n* (%)
Outpatient appointment	1.49 (2.33), 0 to 10, 19 (54)	1.71 (3.38), 0 to 16, 17 (49)
A&E attendance	0.17 (0.38), 0 to 1, 6 (17)	0.06 (0.24), 0 to 1, 2 (6)
Hospital attendance – other	0.03 (0.17), 0 to 1, 1 (3)	0
Medical inpatient nights	0.17 (1.01), 0 to 6, 1 (3)	0.14 (0.60), 0 to 3, 2 (6)
Assessment/rehabilitation inpatient nights	0.03 (0.17), 0 to 1, 1 (3)	0
Other inpatient nights	0	0

A&E, accident and emergency; max., maximum; min., minimum.

TABLE 19 Hospital use at follow-up (reduced sample, $n = 61$)[a]

Resource	Intervention ($n = 27$), mean (SD), min. to max., *n* (%)	Control ($n = 34$), mean (SD), min. to max., *n* (%)
Outpatient appointment	1.12 (1.53), 0 to 6, 15 (57)	1.57 (2.03), 0 to 7, 16 (53)
A&E attendance	0.12 (0.59), 0 to 3, 1 (4)	0.17 (0.38), 0 to 1, 5 (17)
Hospital attendance – other	0.04 (0.20), 0 to 1, 1 (4)	0
Medical inpatient nights	0	0.30 (1.29), 0 to 7, 3 (10)
Assessment/rehabilitation inpatient nights	0.04 (0.20), 0 to 1, 1 (4)	0.03 (0.18), 0 to 1, 1 (3)
Other inpatient nights	0	0

A&E, accident and emergency; max., maximum; min., minimum.

a Although 61 participants (27 intervention group, 34 control group) were included at the 6-month follow-up, there are missing data for five of these participants (one intervention group, four control group). Percentages of participants are based on the 56 with data.

Medication

TABLE 20 Medication use in the 3 months before baseline (whole sample, $n = 157$)

Resource	Intervention ($n = 78$), mean[a] (SD), min. to max., *n* (%)	Control ($n = 79$), mean[a] (SD), min. to max., *n* (%)
Sleeping medication	0.12 (0.36), 0 to 2, 8 (10)	0.06 (0.29), 0 to 2, 4 (5)
Depression/anxiety/mood medication	0.13 (0.34), 0 to 1, 10 (13)	0.08 (0.27), 0 to 1, 6 (8)
Total	0.12 (0.35), 0 to 2, 17 (22)	0.07 (0.28), 0 to 3, 9 (11)

Max., maximum; min., minimum.
a The mean is the mean number of prescriptions, i.e. a participant may have more than one prescription for each category.

TABLE 21 Medication use in the 3 months before baseline (reduced sample, $n = 70$)

Resource	Intervention ($n = 35$), mean[a] (SD), min. to max., *n* (%)	Control ($n = 35$), mean[a] (SD), min. to max., *n* (%)
Sleeping medication	0.20 (0.47), 0 to 2, 6 (17)	0.09 (0.37), 0 to 1, 5 (14)
Depression/anxiety/mood medication	0.14 (0.36), 0 to 2, 2 (6)	0.09 (0.28), 0 to 1, 3 (9)
Total	0.17 (0.42), 0 to 2, 10 (29)	0.09 (0.33), 0 to 3, 4 (11)

Max., maximum; min., minimum.
a The mean is the mean number of prescriptions, i.e. a participant may have more than one prescription for each category.

TABLE 22 Medication use at follow-up (reduced sample, $n = 61$)[a]

Resource	Intervention ($n = 27$), mean[b] (SD), min. to max., *n* (%)	Control ($n = 34$), mean[b] (SD), min. to max., *n* (%)
Sleeping medication	0.15 (0.37), 0 to 1, 4 (15)	0
Depression/anxiety/mood medication	0.15 (0.37), 0 to 1, 4 (15)	0.07 (0.25), 0 to 1, 2 (7)
Total	0.15 (0.36), 0 to 1, 8 (31)	0.03 (0.18), 0 to 1, 2 (7)

Max., maximum; min., minimum.
a Although 61 participants (27 intervention group, 34 control group) were included at the 6-month follow-up, there are missing data for five of these participants (one intervention group, four control group). Percentages of participants are based on the 56 with data.
b The mean is the mean number of prescriptions, i.e. a participant may have more than one prescription for each category.

Day service use

TABLE 23 Day service use in the 3 months before baseline (whole sample, $n = 157$)

Resource	Intervention ($n = 78$), mean (SD), min. to max., n (%)	Control ($n = 79$), mean (SD), min. to max., n (%)
Lunch club	1.26 (3.50), 0 to 15, 12 (15)	0.62 (3.20), 0 to 24, 4 (5)
Social club	0.81 (3.54), 0 to 3, 1 (1)	0.89 (3.40), 0 to 3, 1 (1)
Other	0.73 (3.44), 0 to 25, 6 (8)	2.95 (10.70), 0 to 72, 9 (11)
Total	0.93 (3.49), 0 to 28, 18 (23)	1.49 (6.79), 0 to 78, 16 (20)

Max., maximum; min., minimum.

TABLE 24 Day service use in the 3 months before baseline (reduced sample, $n = 70$)

Resource	Intervention ($n = 35$), mean (SD), min. to max., n (%)	Control ($n = 35$), mean (SD), min. to max., n (%)
Lunch club	0.66 (2.71), 0 to 12, 2 (6)	0
Social club	0	0.17 (1.01), 0 to 6, 1 (3)
Other	0	0
Total	0.22 (1.58), 0 to 12, 2 (6)	0.06 (0.59), 0 to 6, 1 (3)

Max., maximum; min., minimum.

TABLE 25 Day service use at follow-up (reduced sample, $n = 61$)[a]

Resource	Intervention ($n = 27$), mean (SD), min. to max., n (%)	Control ($n = 34$), mean (SD), min. to max., n (%)
Lunch club	1.08 (3.27), 0 to 12, 4 (15)	1.10 (3.90), 0 to 18, 3 (10)
Social club	2.35 (6.83), 0 to 30, 4 (15)	0.90 (2.76), 0 to 12, 4 (13)
Other	4.65 (11.20), 0 to 42, 5 (19)	0.50 (1.94), 0 to 9, 2 (7)
Total	2.69 (7.84), 0 to 42, 10 (37)	0.83 (2.95), 0 to 18, 9 (30)

Max., maximum; min., minimum.

a Although 61 participants (27 intervention group, 34 control group) were included at the 6-month follow-up, there are missing data for five of these participants (one intervention group, four control group). Percentages of participants are based on the 56 with data.

Community service use

TABLE 26 Community service use in the 3 months before baseline (whole sample, $n = 157$)

Resource	Intervention ($n = 78$), mean (SD), min. to max., *n* (%)	Control ($n = 79$), mean (SD), min. to max., *n* (%)
GP	1.51 (1.42), 0 to 8, 59 (76)	1.28 (1.61), 0 to 6, 44 (56)
Practice nurse	1.08 (1.84), 0 to 13, 39 (50)	1.28 (2.23), 0 to 12, 38 (48)
District nurse	0.24 (1.43), 0 to 12, 4 (5)	0.70 (3.42), 0 to 25, 6 (8)
Chiropodist	0.32 (0.67), 0 to 2, 16 (21)	0.28 (0.68), 0 to 3, 14 (18)
Counsellor	0	0.05 (0.45), 0 to 4, 1 (1)
Dietitian	0.01 (0.11), 0 to 1, 1 (1)	0
Health visitor	0.04 (0.34), 0 to 3, 1 (1)	0
Home care worker	0.63 (5.55), 0 to 49, 1 (1)	3.39 (22.65), 0 to 84, 2 (3)
Home care assistant	11.14 (53.20), 0 to 357, 4 (5)	5.01 (44.55), 0 to 396, 1 (1)
Home care attendant	1.18 (10.42), 0 to 92, 1 (1)	0
Care manager	0.01 (0.11), 0 to 1, 1 (1)	0.01 (0.11), 0 to 1, 1 (1)
Occupational therapist	0.03 (0.23), 0 to 2, 1 (1)	0.08 (0.68), 0 to 6, 1 (1)
Physiotherapist	0.59 (1.98), 0 to 12, 9 (12)	0.41 (2.29), 0 to 19, 5 (6)
Social worker	0.01 (0.11), 0 to 1, 1 (1)	0
Other	0.27 (1.41), 0 to 12, 7 (9)	0.22 (1.39), 0 to 12, 4 (5)
Total	1.14 (14.28), 0 to 360, 70 (90)	0.85 (12.98), 0 to 396, 65 (82)

GP, general practitioner; max., maximum; min., minimum.

TABLE 27 Community service use in the 3 months before baseline (reduced sample, $n = 70$)

Resource	Intervention ($n = 35$), mean (SD), min. to max., *n* (%)	Control ($n = 35$), mean (SD), min. to max., *n* (%)
GP	1.57 (1.29), 0 to 4, 27 (77)	1.31 (1.68), 0 to 6, 18 (51)
Practice nurse	0.97 (2.32), 0 to 13, 12 (34)	1.11 (2.03), 0 to 10, 16 (46)
District nurse	0.09 (0.51), 0 to 3, 1 (3)	0.03 (0.17), 0 to 1, 1 (3)
Chiropodist	0.29 (0.62), 0 to 2, 7 (20)	0.20 (0.53), 0 to 2, 5 (14)
Counsellor	0	0.11 (0.68), 0 to 4, 1 (3)
Dietitian	0.03 (0.17), 0 to 1, 1 (3)	0
Health visitor	0.09 (0.51), 0 to 3, 1 (3)	0
Home care worker	1.40 (8.28), 0 to 49, 1 (3)	0
Home care assistant	20.03 (73.84), 0 to 357, 3 (9)	0
Home care attendant	2.63 (15.55), 0 to 92, 1 (3)	0
Care manager	0.03 (0.17), 0 to 1, 1 (3)	0
Occupational therapist	0.06 (0.34), 0 to 2, 1 (3)	0
Physiotherapist	0.89 (2.62), 0 to 12, 5 (14)	0.11 (0.47), 0 to 2, 2 (6)
Social worker	0.03 (0.17), 0 to 1, 1 (3)	0
Other	0.14 (0.49), 0 to 2, 3 (9)	0.09 (0.51), 0 to 3, 1 (3)
Total	1.88 (19.98), 0 to 360, 30 (86)	0.20 (0.83), 0 to 17, 27 (77)

GP, general practitioner; max., maximum; min., minimum.

TABLE 28 Community service use at follow-up (reduced sample, $n = 61$)[a]

Resource	Intervention ($n = 27$), mean (SD), min. to max., *n* (%)	Control ($n = 34$), mean (SD), min. to max., *n* (%)
GP	1.08 (1.57), 0 to 6, 13 (50)	1.43 (1.87), 0 to 7, 19 (63)
Practice nurse	0.42 (0.76), 0 to 3, 8 (31)	1.17 (2.05), 0 to 10, 14 (47)
District nurse	0.04 (0.20), 0 to 1, 1 (4)	0.07 (0.37), 0 to 2, 1 (3)
Chiropodist	0.58 (0.95), 0 to 3, 9 (35)	0.27 (0.64), 0 to 2, 5 (17)
Counsellor	0	0
Dietitian	0	0
Health visitor	0	0
Home care worker	0.15 (0.78), 0 to 4, 1 (4)	0
Home care assistant	14.19 (72.16), 0 to 368, 2 (8)	0
Home care attendant	3.54 (18.04), 0 to 92, 1 (4)	0
Care manager	0.12 (0.59), 0 to 3, 1 (4)	0
Occupational therapist	0	0
Physiotherapist	0	0.30 (1.21), 0 to 4, 2 (7)
Social worker	0	0
Other	10.77 (54.91), 0 to 280, 1 (4)	0.27 (0.24), 0 to 3, 4 (13)
Total	2.06 (23.82), 0 to 369, 21 (81%)	0.23 (0.92), 0 to 11, 23 (77%)

GP, general practitioner; max., maximum; min., minimum.

a Although 61 participants (27 intervention group, 34 control group) were included at the 6-month follow-up, there are missing data for five of these participants (one intervention group, four control group). Percentages of participants are based on the 56 with data.

Chapter 5 Results of the qualitative research

Results of the participant interviews

The sample

Twenty-four participants out of 78 (pilot study $n = 35$) randomly allocated to the research intervention arm were allocated to a volunteer over the course of the study. We attempted to interview all 24. One participant was withdrawn from the study (because of protocol non-compliance) before being invited to an interview. Of the remaining 23 participants, two did not consent to an interview (one had withdrawn after the first one-to-one call and one had withdrawn before the calls started), one could not be contacted (no dial tone, e-mail sent) and one declined to take part in an interview (no reason given). Those participants allocated to the intervention but who were not allocated a volunteer facilitator and were not followed up were not invited to take part in an interview.

Nineteen (83% of the target) participants in the intervention arm participated in semistructured interviews between March 2013 and April 2013. The baseline characteristics of the interview population compared well with the baseline characteristics of the trial participants who did not take part in interviews. Those interviewed were slightly older than those not interviewed, were more likely to live alone (79% vs. 63%) and scored slightly higher for mental health function at baseline. Conversely, those interviewed scored slightly lower for physical function at baseline (see *Appendix 10*).

Prior states

Reasons for taking part

Altruism

Participants reported wanting to help with what they felt was useful research. Some were recognisable as serial 'joiners', with one describing herself as 'always willing to be a guinea pig' (037, female). Six participants explicitly asserted that they were helping others by participating and did not need help themselves (see also *Value*).

> *I joined the group because I wanted to help this research, not because I desperately needed to talk to somebody.*
>
> *006, female*

Curiosity

Some participants said that they were motivated to participate by general interest in the research or in what other participants might have to say or that they were novelty-seeking. One person was specifically interested in how the group calls worked in case his church ever thought of having a telephone group.

External influence

One participant felt that he should participate as the invitation letter came from his general practitioner (GP):

> *I thought probably he'd [GP] referred me because . . . knowing that I'm on my own and that I do smoke . . . I thought it was probably an anti-smoking group or something like that.*
>
> *019, male*

Expectations of telephone friendship groups

Prior expectations of the TF groups generally overlapped considerably with the altruistic reasons for participating in the project. An exception was when participants recalled having concerns about the practicalities of talking over the telephone with a group of people, including how conversations would be facilitated (see *Acceptability*):

> *I thought we might, I must confess, I thought we might find ourselves talking over one another or horrible pauses, not knowing where to come in and so on.*
>
> *058, male*

Perceived needs

Again, most participants expected that they would be helping those in need rather than benefiting themselves by participating (see *Altruism*). They characterised themselves as self-sufficient, socially active or happy in their own company, but felt that the telephone groups would be helpful for those who are housebound or who have less contact:

> *I don't feel the need quite as much as I can understand some people, you know, who have interests but a limited access to various things.*
>
> *055, female*

Only a small minority of participants referred to their own needs and then often still with reference to an imagined, more generalised need:

> *I mean I've been feeling very sorry for myself after my husband died . . . I was still in a fog . . . yeah I can see why people would go into the homes and if they'd lost somebody they could . . . sort of shut themselves off if you like.*
>
> *081, female*

Acceptability

Twelve participants described TF in positive terms such as 'enjoyable', 'pleasant' or 'quite good'. Nine participants described the process as being easy. A further three participants described their experience as 'interesting'. Some of these participants found the group to be an acceptable vehicle for sharing life experiences:

> *It was interesting, it was good to meet other people [er] and find out about them and how they ticked and how they, you know, had a life before, it was good, I enjoyed it.*
>
> *006, female*

Conversely, some participants felt that the one-to-one volunteer befriending was acceptable but that the group was not for them:

> *You don't know what to talk about when you don't know people and you don't know what they want to talk about.*
>
> *015, female*

Some participants described a level of initial apprehension, which diminished over time as they began to recognise the voice that was speaking and found that they had enough in common with other group members. A minority of participants found friendships based solely on telephone conversation inferior to those outside the group that also involved face-to-face communication:

> *Well it's an unusual sort of, I mean if I want to telephone friends I do, you know, of course talking to people who you don't know and you haven't seen, that's different.*
>
> *038, female*

the thing I found difficult first was that you were talking to people you'd never seen, I think visual things are so important, and therefore when you are talking in a group, you're listening politely to what they say, and you don't know really when to come in.

065, male

it was strange . . . you listen to one person and then you listen to another person and then another, I just found it difficult.

015, female

Technical concerns

The majority of those interviewed found the timing, duration and frequency of the TF group meetings acceptable and accessible. Three participants felt that the group calls could have been made at a more convenient time and noted that the time was a compromise for the group. One reported feeling 'tied down' by the booking. Participants in two different groups found their groups too small after members dropped out. They reflected on how this restricted the range of topics and discussion and that the length of calls was reduced to 30–45 minutes (see also *Group dynamics*). A minority of interviewees reported having difficulty hearing some members in their group and one reported having difficulties with the telephone line.

Closure of time-limited groups

How individual participants characterised the experiences of their group ending was influenced by the group that they were in (see *Assessment of group intervention delivery by volunteer facilitators*). In general, most accepted that the groups were time-limited. Some felt that it was a pity that the calls were ending and wanted the groups to continue and to stay in touch with members of the group (see *Value*). Nine participants described feeling sad, disappointed or sorry that the group calls ended:

Awful because I'd nothing to look forward to . . . And that was quite, quite . . . yeah I missed talking to them.

008, female

I would like to get to meet these people . . . seeing them is better than a voice . . . so I thought, sort of form a friendship . . . that's what I thought it would lead to and that's not been the case.

027, male

Well, I enjoyed doing it but as I say, I was so upset when they came to a full stop.

019, female

Some participants criticised the way in which the facilitators ended the 12-week group call programme (see the following section). Several talked about the end of the programme being like a 'full stop' or being 'cut off'. Some reported having discussions in their group about staying in touch after closure. There was a general feeling that this aspect was not well managed by the facilitators, resulting in some reported disappointment. Six participants reported acceptance that the groups were time-limited or relief that a perceived obligation had been lifted.

Implementation and facilitator performance

Participants who found the befriending groups acceptable generally described their volunteer facilitator in favourable terms, such as 'good' or 'unobtrusive' or as a 'co-ordinator' or a 'leader'. Participants who were less satisfied focused on facilitators changing the topic of discussion (e.g. when it had strayed onto politics) or intervening when it was not necessary. Some participants in larger groups experienced problems starting conversations, with everyone trying to talk at the same time:

[the volunteer] butted in from time to time, diverted us to get onto things, that did a little bit and then tended to sort of fizzle out and I didn't want to sort of chip in and, and dominate things so, you know, I waited to have a little sort of, little sort of lead from the other two but it rarely materialised.

037, female

Volunteer facilitators were trained to establish minimum ground rules for participants, including saying your name before speaking, but one participant described this not being implemented:

> *At first we didn't recognise each other's voice until someone said, 'hello, this is . . .' . . . and I have a very bad memory and I couldn't remember the names and I felt quite bad that I couldn't remember . . . and I wrote them down but I still couldn't remember who was talking.*
>
> *005, male*

Participants who talked about the one-to-one calls that they received from the volunteer before joining the group, generally felt that they were a good idea, with three participants stating that they preferred them to the group calls. There were some complaints about continuity of care. Volunteer attrition meant that some individuals received a different volunteer in the one-to-one and group calls, but some reported that they were not warned of this or told why (see also *Chapter 3*, *Monitoring volunteers*).

Maintaining contact with other participants after closure of the time-limited groups was of concern to many participants, but they often felt that closure of the groups was not dealt with well. Volunteer facilitators had been advised by the host charity to inform the charity if participants wanted to share contact details. One volunteer facilitator failed to refer such a request back. Another arranged a face-to-face meeting but some participants were not given or were not able to follow the instructions, resulting in failure of the meeting and some dissatisfaction.

Group dynamics

The dynamics of each group were in part influenced by the volunteer facilitator; coded content was often also coded under the heading 'acceptability'. Three key subthemes were identified within group dynamics: cohesiveness, disclosure and peers.

Cohesiveness

Both within and across the groups participants varied in the extent to which they felt part of the group. The degree to which the groups 'bonded' is likely to be linked to 'facilitator performance' (see *Group dynamics* and *Results of the fidelity assessment*) and the 'needs' and expectations of the members of the groups. The size of the groups varied from three to six participants across the 12 weeks because of participants withdrawing from or missing group calls. One group that experienced no withdrawals seemed relatively cohesive to participants, four of whom had a health-care career in common:

> *We gelled, we waited for each other, we were patient with each other, we wanted to know, we were interested.*
>
> *006, female*

Not everyone within the larger groups identified as much with the other members of the group, with some individuals feeling excluded from topics of conversation at times, despite the efforts of facilitators to involve them. A number of participants in the two smaller groups noted that having more members might have enriched the groups' conversations, although another participant suggested that those who were left in the group were more interested in taking part:

> Interviewer: *And how many did that go down to?*
>
> Participant: *Oh, it went down to about three or four at the end of it.*
>
> Interviewer: *Did that make any difference to the discussions?*
>
> Participant: *Not really because [er] the people who were interested and involved kept on with the course.*
>
> *019, male*

Across the groups none of the participants identified a clear goal of or purpose to the group. A number of the interviewees discussed the need to have a mix of people in the group, with different needs and interests, to keep it stimulating:

> *I still feel you've got to have some interesting people to keep the group active.*
>
> *055, female*

> *I feel it's more beneficial to people who are actually housebound because it's a contact with the outside world. Whereas, as you can see, I'm pretty active and, you know, and [erm] and busy, but I can see the reason why you need the mixture because if they're all not getting out there's going to be no conversation, so I see a benefit both ways.*
>
> *055, female*

Disclosure

No direct conflicts were reported to have occurred in any of the groups. The majority of members described the discussions as being about everyday occurrences. Some participants wanted the discussions to be about superficial events and to keep the conversations light and not to go too deep:

> *were nothing very deep or, you know, political . . . it's got to be avoided things like that, so you know then we, we've kept it very smooth and easy.*
>
> *038, female*

> *if you go into somethin' too deep with people who you don't know, you fall out . . . nobody wanted to fall out you know . . . so we skipped over things like that.*
>
> *003, female*

Conversely, other participants felt that the conversations were too light and that they wanted more meaningful conversation or to explore specific topics:

> *but it was just chat . . . nothing too interesting.*
>
> *027, male*

Value

Perceived benefit

Participants did not identify direct changes to their health or their ability to carry out tasks as a result of being part of a group. One participant felt that the group had made her more inclined to socialise and another felt that the group had enabled her to meet people without inconveniencing others:

> *Well I have always liked socialising, I always have, but the thing is, to get anywhere I have to be taken and that interferes with other people's lives . . . I enjoyed it 'cos you were meeting people without physically meeting them.*
>
> *003, female*

The majority of participants who remained in their groups talked in positive terms about hearing other people's perspectives, opinions and views on the world. Some felt that they had developed or found comfort in the groups:

> *all in all I think it's made me more observant, not only of the natural world, but people around me.*
>
> *081, female*

It helps me, it helps me to think that there are other people in [locality] to whom I've been talking and they are getting on with their lives and so you get on with yours.

006, female

Yeah it was nice . . . it filled . . . the winter days . . . And I looked forward to it, yes.

002, female

Four participants talked about the moral support that they received from being in the group, that it inspired them to try new things and that they gained confidence in their voice:

Well, when you're talking on the phone it's, it's a sort of moral support you get . . . you're just talking to people, you've never met them . . . and you just have to sort of grasp, you know, who they are and what they do, or what they've done. [Er] You know, to give you an insight on [er], you know, on [er] on things.

003, female

Several participants reported that it had been nice but that it had no direct benefits or that they did not learn anything:

Personally I don't know that it brought any great benefit . . . I don't know that it, it's changed my life or not or made me think of anything wildly different or anything of that kind.

058, male

I wouldn't say they were important, they were interesting . . . you know, and enlivened the day and there are masses of days when you didn't see or hear . . . from anybody . . . 'cos I'm a voracious reader and enjoy listening to music . . . I've learnt to occupy myself.

037, female

One of the reasons that participants gave for joining the study was the perceived needs of 'others' (see *Prior states*). Many participants expressed hope that, although the group was not benefiting them directly, it was helping other people. However, one participant who started her participation in the group with this belief felt that in the end the group had helped her because she was unable to go out as she was recovering from a lengthy stay in hospital:

whereas like, you'd go out with your friends and go for a coffee . . . or go for a meal. Well I couldn't do that at that time. So I suppose, yeah, I suppose it did help really.

002, female

Preferred alternatives

Fifteen participants talked about alternatives to telephone-based discussions. The alternatives suggested were meeting facet to face as a group; taking part in an activity group; including people of similar or different ages in the group; and having one-to-one telephone conversations rather than group telephone calls. A number of participants also suggested that the telephone group could be improved by being able to see the other people in the group, for example through the use of video conferencing.

this thing of getting us all together to talk, I thought was wonderful [er] it's marvellous what they can do now, you know, all we need now is as Skype.

065, male

Six participants indicated that it was difficult to form new relationships without face-to-face contact (see also *Group dynamics*).

> *You can't see people's gestures, you can't see people visually, and you can't see . . . those facial expressions, I haven't felt anything like that from the conversations, but I'd like to have seen more.*
>
> *065, male*

> *I would like to get to meet these people . . . seeing them is better than a voice . . . sort of form a friendship . . . That's what I thought it would lead to . . . Well, like I say it was just a voice.*
>
> *027, male*

> *I think there's only so long you can speak to people in that way, you know, it's not like having close friends.*
>
> *055, female*

Participants often talked about other members of the group not being there, either dropping out or missing calls (see also *Group dynamics*). Reasons for missing calls included planned events such as going on holiday, attending hospital appointments or having visitors. Several participants commented that they had to leave calls part-way through because of the arrival of carers, family or friends.

Willingness to pay

Six participants said that they would pay for the service; however, the majority of the participants were not willing to pay for the service for a variety of reasons, including feeling that they did not need the group, that there was a better alternative that they could spend their money on or that they should not have to pay. Some participants were willing to pay if they felt that they needed it but thought that it was not for them at this point in time.

Results of the volunteer interviews

The sample

We attempted to interview all volunteers who remained in contact with the service provider ($n = 8$) about their experiences. This included volunteers who dropped out before, midway through and post completion of the group facilitation skills training. Three volunteers consented to an interview: two had completed delivery of the intervention and one had dropped out during the group facilitator training.

The volunteers participated in semistructured interviews between February 2013 and April 2013. Sociodemographic data were not collected for volunteers; however, those who were inducted by the service provider were aged from their 20s to their 70s. The sample included one volunteer of working age (working part-time) and two who were retired.

We used the same macrolevel themes for the volunteer interviews as for the participant interviews and most material could be categorised under the 'prior states' and 'technical' headings. The results of the volunteer interviews are presented first and the analysis of intervention fidelity is presented in *Results of the fidelity assessment*.

Prior states and expectations

All facilitators said that they had volunteered because of a desire to help others and because the telephone facilitator role sounded interesting. Two volunteers said that they wanted to get something out of volunteering themselves (VF01, VF03). One volunteer expected the role to involve more face-to-face interaction with participants (VF02). Having dropped out, they also reflected on the type of role that they would have preferred, such as working in a day centre where they would meet people. Another volunteer described being apprehensive about making group calls and being especially worried about conflict arising

in the group (VF03). Volunteers expected TF groups to consist of participants who were isolated, lonely and housebound but found that there was more variation (see *Chapter 3*, *Monitoring volunteers*).

Technical

Acceptability and accessibility of telephone friendship groups

Generally, both volunteers who had delivered the intervention described their experience as good and felt that they had benefited from taking part. One noted that the one-to-one calls were very easy, that the 12 weeks of group calls went quicker than she anticipated and that it was so enjoyable that she had since found two other volunteer roles (VF03). The other talked about the calls broadening his knowledge of the locality and challenging his assumptions about people (VF01).

There were perceived problems for the facilitators. One volunteer described wanting more direct contact with 'participants' (VF03). Both volunteers felt that the time commitment associated with facilitation was significant. One reported that the combination of the calls and the paperwork meant that involvement with the programme took longer than an hour a week (VF03). The other found it difficult to catch individual participants at home for one-to-one calls and to schedule a convenient day and time for the group calls (VF01). This volunteer reported that using the Community Network system for one-to-one calls was time-consuming, especially as participants often put off a prearranged call for other priorities, such as going out or having their tea. He felt that the majority of participants did not need the one-to-one calls before participating in the group calls (see *Prior states*) and that the number of one-to-one calls could be reduced from six to three or four. This volunteer facilitator also suggested that the availability of participants should be ascertained before recruiting them for the service, although he did not suggest who might carry out this work (see also *Monitoring volunteers*).

One volunteer commented that there had been good communication with the Community Network operators, which helped her keep track of group member cancellations (VF03). The other volunteer felt that it would have been desirable to be able to make calls after 1700 as participants were more available after this time; however, this facility was not available (VF01).

Volunteer training

Volunteers talked about the one-to-one and group facilitation skills training. All volunteers said that they found the information provided by the service provider about the telephone facilitator role clear. Volunteers discussed how prepared they were for the role. Generally, volunteers felt that the one-to-one training was good. Volunteers' views of the group training varied. One felt overfaced by the amount of material and selected what they felt was most useful from the group training (VF01). The other volunteer who went on to facilitate a group felt that the group training was good but that it did not prepare her for actually carrying out the role (VF03). This volunteer also commented that the interval between the facilitation skills training and facilitating a group could have been shortened, suggesting that 2–3 weeks would be desirable. The other volunteer discontinued training because of a lack of confidence and because of finding the group training intimidating (VF02).

Volunteer monitoring and support from the service provider

Only one volunteer who facilitated a telephone group described having any mentoring contact with the service provider's volunteer co-ordinator (VF01). He had been contacted by the service provider in the early stages of the group work. The same volunteer went on to say that there were times when he was unsure about how to deal with certain situations, for instance when participants missed calls, and had resorted to contacting the study team and Community Network rather than the service provider.

Facilitator performance

Volunteers demonstrated variable understanding of the training provided and their role in issues such as maintaining confidentiality. One volunteer (VF03) showed awareness of a procedure, if not the precise details, for allowing participants to stay in touch with each other after the termination of the facilitated

group (see *Chapter 2*, *Methods for the fidelity assessment*, and *Appendix 4*). The same volunteer also prepared the group for the end of the 1-hour discussion and allowed space for the group to choose topics for the following week (see *Chapter 2*, *Methods for the fidelity assessment*, and *Appendix 4*). However, contrary to the facilitation skills training, the volunteer also found it difficult not to 'participate' in the group discussions and felt that she needed to join in to help the conversation flow. She described the role of the volunteer facilitator as different from her approach, acknowledging that she was more comfortable joining in. The other volunteer (VF01) described his approach to facilitating the discussion as 'laissez-faire', when he should have been facilitating the group members to agree topics for discussion. This is echoed by the participants, who felt that the groups could have been more focused on 'topics' of conversation rather than just 'chat' (see *Group dynamics*). One volunteer (VF03) described the training materials as 'guidelines' and useful for instructions on technical issues, but did not refer to instructions on her role in facilitating the group (see *Chapter 3*, *Training*). The two volunteer facilitators (VF01, VF03) discussed the group calls coming to an end with their groups. Both volunteers introduced the idea of group members staying in touch and/or meeting face to face. One volunteer facilitator said that participants had 'hinted at it' before the end and had prepared in advance by checking the handbook for instructions (VF03).

Perceived benefit to participants

The volunteers did not feel that the group had benefited participants greatly because many participants were physically or socially active. However, they still perceived a level of enjoyment from the telephone calls by members of the group. They went on to say that the participants felt that the service would have benefited people who they knew who were very lonely and isolated. Both volunteer facilitators noted that participants seemed to share more in the group discussions than during one-to-one calls, describing group members as 'more forthcoming' (VF01) and the group calls as more 'dynamic' than the one-to-one calls (VF03).

Results of the fidelity assessment

The fidelity assessment aimed to examine the extent to which volunteers facilitated the group telephone calls as intended. A number of strategies were employed across the study to aid this assessment. The strategies were based on the framework set out by the Behaviour Change Consortium:[54] study design, training, delivery, receipt and enactment. Volunteer facilitators' assessment of their own performance (see *Results of the volunteer interviews*, *Technical*) and participants' engagement in the intervention, when relevant, are brought together with reference to this framework.

Study design

A minimum and maximum number, duration and frequency of telephone contacts were established as part of the intervention design (see *Chapter 2, Interventions* and *Telephone befriending design*). Nine participants received the per-protocol minimum number of calls of nine (out of 12). *Table 29* summarises the number of group calls made by the volunteer facilitators and shows the time period over which

TABLE 29 Frequency and duration (weeks) of group calls

Group	Completed 12 calls	Duration (weeks)	Description (occasions)
1	Yes	12	
2[a]	Yes	18	Break after week 1 (4 weeks), reason unknown; break for Christmas (2 weeks)
3	Yes	12	
4[a]	Yes[b]	14	Facilitator absence ($n = 1$); availability of participants ($n = 1$)

a Both groups were facilitated (consecutively) by the same volunteer.
b Calls registers for weeks 7–12 were not returned. Calls were confirmed by the volunteer (field note, 26 April 2013).

calls took place. Two volunteer facilitators conducted 12 discussions with each taking place 1 week apart for 12 weeks. The two other groups, facilitated by the same volunteer (consecutively), completed 12 calls over a longer period of time.

Assessment of volunteer experience and competence (training)

A set of qualities and skills required of volunteers to enable them to carry out the volunteer befriender/facilitator role were agreed prior to the service provider promoting the opportunity in the locality. Volunteers were screened by the service provider, which included a criminal records check with the UK Disclosure and Barring Service to assess their suitability for the role. All volunteers had some experience of communicating either face to face or by telephone in their current or previous employment. The majority of the volunteers had some experience of volunteering although none had done so by telephone.

One-to-one calls training

Induction sessions were led by the service provider's customer engagement manager. Generally, volunteers were inducted and trained in making one-to-one calls in groups of between two and seven, depending on the number of volunteers expressing an interest in the role at the time. Induction sessions lasted between 1 and 2.5 hours, depending on the size of the group. The induction consisted of an ice-breaker and provided information on issues facing older people (training video), information on confidentiality and equality and an introduction to the TF groups service. The induction also included information about the research study and training in making one-to-one calls. On occasion, the content was delivered over two sessions, with 'new' (potential) volunteers being invited to join meetings with volunteers who had already agreed to take on the role. The service provider held regular meetings with volunteers between the initial contact and the start of intervention delivery. The customer engagement manager contacted volunteers periodically during the group call part of the intervention; the frequency of contact was not recorded (see *Results of the volunteer interviews*, *Technical*, and *Chapter 3, Monitoring volunteers*).

Group facilitator training

Volunteers received four 1-hour training sessions in group facilitation skills. Training was delivered over the telephone using Community Network's teleconferencing system and training groups included up to a maximum of five trainees. All volunteers were trained by the same trainer and received the standardised content that is delivered to all volunteer facilitators running TF groups using Community Network's system. The training modelled the scenarios that volunteers could expect when facilitating their own groups, including facilitating a 5- to 10-minute group discussion. The training was supported by a written manual that was adapted to align it with the intervention design (e.g. references to one-to-one calls). Community Network's existing policies regarding confidentiality and sharing information relating to participants were adopted for the study. The service provider also worked with its existing volunteer policies in terms of confidentiality and safeguarding 'participants' (see *Chapter 3*, *The contract with the service provider*).

Assessment of training content delivered by the trainer

The sample

Facilitator training was delivered in four 1-hour sessions. Nine (56%) of these 1-hour sessions were audio recorded. Training content could vary across the four sessions depending on the understanding of each trainee in a group; therefore, at least two samples of each of the four sessions were recorded. The sample of recordings was assessed by two observers using the training content checklist (see *Appendix 8*). The checklist was designed to ensure consistency in the content delivered to volunteers and to make sure that the trainer tailored the content to ensure provider (volunteer) skill acquisition. The checklist accounted for content anticipated but not covered in the sampled session, for instance if the trainer had to spend longer on one component and moved other content to the next session.

Training content fidelity scores

Table 30 shows the percentage fidelity scores of the training content delivered to volunteers by the trainer. The median was used to calculate the overall percentage fidelity score for each group. The trainer scored > 91.0% based on the median scores taken from the observers. For groups 1 and 2, the percentage fidelity score was > 95.0%. Observers noted that groups 1 and 2 seemed different from group 4 in terms of the flow of discussion and a greater degree of input from the trainees, although this was not formally measured.

The checklist also assessed provider (volunteer) skill acquisition using three items: reflection on own style of communication, impact of their style on the group and reflects on skills learned. Observers scored trainees in all groups as 100% for overall fidelity against these criteria. Volunteers' perceptions of the facilitation skills training are detailed in *Results of the volunteer interviews*, *Technical*.

Assessment of group intervention delivery by volunteer facilitators

The sample

A sample of facilitated telephone discussions was audio recorded by Community Network, both within and across groups. We assumed that overall facilitator performance may not always adhere to that prescribed by the training content delivered and that the groups would require less input from volunteer facilitators as they developed over time (see *Appendix 4*). The sample therefore consisted of recordings of the same group at different time points throughout intervention delivery to enable facilitator performance to be assessed. A total of 11 (22.1%) audio recordings were made from four groups at three time points: weeks 1, 6 and 12. At least three samples at each time point were audio recorded. The sample was assessed by two observers using the intervention delivery checklist (see *Appendix 8*). The checklist included core skills and practices that are important to help the groups fulfil their purpose. The checklist was designed to examine whether the intervention's core components were implemented.[56] The checklist accounted for content that was not applicable to individual sessions sampled. The minimum duration of the group telephone discussions sampled was 23 minutes and the maximum was 69 minutes, with a median of 55 minutes.

A narrative summary of observations made during completion of the checklist is presented alongside the fidelity scores.

Intervention delivery fidelity scores

Table 31 shows the percentage fidelity score for each group volunteer facilitator at the three time points sampled. The median from the observed scores was used to calculate the overall percentage fidelity for each group. The volunteer facilitators scored between 30.2% (group 2) and 52.1% (group 4) based on the median score taken from the observers.

TABLE 30 Fidelity scores by group: training content delivered by the trainer[a]

	Group 1			Group 2			Group 4		
	Observer 1	Observer 2	Median	Observer 1	Observer 2	Median	Observer 1	Observer 2	Median
Score	35/36	34/36	34.5	39/42	38/39	38.5	33/36	35/38	34.0
Percentage fidelity[b]	97.2	94.4	95.8	92.9	97.6	95.1	91.7	92.7	91.9

a Training group 3 not sampled.
b Percentage calculated based on scored items considered 'applicable', which varied slightly between observers.

TABLE 31 Fidelity scores by group: intervention delivery

	Group 1				Group 2				Group 3[a]				Group 4			
	Observer 1	Observer 2	Median	%[b]	Observer 1	Observer 2	Median	%[b]	Observer 1	Observer 2	Median	%[b]	Observer 1	Observer 2	Median	%[b]
Week 1	18	21	20	47.6	12	14	13	32.5	19	18	19	55.2	27	27	27	70.1
Week 6	13	14	14	45.8	7	6	7	20.6	17	12	15	46.0	13	15	14	38.9
Week 12	10	9	10	33.3	13	12	13	35.7	–	–	–	–	15	13	14	45.2
Percentage fidelity[c]	41	44	43	42.9	32	32	32	30.2	36	30	33	50.7	55	55	55	52.1

a Intervention delivery ongoing at the time of assessment; percentage calculated based on two sessions.
b Percentage fidelity based on the median scores between the two observers.
c Calculated based on scored items considered 'applicable', which varied slightly between observers.

Overall, the fidelity scores for all volunteer facilitators were low. The highest score was just over 50%. This indicates that volunteers did not facilitate the group discussions in line with the training content delivered.

Two groups show a decline in fidelity score over the time points sampled. The volunteer facilitator of group 4 scored the highest (70.1%) weekly score overall. The lowest weekly score of 20.6% was observed in group 2. The percentage fidelity score overall for this group was also the lowest across all of the groups. It is worth noting that the number of items observed as 'not applicable' reduced over time in all groups. These were items that did not arise during the conversations sampled (e.g. encourages a quieter participant to join in).

The extent to which the volunteer facilitators discussed and agreed ground rules with their group varied. Establishing norms within the group is important[57] and agreeing ground rules is one technique for establishing norms. The facilitator training material recommends setting minimum ground rules, of which confidentiality and respect are key (see *Appendix 8*). Volunteer facilitators are trained to establish ground rules with the group, inviting discussion and agreement. This creates an environment in which the group can develop into a 'group', perform well and fulfil its purpose.[57] One volunteer facilitator mentioned confidentiality; however, not all members of the group had joined the call at this point (group 2, week 1). This volunteer facilitator went on to tell all participants to use only first names and not to share contact details and also stated the purpose of the group (to share interests and experiences). However, this volunteer facilitator then addressed one member of the group and informed her that he had met someone recently who knew her (group 2, week 1). The context of the discussion between the volunteer facilitator and the acquaintance is unknown; however, volunteer facilitators were trained by the service provider not to discuss participants outside the group. In addition, disclosing this information to the group may have impacted on the participants (see *Results of the participant interviews*, *Group dynamics*).

One volunteer facilitator mentioned that members of the group should say their name before speaking but did not discuss ground rules (group 1, week 1). The volunteer facilitator of group 4 demonstrated a good understanding of the process of establishing ground rules. They talked briefly about her role and stated that participants did not have to talk, that sessions are time limited and that participants should stop talking when asked. Although she did not specifically mention confidentiality, she did talk about respecting others in the group, providing examples. This volunteer facilitator also invited the group to think of any additional ground rules (group 4, week 1).

The facilitator role is to make the group conversations 'easy'.[58] The facilitator training informed volunteers that a 'high-performing' group is one in which little intervention is needed from the volunteer facilitator. Observers noted that on several occasions checklist items were performed by group participants (e.g. group 1, weeks 6 and 12; group 4, weeks 1 and 6), which suggests that less input was required from the volunteer facilitator and provides an indication that some groups were working well (see *Chapter 2, Interventions* and *Telephone befriending design*). Conversely, observers noted in all groups that the extent to which volunteer facilitators intervened in (or 'directed') group discussions was greater than necessary. This theme emerged in a number of participant interviews and in one volunteer facilitator interview (see *Results of the volunteer interviews*, *Technical*, *Facilitator performance*, and *Results of the qualitative research, Acceptability*, *Implementation and facilitator performance*). The type and degree of 'direction' by volunteer facilitators varied between groups. For instance, the volunteer facilitator of group 2 often directed closed questions to specific members of the group. They responded to their own question rather than leaving space for others to join in and the facilitator then asked a different question to another participant. Little space ('silences') was left to allow quieter group members to join in or respond to discussion. The degree of direction did not lessen over time as this was also observed in weeks 6 and 12. Observers noted that this 'style' resulted in the group calls ending abruptly, with one participant (who was talking about needing to leave) and the volunteer facilitator saying goodbye. The volunteer facilitator did not invite final thoughts or a group 'goodbye' (group 2, weeks 1 and 6). The other groups diverged from this style and conversation seemed more inclusive and steered by the group rather than by the volunteer facilitator. The volunteer facilitators of groups 1 and 4 asked questions but these were more often

addressed to the group and were open rather than closed. The facilitator of group 1 had less input to the conversations and allowed space for the group to talk. Observers noted examples of 'monitoring', for instance noticing an issue with background noise (group 1, week 1) and bringing participants in who others were talking over (group 1, week 12). However, in group 1 participants were observed talking over each other and the volunteer facilitator did not intervene (week 6). At this point one intervention by the volunteer facilitator might be to remind the group about the ground rules; however, this volunteer facilitator had not agreed any ground rules with the group.

All volunteer facilitators contributed to the discussion in a number of ways including giving advice, offering opinions and talking about their interests and experiences. Volunteer facilitators are trained to give responsibility to the group whenever possible and to ask the group before giving advice. No occasions were observed when the volunteer facilitator asked the group before offering advice or opinions. Some examples included giving advice about falls (group 1, week 1), offering opinions on taxation (group 1, week 6) and social networking and privacy (group 4, week 6), recalling historical events and offering opinions on nuclear power (group 4, week 12), asking a leading question on corporal punishment and offering their own view (group 1, week 1) and sharing local knowledge (group 2, week 12).

It was the role of the volunteer facilitator to discuss with the group their choice of topics. Specific intervention by volunteers in terms of giving responsibility to the group to discuss and agree topics was limited in the observed sample. This was echoed by some participants who reported being unsure of what to talk about in the group (see *Prior states*). Volunteer facilitators of groups 1 and 4 were observed changing the topics being discussed by the group. The reasons for this were sometimes obvious and demonstrated an understanding of their role as a facilitator. For instance, one discussion resulted in a participant's perspective isolating them from the rest of the group (group 4, week 6). One volunteer facilitator changed the topic because the same topic had been discussed for 30 minutes without a clear perceived need expressed by the participants or identified by the observers (group 2, week 6).

Observers noted instances of volunteer facilitators diverging from the training, including introducing information discussed with an individual (in the one-to-one calls) by asking direct questions to that member of the group. Furthermore, one volunteer facilitator (group 2) said that he would call a participant who the operator had said was not answering the telephone (group 2, week 12). The service provider's policy was for volunteers to contact the service provider if a participant did not answer a prearranged call.

Observers noted occasions when volunteer facilitators appropriately and proportionately balanced the needs of the individual with those of the group. One volunteer facilitator allowed a participant to talk about an upsetting experience and then moved the conversation on when another member of the group tried to change the subject (group 4, week 1).

The volunteer facilitator of group 1 shared his telephone number with group members during the 12-week group phase; this was not prohibited but the intervention protocol did state that contact was supposed to be through Community Network's telephone services, to protect personal information (participant telephone numbers). The same volunteer also arranged for the group to meet face to face (group 1, week 12) without referring this activity through the service provider as per protocol; a member of the group was inappropriately excluded from this meeting because of restricted mobility. An individual participant was saddened by this experience (see *Results of the participant interviews*, *Value*).

In summary, intervention fidelity scores achieved by volunteer facilitators were low, indicating that the volunteers did not facilitate the group discussions in line with the training content provided. Group 4 also demonstrated a decline in fidelity score over the time points sampled, from an initially satisfactory score. Volunteer facilitators were inconsistent in how they set ground rules, maintained participant confidentiality and satisfactorily and sensitively brought the 12-week group programmes to an end.

Participant engagement in group calls (receipt)

Interview transcripts from the qualitative interviews and audio recordings of observed group discussions were reviewed for problem behaviours associated with group cohesion.[31] One volunteer facilitator mentioned an incidence of monopolistic behaviour in her group (VF03). One incidence of silence and lack of participation was self-reported by a participant (R002). There was no evidence of band-aiding, acting superior, hostile behaviour, dependency or socialising outside of group calls before the end of the programme.

The intervention delivery checklist included four fidelity items that assessed group members' participation in calls: observing ground rules, introducing topics, showing support and commitment (see *Appendix 8*, *Intervention delivery checklist*). The role of the facilitator was to make it easy for participants to join together as a group to discuss whatever they liked. The volunteers were asked to use their skills to facilitate discussion, monitor development of the group and allow the group to 'perform' as a group. The extent to which participants were able to 'perform' in the group is closely related to volunteer facilitator performance, for instance if the volunteer facilitator did not discuss and agree ground rules then the participants could not be expected to comply with them. This was accounted for in the scoring of the checklist.

Table 32 shows participant fidelity scores for each time point by group and overall percentage fidelity based on median observed scores.

The small sample of observed groups prevents the use of formal statistical tests to investigate the association between low facilitator fidelity and low participant fidelity, but some observations on apparent association may be worthwhile. Participants in group 2 were observed as having the lowest overall percentage fidelity; the volunteer facilitator score for this group was also the lowest across the groups sampled. Similarly, the highest volunteer facilitator and participant fidelity scores observed across groups were both in group 4.

Interview transcripts and audio recordings were also reviewed for relevant characteristics associated with the transitional phase, which the group must recognise and deal with to progress to the working stage (see *Chapter 2, Methods for the fidelity assessment*, *Telephone befriending receipt and enactment*).[32] One incidence of confrontation was reported (see *Results of the volunteer interviews*, *Technical*, *Facilitator performance*) and one incidence of conflict was observed (group 4, week 1). There was no evidence of defensiveness and resistance.

In summary, the assessment of participant fidelity indicated little evidence of groups moving through the behaviours expected in the transitional phase of group formation, which group dynamics theorists think of as necessary in the early stages for a group to become high functioning. In lay terms, the group members are acting in ways that could be characterised as reserved and tentative rather than open and expressive. These findings almost certainly relate to both the generally poor intervention fidelity of the volunteer facilitators and the fact that the groups were time-limited, discouraging emotional investment.

TABLE 32 Participant percentage fidelity scores for weeks 1, 6 and 12 by group

	Group 1			Group 2			Group 3			Group 4		
	Observer 1	Observer 2	Median	Observer 1	Observer 2	Median	Observer 1	Observer 2	Median	Observer 1	Observer 2	Median
Week 1	7/12	8/12	8	6/12	4/12	5	6/12	6/12	6	11/12	9/12	10
Week 6	7/12	9/12	8	5/12	5/12	5	9/12	8/12	9	8/12	7/12	8
Week 12	6/12	8/12	7	8/12	7/12	8	–	–	–	9/12	8/12	9
Percentage fidelity	20/36	25/36	62.5%	19/36	16/36	48.6%	15/24	14/24	60.4%	28/36	24/36	70.8%

Chapter 6 Discussion

Summary of findings

The internal pilot study assessed the feasibility of the main trial against three success criteria. Two objectively defined success criteria were whether the trial team could, first, recruit ≥ 68 participants in 95 days and, second, follow up 80% of those recruited, 6 months after randomisation. The third success criterion was to determine whether the service provider could recruit and retain a sufficient number of volunteers to deliver the intervention. Although this criterion was not defined quantitatively, targets for the recruitment and training of volunteers were agreed and built into the subcontract between the University of Sheffield and the service provider.

The first two criteria were met: 70 participants were consented and randomised in the first 95 days of recruitment, of whom 56 (80%) provided valid primary outcome data 6 months later, demonstrating that the main trial was feasible. However, the service provider was unable to match the supply of volunteers to the demand from participants randomised to the intervention arm of the trial. As a consequence, participant recruitment closed on 11 January 2013 at which time 50 out of 78 participants allocated to the research arm had not been allocated a volunteer facilitator, that is, had not been treated per protocol. After clarifying that the service provider could not recruit the required number of volunteers and that it would not be viable for another agency to take over this role, the decision to close the trial early was made on 17 January 2013.

Strengths and limitations

Strengths and limitations of the randomised controlled trial

This report presents the results of a pilot trial phase of a discontinued study. As such, it would be inadvisable to use the results as a guide to the potential mental health benefits achievable through befriending programmes; any estimates of beneficial effect presented in the results may be unrealistic because of the limited sample size. The report does, however, demonstrate that recruitment to, and retention in, such a trial is possible.

Recruitment to trials evaluating preventative interventions is known to be problematic, with typically 1–5% of those screened being randomised compared with 20–26% in trials evaluating therapeutic interventions according to one overview.[59] Our consent rate was 1.6% with 147 participants recruited from targeted mail-outs and 10 from referral by health and social care professionals, the voluntary sector or advertisements. These figures are consistent with other trials of health promotion interventions using mass mail-outs for participant recruitment in the same geographical region; these studies also show recruitment through health and social care referral to be wholly inadequate for timely participant accrual.[60,61] It follows that the low take-up rate need not indicate poor acceptability of either the study procedures or the intervention, although it may raise questions whether telephone befriending can be understood as a public health intervention.[62] Similarly, attrition in RCTs evaluating preventative measures in community-dwelling older people is frequently between 20% and 30% because of comorbidity, exhaustion and respondent burden.[63] Our study performed well in limiting attrition to 20%.

At least one RCT evaluating professionally led befriending groups for older people has been published.[64] To our knowledge, this is the first RCT that has sought to evaluate a volunteer-led group intervention co-ordinated by the voluntary sector, or one mediated by telephone rather than face to face. However, there are three aspects of the trial's external validity of which readers should be aware before attempting to generalise from our results. These are the unique use of a hybrid (one-to-one followed by group)

intervention (see *Other studies evaluating interventions to address loneliness*); intervention delivery by a local franchise of a charity with a federal structure (see *Other studies involving volunteer provision*); and the character of the randomised population, which we consider now.

Trial participants who were interviewed for the qualitative substudy did not generally identify a need to take part in a telephone group, instead expressing a wish to help with the research or to help other older people who were genuinely lonely or isolated (see *Chapter 5*, *Results of the participant interviews*, *Prior states*). There are a variety of ways in which we can interpret this finding. First, it is possible that the study was subject to a severe form of 'volunteer bias' or 'self-selection bias', defined as systematic error deriving from the sample containing only those people who are willing to participate in the research study and not those who would otherwise have sought help from the service.[65] This hypothesis is given weight by the distribution of scores for the de Jong Gierveld Loneliness Scale and the GSE. The mean (SD) de Jong Gierveld Loneliness Scale score for intervention participants in our study was 3.6 (3.2), on a scale in which a score of ≥ 3 indicates loneliness and a score of ≥ 9 indicates severe loneliness.[66] de Jong Gierveld reports the Dutch population norm for this scale as 4.9, somewhat higher than the mean in our study. GSE mean (SD) scores for intervention participants at baseline [32.9 (5.1)] are also higher than the population mean reported in a multinational psychometric study [29.5 (5.32)].[67] It is relatively well documented that 'joiners' – those with a propensity to establish and sustain group membership – are psychologically healthier than those who are not 'joiners'.[68] There were indications through intervention delivery and reiterated during interviews that some participants were well supported and socially engaged (see *Chapter 5, Results of volunteer interviews, Technical*). However, we must allow for the possibility that a number of participants were genuinely help-seeking but unwilling to define themselves as such, anticipating that they would be viewed negatively by the interviewer (social desirability bias[69] or unacceptable disease bias[65]). Similar claims, that participation in research is altruistic and not help-seeking, have been noted in other studies in which the medical condition (e.g. depression) or risk factor (e.g. loneliness) is in some way stigmatised.[70,71] Although this may appear to have serious consequences for the external validity of the research, there is some evidence that this dynamic does characterise routine clinical practice too. For instance, a strength of group psychotherapy is that people gain a sense of self-worth by being part of the group and from feeling of benefit to others rather than being a burden.[57] For these reasons we might understand the expression of altruism and denial of need as not only inevitable in research but also a likely response to service receipt.

Sustained attempts were made between September 2011 and March 2012 to engage members of the public in the development and implementation of the intervention, beyond the support offered by lay representatives on the TMG and TSC. These attempts were unsuccessful and may have adversely affected the quality of the project outputs. That said, the intervention was based on the findings of consultations with those who had delivered and received telephone befriending based in other settings and so the design and implementation of the intervention were not without lay perspectives.

Strengths and limitations of the qualitative research

A qualitative research component was integrated into the study to better understand the success or failure of the delivery of the intervention.[72,73] The design and conduct of the qualitative research met the recommended standards for conduct and reporting, with qualitative researchers, independent from the interventionists, contributing throughout with clearly stated aims.[74] Although we made every effort to interview as many as possible of those who received the intervention, the small numbers available mean that it is unlikely that descriptive or theoretical saturation was achieved. Many of the reported themes identified echo findings from existing related literature, but we cannot overlook the possibility that new descriptive codes, categories or themes might have emerged with the analysis of further data.

Strengths and limitations of the fidelity assessment

A major strength of this study is the detail presented on the development of the intervention and its adaptation for delivery through a particular teleconference provider under the co-ordination of a host charity in one locality. The content of and adherence to the volunteer training programme and the intervention delivered to participants are described in detail. Standardised manuals, guidelines and training

were all provided to ensure that each volunteer received the same support to deliver the intervention. This level of description of the complexity of the intervention is in line with the Medical Research Council framework[75] and is beyond that available for most interventions intended to ameliorate social isolation or loneliness.[53]

Although the service provider initially agreed to give volunteers ongoing support after training, in the end they had a 'hands-off' approach to co-ordination, without any monitoring of volunteer facilitators or feeding back to volunteer facilitators on the quality of their intervention delivery. Given the resource and knowledge constraints under which devolved charities operate, this model is likely to be generalisable for third-sector organisations that operate as small independent 'franchise' organisations. Charities that operate a command and control model may be better resourced to undertake the ongoing support and continuous quality improvement work necessary to facilitate intervention adherence and prevent intervention 'drift', a decline over time in the fidelity with which the intervention is delivered, when initial competence is established.[54]

The fidelity substudy, embedded within the trial, used a framework based on that developed by the Behaviour Change Consortium.[54] Although this system worked well for evaluating training and delivery, it proved problematic for assessing the receipt and enactment of the intervention, the mechanics of which were aimed at the management of group dynamics within 1-hour group sessions (see *Chapter 2*, *Treatment fidelity assessment and methods*) rather than at changing individual clinical outcomes over the long term. Enactment is one facet of a more general concept of responsiveness, which our qualitative research tried to assess in terms of which participants viewed the intervention as being of relevance to them. The results suggested that some participants were not fully engaged in the group discussions. In part, this response may be an effect of the nesting of the intervention within a research study (see *Chapter 3*, *Boundaries between research and service delivery*). The denial of need by many participants (see *Chapter 5*, *Results of the participant interviews*, *Prior states*) as well as the occasional claims that group cohesiveness could be low (see *Chapter 5*, *Results of the participant interviews*, *Group dynamics*) may suggest that the participants were unresponsive to the intervention, regardless of intervention fidelity achieved by the volunteers. These findings provide an important frame through which the positive but uncertain quantitative results should be viewed.

A shortcoming of the fidelity substudy was that limited data were collected on the content delivered by volunteers during the one-to-one calls. The study used Community Network's system to record a sample of one-to-one and group conversations. One volunteer reported to the study manager having technical difficulties recording one-to-one calls, and Community Network reported difficulties in extracting the recordings from the system as volunteers were able to arrange calls at any time rather than them being set up through an operator (Community Network)-managed call. The group intervention delivery checklists will not have captured some volunteer behaviour during one-to-one calls that may have contravened the protocol and/or impacted on outcomes. For example, we would not be aware if, during these one-to-one discussions, volunteer facilitators had introduced participants to group ground rules, which are supposed to be agreed by all participants at the outset but were not evidenced through the recorded group calls in most cases.

Perspectives on the intervention from the group therapy intervention literature

We have already identified that a strength of the research intervention was that it required a protocolised training programme for its volunteer facilitators, which informed them about how to manage group dynamics and the practice of group facilitation. The format of the training itself enabled trainee facilitators to receive a group experience as a participant. Because of resource constraints, the training programme was relatively limited compared with that provided for trainee psychotherapists, who would typically be able to observe experienced group therapists at work and receive close supervision when facilitating their maiden group.[57] The practice of psychotherapy is not necessarily a good analogue for what is achievable or desirable in interventions to enhance social support or increase opportunities for social interaction (see *Other studies evaluating interventions to address loneliness*). Nonetheless, our sense is that,

without ongoing training and monitoring, 4 hours of training was insufficient, given the fidelity scores (see *Perspectives on the intervention from the group therapy intervention literature* and *Other befriending intervention studies*). In the face of public health challenges there is a temptation to think that any service is better than none.[76,77] Although group interventions have the power to transform the health and potential of individuals, it is well documented that groups that are hastily thrown together or led by someone without proper training may be 'more damaging than beneficial' (p. 5).[31] Although a small number of participants were dissatisfied with the intervention and others expressed disappointment at how the groups ended, the study did not find any evidence of harm. Nonetheless, the ongoing monitoring of group characteristics and processes throughout an intervention is the sine qua non of a successful group intervention and our research casts doubt that volunteers with 4 hours of training in group facilitation are properly prepared for the task.[31,57,58]

Good mental health or well-being outcomes and participant adherence are typically associated with good group cohesion, which in turn is made possible through the promotion of group bonding during early sessions.[31,57] Group cohesion is linked to an individual's motivations and feelings about the group, the extent to which the members of the group feel similar to one another and whether the group has a goal or objective.[78] The early closure of the trial means that there are too few data to make any definitive remarks about the success of the intervention in promoting group cohesiveness. However, participant interviews indicated that one group, which expressed high levels of mutual interest and reported flowing conversation, maintained all six group members throughout the programme and seemed to be the most cohesive of the four groups. Participants from the smaller groups discussed members leaving the group and missing calls, leaving the group with less to talk about (see *Chapter 5, Results of the participant interviews*, *Group dynamics*). Although optimal group size is a function of session and programme duration, there seems to be some agreement in the literature that the group size for adults should not drop below five or six participants with one facilitator.[31,57,79] The opportunities to engage with others are reduced as the group size diminishes, with passive behaviour and negative group image being frequent consequences. For these reasons, some theorists advocate replacing group members or combining small groups in preference to persisting with insufficient membership.[57] These techniques were deliberately eschewed in the design of the PLINY intervention as the introduction of new members can adversely affect the promotion of group cohesion.[31] Face-to-face group therapists can address this issue by setting the group size at nine or ten, the level at which a group can withstand likely attrition, especially if closed to new participants and time limited.[57] However, we are uncertain whether a group of this size can be sustained with a group telephone intervention.

Elsewhere in the literature, group cohesiveness is associated with high self-disclosure.[57] No participant from any group expressed high levels of self-disclosure in our study, with some participants indicating the difficulties in developing real friendships without face-to-face contact (see *Results of the participant interviews, Value*). This finding is confirmed in other qualitative research that has explicitly compared telephone with face-to-face befriending for older people in the sighted population.[80] However, it is worth noting that a recently completed study found that older people with visual impairment often prefer technology-based communication (social media, e-mail, telephone). The lack of visual cues did not give them additional communication difficulties but, rather, made them feel equal with those with whom they were communicating through electronic media (Patrick Okonji, Northumbria University, 2013, personal communication).

The intervention was designed so that, when possible, participants with 'similar interests' would be placed in the same group. This was not possible in practice because of resource constraints but also because of restrictions imposed by the design of the intervention itself. More specifically, one-to-one calls had to be initiated by a volunteer facilitator before interests could be established. It was felt that continuity of volunteer contact between the one-to-one and the group phases was more important than the matching of interests, which would have necessitated passing participants between volunteers to form a group with specific shared interests. The service provider decided to allocate six participants sequentially to each group, delegating first contact with this group of participants to the next available volunteer. Participants would have waited longer for a group to start if they were to be matched to others with

similar interests. 'Matching' participants on the basis of similar interests is, in general, less critical to successful group composition in personal growth interventions.[31] Some research suggests that older people tend to place a higher value on social skills and a friendly disposition than on shared interests.[80]

Group cohesion can be increased or challenged by members socialising outside scheduled sessions.[31] The original intention was that our research intervention should encourage contact among participants in the hope that they would establish acquaintances and friendships that could extend beyond the 12-week group programme, which would include the initiation of independent calls during the 12 weeks of facilitated calls. However, the policy of the teleconference provider, Community Network, discouraged contact outside friendship group calls, to maintain confidentiality and ensure that participants do not share personal information. Volunteer facilitators were therefore trained to discourage contact and were advised to introduce confidentiality as a 'minimum' ground rule. The facilitator training also highlighted the potential impact of such contact on the dynamics of the groups, for instance cliques may form or some participants may become isolated within the group. Community Network advises host organisations to decide whether to permit sharing of information among users of the service and to manage this process, recommending that written permission for sharing telephone numbers is obtained ideally at the end of group calls to limit adverse impacts on the group. From what we are able to ascertain from the interviews with the volunteer facilitators and participants and observations recorded in field notes, adherence with Community Network policy was uneven. On the one hand, information seems to have been shared between participants and/or the volunteer facilitator without express permission, against the intervention protocol (see *Chapter 5, Results of the fidelity assessment, Assessment of group intervention delivery by volunteer facilitators*). On the other hand, some participants who wanted to continue with contact after the group ended were left disappointed (see *Chapter 5, Results of the participant interviews, Acceptability*).

Strengths/limitations of the research compared with those of other studies

Other befriending intervention studies

One recent non-systematic review has highlighted the absence of, and need for more, RCTs that, like our own, incorporate standardised quality of life measures.[53] We are aware of one systematic review of RCTs of interventions focused on community befriending, the searches for which were updated in April 2008.[81] Compared with usual care or no treatment, befriending demonstrated a small but statistically significant effect on self-reported symptoms of depression in nine studies with follow-ups of < 12 months [standardised mean difference (SMD) 0.27, 95% CI 0.48 to 0.06, from nine studies) and > 12 months (SMD 0.18, 95% CI 0.05 to 0.32, from five studies). These results should be interpreted with caution for at least two reasons. First, the researchers used a funnel plot, a graph developed to assess the risk of publication bias, to show that studies with negative results may remain unpublished. Second, only half of the studies in the systematic review involved befriending by lay volunteers, as in our study, with the remainder evaluating provision by various professionals. The content, duration, frequency and intensity of the befriending programmes are not explicit in the data abstraction tables but, based on the findings of the other review,[53] interventions are unlikely to be well described in the original articles.

One well-described UK RCT, the Befriending and Cost of Caring (BECCA) study, evaluated the effectiveness of volunteer-led befriending for carers of people with dementia, successfully recruiting 236 participants to the trial.[82] As with our study the befriending schemes were established for the purposes of the trial and were nested within charitable organisations with experience of supporting volunteers undertaking befriending. Like the PLINY trial, the BECCA project worked with a national charity to set up local networks of volunteer befrienders. Unlike the PLINY trial, the BECCA team partnered with organisations other than local branches of the partner national charity. The BECCA team also found the resource to employ dedicated volunteer co-ordinators in each locale, jointly managed by the operations manager from the 'host' organisations and the research team. In contrast, the part-time volunteer co-ordinator in the PLINY

project was an existing member of staff at the host organisation, with existing commitments and responsibilities. BECCA volunteers received 12 hours of training and were supported by the organisations throughout. Volunteers and carers were matched and introduced by the befriender co-ordinator. Training content was similar to that received by volunteers in the PLINY trial; however, PLINY volunteers made their own introductions to participants during the first one-to-one call. The boundaries for volunteers – for instance signposting, rather than giving advice – although slightly different from those of the PLINY trial, were clearly set out in the training. The BECCA trial reported that 60 out of 124 (48%) volunteers who expressed an interest completed training and that 49 out of these 60 (82% of those trained) delivered the intervention; this compared with 10 out of 42 (24%) and three out of 10 (30%), respectively, in our study.

Other studies involving volunteer provision

Our study shows that the ability of a local franchise of a national charity to recruit and retain volunteers (interventionists) will not always be adequate for the rapid roll-out of a public health intervention at scale during a trial. The literature on volunteering is dominated by correlates studies, proposing psychometric or demographic factors that characterise those who volunteer and who adhere to volunteer roles, with comparatively few articles describing the frequency and duration of volunteer involvement in the population, recruitment techniques or organisational factors that improve volunteer recruitment and retention.[83]

As we have demonstrated, volunteer recruitment represents a significant management challenge, particularly for smaller organisations, even when a part-time paid volunteer co-ordinator exists, unless that post is dedicated to the intervention. The limited evidence on best practice, summarised by an up-to-date systematic review,[84] indicates that direct contact by representatives of the organisation and word of mouth are the most common and probably the most effective methods of recruiting volunteers, with advertising providing a supporting role.[85] From this, as well as from personal communications with representatives of Age UK National, we might conclude that the right methods of recruitment were used but that the task of recruitment that was set for the service provider was too onerous, given the rates of volunteer recruitment required for the success of our study.

The literature divides the variables that affect the retention of volunteers once recruited into categories of personal and organisational factors.[84,86] There is only weak or contradictory evidence for an association between volunteer retention and demographic or psychometric variables. Personal factors that do appear to predict adherence to volunteer programmes include higher levels of education, previous experience as a volunteer and 'stability or continuity in the life course', including a volunteer's changing relationships with the geographical locality, higher education, their family and the labour market. The requirement by the UK government for those receiving state benefits to be available for paid work, along with the increasingly tough sanctions for those perceived as 'work-shy', are thought to be making volunteering increasingly difficult for many who were previously in a position to do so.[87] In our study, two volunteers dropped out, one before and one after training, because of finding full-time work or additional part-time work. The service provider also reported having to take on volunteers referred by Jobcentre Plus, an executive agency of the UK Department for Work and Pensions, but that these volunteers were unsuitable for delivery of the study intervention, being extrinsically motivated.

This is not the only area of interaction between the state and the voluntary sector that might make recruitment and retention of volunteers difficult. Two trained volunteers cited discomfort with the programme itself as a reason for them discontinuing their involvement. One expressed a belief that funding for the research was inappropriately taking funds away from health services. The other felt that the research was trying to prove that services that might otherwise be delivered by health and social care professionals could be delivered 'on the cheap' by using volunteers. By the time the PLINY intervention was being delivered it had become difficult to talk about voluntary work in the UK without reference to the 2010 government's Big Society policy, a stated objective of which is 'a society where people come together to solve problems and improve life for themselves and their communities'.[88] This policy has had its detractors in the academic literature with some seeing it as ineffective[89–94] and others going further, accusing it of providing rhetorical cover for an agenda of spending cuts, privatisation and regressive taxation that will increase inequality,[95–98]

not least because small-scale voluntary sector organisations are thought to have been most seriously compromised by the deficit reduction programme.[99] Our study provides limited evidence that some individuals who might previously have volunteered are deterred by an association with a political agenda that they eschew, which adds to an ongoing debate about whether such policies are eroding confidence in the third sector.[100,101] More generally, voluntary sector organisations committed to delivering a service using volunteers should seek to establish congruence between the goals and ideals of the volunteers and those of the organisation.[86]

A number of organisational factors thought to influence volunteer retention are more in the control of voluntary sector organisations. Negative experiences related to organisational factors are commonly cited reasons for volunteer attrition.[86,102–104] Field notes from our study recorded instances when volunteers reported frustration at being unable to reach the volunteer co-ordinator at the service provider, which was reflected in an over-reliance on the study team to answer queries or solve problems associated with intervention delivery (see *Chapter 3, Boundaries between research and service delivery*). Commitment is known to be positively related to the reception of sufficient support to ensure that volunteers are comfortable with their role and its procedures.[85,86,104–106] A related factor that is known to be a key motivator in retaining volunteers is the availability of ongoing training. Volunteers often cite the availability of ongoing training whilst they are delivering an intervention as a motivation for adherence to a programme.[85,86,105,107] We have already commented on the lack of ongoing training to increase the confidence of volunteers and to maintain intervention adherence; this is a consequence of constrained costs and is a clear weakness of the intervention evaluated in our study (see *Perspectives on the intervention from the group therapy intervention literature*). When resources allow and volunteers are enthusiastic, volunteer befriending programmes should conduct training booster sessions, conduct in vivo observations or record and review sessions, conduct weekly supervision and hold periodic meetings with, or allow easy access for questions to, trainers for the sake of both intervention fidelity and volunteer retention.[54,57]

Participant recruitment rates to primary prevention trials are known to be low compared with those in therapy trials[59] and it seems likely that the slow start to participant recruitment in the PLINY trial had an impact on volunteer retention (see *Chapter 3*, *Recruitment and retention of volunteers*). Rapid allocation of volunteers to participants on a large scale is possible in established, centrally organised national services such as Talk and Support, the telephone befriending scheme run by the Royal National Institute for the Blind (RNIB), which aims to match a client with a TF group within 4 weeks.[108] Our study suggests that the capacity and degree of flexibility within a local franchise of a national charity to respond to variations in client demand for a newly established service is apparently limited. Talk and Support facilitators usually start facilitating a group within 2 weeks of completing training (Mark Berkeley, RNIB, 24 June 2013, personal communication). Our study suggests that volunteers may be unwilling to wait a period of weeks following training for their role to start (in this case, for there to be sufficient clients to form a friendship group). This indicates a key threat to the successful implementation of volunteer-led interventions co-ordinated by the voluntary sector and to their evaluation in RCTs, which will be met only by more committed and supportive management by volunteer co-ordinators and by the availability of ongoing training.

Other studies evaluating interventions to address loneliness

One of the key aims of the study was to examine the benefits of an intervention that may allay loneliness. Since the start of our study, two systematic reviews of RCTS evaluating interventions to reduce social isolation have been conducted. The first, by Dickens *et al.*,[109] aimed to evaluate interventions designed to reduce social isolation and loneliness in older people. The review included studies of group and one-to-one interventions, with 79% and 55%, respectively, reporting at least one improved participant outcome. The review found two studies that involved telephone interventions. A quasi-experimental study that examined 1-hour group telephone support for blind community-dwelling older people in the USA reported reduced loneliness and an increased number of social activities at 8 weeks.[110] The intervention is described as 'short-term problem-solving and discussion of coping methods'. The second study reported that

one-to-one telephone support for low-income housing residents in the USA did not result in a reduction in the level of self-reported loneliness compared with no intervention.[26] Only one study included in this review combined one-to-one approaches with group approaches to combat social isolation; this was in caregivers to people with Alzheimer's disease in the USA.[111] The reviewers concluded that the evidence base needs to be improved by carrying out well-conducted studies. They did indicate that 'common characteristics of effective interventions may include having a theoretical basis, and offering social activity and/or support within a group format'. The reviewers also noted that interventions that include older people as 'active participants also appeared more likely to be effective' (p. 20).[109] These primary research studies, all of which were classified by the reviewers as at high risk of bias,[109] confirm that the combination approach to intervention (one-to-one plus group befriending) was relatively novel and that our study is one of the better designed and conducted of its type.

The second systematic review, by Masi *et al.*,[112] evaluated four primary intervention strategies. Four trials evaluating social cognitive training interventions showed greater effect sizes than 12 trials of interventions to enhance social support, two trials of interventions to improve social skills and two trials of interventions to increase opportunities for social interaction. Potential modifiers of effect, such as group-based format or the use of technology, were not found to be statistically significant. The reviewers concluded that 'simply bringing lonely people together may not result in new friendships because the thoughts and behaviours of lonely individuals make them less attractive to one another as relationship partners' (p. 257).[113] On the other hand, 'correcting maladaptive social cognition (for instance through CBT [cognitive–behavioural therapy]-style interventions) offers the best chance for reducing loneliness' (p. 259).[113] This review, then, provides a question mark over the value of befriending interventions that do not involve an active psychological component intended to induce behaviour change. This said, it is far from clear that cognitive–behavioural approaches can address precursors of loneliness such as bereavement,[113] and our research team shares the concerns of those who counsel against the medicalisation of commonplace experiences such as loneliness.[114,115] Even if one accepts the research findings of Masi *et al.*,[112] financial constraints and policy decisions by state health providers mean that access to trained cognitive–behavioural therapists is limited and available only within stepped-care models for those with more serious mental health problems.[116] Given the ability of volunteers to faithfully deliver quite basic group facilitation, when trained within typical voluntary sector financial constraints, it seems unlikely that widespread and systematic access to more psychologically sophisticated behaviour change interventions is feasible for the alleviation of loneliness, even if they do have an impact.

Previous studies evaluating interventions to prevent loneliness and social isolation have been criticised for failing to publish data on organisational set-up and implementation costs.[53,109] Although we were unable to conduct a full cost-effectiveness analysis as part of our study, a strength of our report is that it does include cost impact data.

Implications for providers and policy-makers

Our research does not provide definitive evidence that telephone befriending is an effective way to alleviate loneliness in community-dwelling older people. The key implications for those considering commissioning a befriending intervention relate to three challenges: the recruitment and retention of volunteers; the buy-in of local providers for the management and support of volunteers; and the ability of providers to match clients with similar interests and identities in groups.

The recruitment of large numbers of volunteers from a given locality in a short space of time is a challenging prospect for volunteer co-ordinators of small or local franchises of voluntary sector organisations. For an intervention such as telephone befriending, in which face-to-face contact is not necessary, one solution may be to outsource to a provider who is experienced in and resourced for the recruitment and retention of volunteers and able to provide the training, support and oversight that the intervention entails (see *Other studies involving volunteer provision*). Community Network recruit and

retain volunteers to befriend people with a view to preventing loneliness. In 2012–13, Community Network trained 126 volunteer facilitators for its funded projects, working in partnership with other organisations, and ran 38 telephone befriending groups across different projects. It provided a teleconferencing infrastructure with or without support training according to resources. Some host charities already use volunteers as well as infrastructure sourced through Community Network (Angela Cairns, Community Network, 1 July 2013, personal communication).

The difficulties experienced by the service provider and volunteers in delivering the intervention per protocol, or in being responsive to the declared wishes of the participants (see *Perspectives on the intervention from the group therapy intervention literature*), reflect both organisational and individual capacities and capabilities. In signing the contract the service provider seems to have overestimated its ability to recruit and retain sufficient numbers to a timetable that was contingent on the availability of a professional group facilitation trainer (see *Chapter 3*, *The contract with the service provider*, item 2) or to provide cover for groups (see *Chapter 3*, *The contract with the service provider*, item 4). The service provider did not feel equipped to co-ordinate the intervention, specifying that volunteers would be responsible for scheduling calls with clients (see *Chapter 3*, *The contract with the service provider*, item 3). Certain aspects of the contract between the University of Sheffield and the service provider could have been more specific, for example the contract included a requirement that the service provider 'provide ongoing "mentoring" to volunteers', but the minimum frequency, duration or content of mentoring could have been better described (see *Chapter 3*, *The contract with the service provider*, item 5). The needs of volunteers were sometimes wide-ranging; those who were interviewed reported not knowing whom to contact with queries about client management, and appeals of this nature were directed to the study team.

The problems that the service provider had with accepting ownership of the intervention may have resulted in part from the unusual nature of how it was established within the service, as part of a robust, university-led research study. This undoubtedly led to unrealistic promises being made by the service provider and may have caused some uncertainty and anxiety among those then charged with delivering what had been agreed. Our study aimed to recruit 30 volunteers to deliver telephone befriending to 20 groups of six people over 1 year in one urban centre. By comparison, the RNIB, a charity with a national command and control structure, maintains 90 volunteers, running 100 groups of six people UK wide.[108] It has been able to build this capacity up over a period of > 10 years, using a strict, centrally agreed and disseminated intervention protocol, in a way that is likely to be beyond small, locally based, independently constituted voluntary sector organisations. Also, such organisations that have existing successful telephone befriending services have committed to the intervention as part of their portfolio of activity and properly resourced it. It follows that researchers and policy-makers wishing to roll out evidence-based interventions for older people should form partnerships with large-scale organisations in which volunteer co-ordinators are empowered and sufficiently resourced and take responsibility for bridging 'the gap between organisational bureaucracy and communities' (p. 237).[117] It is also important to consider the role of researchers as intervention innovators – is this appropriate or is it more acceptable and feasible to evaluate services that are already well established outside of research?

Successful group interventions require participants to identify with a common purpose.[31,57] In the absence of an active psychological component, some may feel that there is a need to match clients based on shared values, needs or experiences. This is also true for successful, large-scale telephone befriending services, for example the RNIB aims to match adults with sight loss with others with similar interests[108] and Community Network aims to bring retired seafarers together.[118] Both the RNIB and Community Network use paid staff to match participants to groups as it is a skilled and time-consuming activity. Arguably, this matching of interests becomes even more difficult in programmes supporting essentially healthy populations, such as older people at risk of loneliness, with no obvious pre-existing work-related or social connections. With no geographical limits on telephone befriending, the identification and interest matching of participants might be more easily achieved through a national approach, with members of any friendship group drawn from diverse areas of the country, if this was acceptable to participants.

Implications for researchers and funders

The scope of this research was identified, prioritised and commissioned by the National Institute for Health Research Public Health Research programme. In common with the design of a number of other contemporary psychosocial studies, the research involved modelling a new complex intervention and embedding it into a service with accompanying rigorous evaluation.

Considerations for future service evaluation and research are summarised in the following sections.

Service development and implementation

In common with the findings from previous research,[53,117] we found that the successful implementation of a service that aims to reduce loneliness requires strong partnership arrangements with commissioners and other providers. The scale of operation of individual third-sector organisations, such as the local provider involved in this study, means that, for any intervention to be delivered to more than a small number of individuals, partnership and cross-agency working is essential.

To demonstrate future sustainability, funding to deliver the intervention had to be identified from organisations that might feasibly provide such a service. Identifying funding for an intervention to meet needs that currently fall outside the remit of existing statutory service provision proved challenging, with third-sector organisations being the only avenue available. This provides some indication of the extent of change that is necessary within both statutory and non-statutory services to meet the current and future needs of an ageing population. The difficulty of identifying people who are lonely and isolated was a factor in recruitment to this study but is also an important consideration for services that aim to meet their needs.

Our findings supports those of a previous Delphi survey which indicated that the sustainability and scalability of telephone befriending services is predicated on sufficient time and resources being dedicated to administer the service.[24] The results of this research demonstrate the deleterious impact of insufficient resources being allocated to volunteer recruitment and ongoing support. After the study closed it emerged that the number of volunteers required for this study equated to the existing total volunteer workforce of the service provider. Therefore, capacity to support the volunteers would have had to double to take into account the needs of the study. The problems resulting from over-reliance on the good will of one or two individuals to scale up services was evident.

The intervention delivered through this study necessitated volunteer participation in mandatory training to prepare them to deliver specific skills. This level of demand can negatively impact on volunteer turnover, with retention then demanding a higher level of resources from the host organisation.[119] Additionally, delivering services that are evidence based is arguably more likely to involve structured and possibly specialised training. This offers greater opportunities for a volunteer workforce who may be looking to improve skills and gain valuable experience for paid work but also places greater resource demands on the host, particularly when a high turnover of volunteers exists. Therefore, the sustainability of such a workforce and what it might deliver can be fragile, emphasising the need to determine the true resource implications of using volunteers to deliver services.

Research

The intervention designed, implemented and evaluated in this study was intended for lonely and isolated older people, particularly the housebound. The process of recruitment confirmed the difficulty of reaching out to these individuals. Substantial efforts were made to involve relevant health and social care professionals in the process of recruitment. However, this was unsuccessful and few people were identified through this route for potential participation. The reasons for lack of recruitment through front-line professionals can be postulated, even though we were not able to pursue this, for example negative connotations of randomisation, lack of time to explain the study, low on list of priorities. In ideal circumstances the study timeline would provide scope to be able to ameliorate such barriers, and resources would be available to be

able to recruit through communities, which can be a successful strategy. Nevertheless, in this instance it proved necessary to use mass mail-outs to potential recruits through GP surgeries to meet the target numbers in the available time. Questions remain regarding how to effectively reach those in need of such an intervention. This is important given the indications of benefit that this research identified.

The need to take time to embed such an intervention into day-to-day practice before subjecting it to rigorous evaluation has been illustrated. Other studies that comprise the development and evaluation of a complex intervention can involve further pilot work or a multistage programme with clear interim progression criteria. This is beneficial when there are a large number of factors involved in both service delivery and the associated research. Quite early in this study it became clear that the demands of the research eroded the already limited capacity of the service provider to organise intervention delivery. Also, study requirements involved protocolisation and randomisation, which is counter to the philosophy of reduced bureaucracy and creating community capital that can exist within charitable organisations.[117] Conversely, it was evident that the idiosyncrasies of the delivery site challenged study progression.

This research demonstrated that a definitive RCT comparing telephone befriending with no telephone befriending is feasible. However, overall success was dependent on two recruitment targets, the first being for older people as participants and the second being for volunteers who were suitable to be trained and supported in a facilitation role. Future research involving volunteers needs to take account of this dual recruitment target. A number of other issues with the implementation of such a trial are worthy of mention to inform the design of future studies.

Was it realistic to expect a franchised third-sector provider to introduce a new intervention and support individuals to deliver it at scale in the manner attempted through this study? Our results would indicate not in the short to medium term. Two other UK voluntary sector organisations are successful in achieving larger-scale delivery of telephone befriending but they have been able to build this capacity over many years and both have paid staff dedicated to running the service and supporting the volunteer workforce. The findings of this study suggest that reduced ambition is necessary to match the capabilities of the programmes under evaluation and there might be benefit in including research to determine the service models that can lead to successful delivery of community-based interventions within constrained finances. However, if funders and researchers deem a full-scale pragmatic trial an appropriate step, then it should be multicentre and, to minimise the risk of intervention failure, use established services already operating at scale, when intervention funding allows. Additionally, there are issues regarding the extent to which intervention components should be standardised and the degree of local adaptation that is acceptable to meet the real-world challenges of delivery.

Research recommendations

As already stated, if funders and researchers deem a full-scale pragmatic trial an appropriate next step, then it should be multicentre and, to minimise the risk of intervention failure, use established services already operating at scale, when intervention funding allows.

If funders and researchers deem further feasibility/pilot work appropriate we recommend that methodological research should be undertaken to inform future trials evaluating specially commissioned volunteer-led services. Mixed-methods research, combining literature review, a time-and-motion study and qualitative research, should be commissioned to record how, and over what period of time, it is possible to develop and sustain large-scale, volunteer-led befriending programmes. Observation of pre-existing, successful, scaled-up and routinely delivered voluntary sector services could help commissioners, policy-makers and researchers understand how the training and management of volunteers can be optimised as well as establish realistic expectations for intervention delivery and fidelity.

Chapter 7 Conclusions

The quantitative findings of this study suggest that, compared with no intervention, TF groups might sustain mental health in community-dwelling older people within a clinically relevant range. However, we were not able to deliver the intervention as specified in the protocol to the majority of participants, which led to early termination of the study. Participant recruitment, retention and safety and intervention acceptability do not present barriers to the definitive RCT needed to replicate these results. Questions remain regarding how to maintain a sufficient number of volunteers to deliver such an intervention and how to resource its management, as well as what techniques and procedures it is reasonable to expect volunteers to learn and deliver.

Before progressing to a full trial evaluating this or a similar intervention, further research may be required to optimise the recruitment and retention of volunteers for the delivery of interventions to address social isolation. In particular, the rates of recruitment and retention of volunteers achieved by different organisational models should be compared to allow realistic planning of future RCTs to evaluate health and social care interventions by the voluntary sector.

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Contribution of authors

Daniel Hind (Assistant Director, CTRU) contributed to the concept and design of the trial and qualitative substudies, contributed to the qualitative research analysis and prepared results for publication.

Gail Mountain (Professor of Health Services Research – Assistive Technology) contributed to the concept and design of the trial, took day-to-day responsibility for its management, chaired the trial management group and took part in preparing the report for publication.

Rebecca Gossage-Worrall (Trial Co-ordinator/Research Associate) contributed to the concept and design of the fidelity assessment, conducted data collection and analysis of qualitative participant and volunteer interviews and fidelity assessment and prepared results for publication.

Stephen J Walters (Professor of Medical Statistics and Clinical Trials) contributed to the concept and design of the trial, conducted the statistical analysis and prepared results for publication.

Rosie Duncan (Research Assistant) conducted candidate screening, participant recruitment and data collection for the RCT and participant interviews, contributed to the qualitative analysis and took part in preparing the report for publication.

Louise Newbould (Research Assistant) conducted candidate screening, participant recruitment and data collection for the RCT and fidelity assessment.

Saleema Rex (Data Manager) contributed to the statistical analysis of the main trial results.

Carys Jones (Health Economist) conducted the review of health economic data.

Ann Bowling (Professor of Health Sciences) contributed to the concept and design of the main trial and took part in preparing the report for publication.

Mima Cattan (Professor in Public Health – Knowledge Translation) contributed to the concept and design of the main trial and qualitative substudies and took part in preparing the report for publication.

Angela Cairns (Chief Executive Officer) contributed to the preparation of the report for publication.

Cindy Cooper (Director of CTRU) contributed to the concept and design of the trial and took part in preparing the report for publication.

Elizabeth Goyder (Professor of Public Health) contributed to the concept and design of the trial and prepared the report for publication.

Rhiannon Tudor Edwards (Professor of Health Economics) contributed to the concept and design of the cost-effectiveness element of the main trial and the review of the health economic analysis, and took part in preparing the report for publication.

Publications

Mountain GA, Hind D, Gossage-Worrall R, Walters SJ, Duncan R, Newbould L, *et al.* 'Putting Life in Years' (PLINY) telephone friendship groups research study: pilot randomised controlled trial. *Trials* 2014;**15**:141.

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Appendix 1 Protocol and changes to protocol

NIHR Public Health Research programme

NHS National Institute for Health Research

PHR Protocol - project ref: 09-3004-01

Version: 4.0

Date: 30 October 2012

Putting Life in Years (PLINY): Telephone friendship groups research study

Evaluation of the effectiveness and cost effectiveness of an intervention to promote mental wellbeing in community living older people.

Chief investigator	Professor Gail Mountain
Sponsor	University of Sheffield
Funder	NIHR Public Health Research Programme
NIHR Portfolio number	83934
ISRCTN registration (if applicable)	28645428

NIHR Public Health Research programme

NHS National Institute for Health Research

Putting Life in Years (PLINY): Evaluation of the comparative effectiveness and cost effectiveness of an intervention to promote mental wellbeing in community living older people

This document describes a clinical trial, and provides information about procedures for entering participants. The protocol is not intended for use as a guide to the treatment of those not recruited into the trial. Amendments may be necessary; these will be circulated to known participants in the trial.

Trial Summary

DESIGN: Pragmatic two arm parallel group randomised controlled trial with feasibility phase.
SETTING: Telephone friendship group intervention: the homes of participants.
TARGET POPULATION: People aged 75 years and over with reasonable cognitive function (Score of 7 or less on the Six Cognitive Impairment Test) living independently or in sheltered/ extra care housing and able to converse and respond in English.
RECRUITMENT: GP mail outs; NHS and Local Authority involvement; Identification by voluntary sector organisations and through pro-active community engagement.
INTERVENTION TO BE EVALUATED: Twelve-week, telephone-delivered, group intervention. The design of the intervention is underpinned by de Jong's loneliness model[28] and Bandura's (1997)[29] theory of self-efficacy, provided by local charities supported by Age UK and the Community Network compared with treatment as usual (control).
FEASIBILITY: An assessment of study feasibility will be made at 18 months, based on a pilot cohort which anticipates 90 people being recruited at 9 months. The feasibility phase will evaluate willingness to be randomised into the study (recruitment rate) as well as the capacity of those delivering the telephone friendship group service and whether they are able to meet demand. To enable those involved in service delivery to cope with the necessary throughput, we anticipate blocks of about 90 participants in total being approached and randomised at 9, 14 and 19 months.
MEASUREMENT OF OUTCOMES: Primary outcome: SF-36 Mental Health (MH) dimension; Secondary outcomes: (1) other dimensions of the SF-36 (and specifically physical health); (2) EQ-5D for health economic analysis (3) General Perceived Self Efficacy (GSE) Scale; (4) Patient Health Questionnaire (PHQ-9); (5) De Jong loneliness scale (6) health and social care resource use questionnaire (7) socio demographic questionnaire including a self-report of health status.
DURATION OF FOLLOW UP: The primary analysis will be undertaken at 6 months after randomisation. All outcomes will be assessed at randomisation, 6 and 12 months.
SAMPLE SIZE: A sample size of 99 participants for each trial arm achieves an 80% power to detect an eight-point difference in mean SF-36 MH scores at 6 months follow-up between the intervention and control groups. Taking into account participant drop out (20%), we will need to randomise 124 subjects to each arm (248 in total).
PLANNED ANALYSES: The aim of the analysis will be to establish firstly whether there are benefits from the intervention compared with the control group. Mean Quality of Life (QoL) scores at 6 months (primary outcome) and 12 months (secondary outcome) will be compared using a marginal general linear model which will include baseline covariates. Ninety-five percent confidence intervals will be reported for the mean difference in scores. We will use data collected at study visits plus standard costs and valuation sources to estimate costs and QALYs (via the EQ5D). We will produce cost-utility analyses from a NHS /social care perspective and a wider societal perspective. Cost-effectiveness will be described using cost-effectiveness acceptability curves.
PROJECT TIMETABLE: Months 1-7: study set up (obtain approvals, convene local implementation groups, agree service provision with charities, recruit and train research

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assistants, launch recruitment, recruit Trial Steering Committee; Months 8-9: participant recruitment of first wave; Month 11: Intervention delivery starts; Months 13-14 participant recruitment of second wave; Month 18 interim assessment of feasibility; Months 19-20 complete recruitment; Months 17-36 follow up; Months 36-38 data cleaning, analysis, write up, dissemination.

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1. Introduction

Introduction

Social isolation and loneliness have long been identified as being problems associated with older people. According to Age Concern England[15] many of Britain's older people are living in isolation, with those over the age of 65 twice as likely as other age groups to spend over 21 hours of the day alone. Mental illness, low morale, poor rehabilitation and admission to residential care have all been found to be correlated with either social isolation or loneliness or both[16]. Seemingly, older people are more at risk of developing mental illness, such as depression, as well as physical ill-health caused by social isolation and loneliness. In response to research gaps highlighted in NICE guidance on interventions to promote mental wellbeing in older people[18], this study proposal is concerned with providing evidence of population benefit of one intervention that aims to improve the mental wellbeing of vulnerable, community living older people.

Over the last decade there has been a continued focus upon the value of providing health promoting interventions to older people with the aim of compressing morbidity in the later stages of the life course and promoting quality of life[7;15,18-21] This is supported by robust evidence which has demonstrated the relationship between extent of social activity and morbidity and mortality[22]. The NICE guidance on interventions to promote mental wellbeing[18] was underpinned by a systematic review of the evidence of effectiveness and cost effectiveness of interventions[21]. However, the evidence to support the introduction of many interventions in practice, and particularly those that aim to promote socialisation and alleviate loneliness is lacking[21;23]. A systematic review[23] of research into interventions which aim to alleviate loneliness and promote socialisation identified 11 studies with sufficiently robust findings out of 30 that met the review inclusion criteria, with the majority of studies originating from North America. Despite the methodological challenges that this review posed, the results were able to identify that the most effective interventions were those conducted in a group with educational and/or supportive input. Only one study showed that benefit could be derived from one-to-one interventions. Further to this, Cattan et al (2010)[24] conducted an evaluation of eight schemes that participated in the “Call in Time” initiative, promoted through two national charities, the Community Network and Help the Aged. The results of the evaluation found that telephone befriending can provide a vital lifeline in helping older people who spend a lot of time in their home to regain confidence and promote levels of engagement and participation with a recommendation that one-to-one telephone calls with older people might be followed by encouragement to participate in telephone clubs. This recommendation echoes that identified out of earlier work conducted in North America[26]. The Foresight Project (2008) also notes that there is a strong case for giving priority to research that would assess the potential use of technologies through the life course, and its impact on individuals, An example cited is social networking for older adults (Foresight Final Report, 2008, p. 248)[27].

Rationale

The NIHR Public Health Research programme published a call for research into the population benefits and cost effectiveness of home based interventions (including telephone support) to promote the mental wellbeing of community living older people without cognitive impairment and aged 75 years and over. The design for this study was submitted and commissioned as a result.

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Intervention

This study will evaluate the efficacy of a 12-week, telephone-delivered, group intervention based on de Jong's loneliness model[28] and Bandura's (1997)[29] theory of self-efficacy. The intervention will be delivered to older people living in the community by local Age Concern charities in the field work site. It involves older people receiving befriending from their peers or from volunteers (who may also be older people) through telephone calls which they take in their own homes. Other settings will be discounted. The intervention will mirror that recommended in the report by Cattan et al (2010)[24]. Participants randomised to receive the intervention will be offered up to six short introductory telephone calls with a volunteer who will introduce them to the concept of group telephone calls. These initial one-to-one calls may be more frequent than weekly, depending upon the preferences of the individual and will last no more than about 20 minutes. The person will then be invited to join a small group of others. The group will be hosted by the Community Network teleconference system and facilitated by a trained volunteer. In this model older people are networked together through a teleconferencing system with assistance from a volunteer facilitator. A total of 12 weeks per recruitment cycle will be provided by the host charities which will not exceed six months overall, for any particular participant. It is appreciated that the interventions need to be sufficiently flexible to match site-contextual needs and some people randomised to receive the intervention may not wish to go on to receive the group based intervention. In this situation, the host charity will be asked to consider if they are able to provide a one-to-one service to these individuals and they will be included in the trial and an intent-to-treat analysis will be performed. For the purposes of this trial we will endeavour to recruit new clients to receive telephone support, who have not previously experienced this intervention to minimise confounding.

The volunteers facilitating the telephone friendship groups will be trained by the Community Network and then supervised and mentored by [service provider]. Volunteers will have received standard volunteer training (including a CRB check) by [service provider] before receiving the specialist facilitator training. [Service provider] will identify volunteers using a number of general and targeted activities. From a pool of 50 volunteers over three recruitment cycles, we anticipate approximately 24 volunteers will be retained as volunteers for this study. For those volunteers who choose the telephone friendship group facilitation, [service provider] will then provide on-going support. This will ensure that volunteers feel sufficiently skilled and confident to cope with the extent and complexity of demand that can emerge when working with the target population. Additionally, a first contact point for troubleshooting any emergent problems with intervention delivery will be provided to participating charities.

Participants randomised to the control arm will not receive any study intervention. However, they will participate in baseline and outcome measurement and the extent of their health and social care service usage will be assessed (as for all participants) by application of a questionnaire to record use of their health, social care and community resources. This will also be used to compare interventions received across participants in the control arm of the study to check whether the groups are similar. It is proposed that all participants will receive communication from the research team **Contact card (17)** (submitted to REC) approximately every two months during the study. The communication will either be by telephone or via a letter/card which will thank the participant, provide an update on progress and help participants feel involved with the potential to help reduce the risk of attrition, especially in the control group (see Section 8).

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Risks and Benefits

Individual participant recruitment: From our previous work we are aware of the challenges that exist when trying to involve older people who have become vulnerable and isolated, particularly in situations where they are not being directed to familiar services by professionals. Restricting the study to people aged 75 years and over increases the risk of attrition which means that enhanced recruitment strategies are necessary. Relevant professionals and others working in the research site will be fully briefed through group meetings and road shows to enable them to signpost people to the study. We will also stimulate recruitment through various sources. This will include mass invitations to participants living within discrete geographical (LA) wards in the study location, identified through the GP databases, (a strategy which has proven successful in other HTA-funded trials). Mail outs will be enhanced by other targeted strategies within each ward such as personal approaches to community staff to request identification of likely participants from their case loads, publicity material placed in local venues frequented by older people including libraries, supermarkets, Post Officers and GP surgeries and information about the project provided through local media using leaflets. Mail outs to different Local Authority wards in the study location will be staggered over the recruitment period thus enabling recruitment to be balanced with the capacity of the participating charities to deliver the intervention. Initial recruitment will focus upon [redacted] city, but if this does not yield adequate numbers of participants we will approach PCTs, the LA and charities in the neighbouring boroughs of [redacted], [redacted] and [redacted] for assistance with recruitment. Informed consent of participants is central to the ethos of the trial and any person who cannot provide full informed consent will not be recruited.

Testing: The extra burden imposed by baseline and post intervention testing are a further consideration as existing research has shown that excessive demands are unlikely to be tolerated, leading to non-participation or loss to follow up[120;121]. To mediate for this, a selection of instruments has been carefully chosen, each of which has modes of completion to match a range of abilities and preferences. The baseline assessment will be conducted via face to face researcher interview. The six month and twelve month follow-up will be completed either independently by the person or by face to face researcher interview. Where assistance is requested by the participant, a researcher will arrange to visit the participant in their home to help them complete the questionnaires. The Health and Social Care Resource Use and SF-36 questionnaires will be completed via telephone by the researcher unless a / follow up visit is already planned; in which case the researcher will complete the Health and Social Care Resource Use and SF-36 questionnaires at the same visit. During the feasibility phase (first recruitment wave) the burden on participants will be evaluated, following double data entry, by examining missing values in the completed questionnaires (likely to be set at more than 2%). The burden on participants will also be explored in the qualitative sub-study (Section 10.3). The benefits may include: sharing interests, good experiences and memories and more contact.

Site recruitment: There is reliance upon existing services and upon third sector partners to support the introduction of the majority of new initiatives to promote mental wellbeing of older people. Thus, the intervention that is the focus of this trial is embryonic across the UK. Where services do exist they tend to be very small scale so there will be challenges providing the necessary scale of interventions for a population based study. To mediate this risk partnerships have been established with Age UK nationally and at the study site.

[service provider] will provide resources for volunteer support. The study is also supported by the national charity "the Community Network" who will deliver the teleconferencing for the telephone friendship groups for a period of 12 weeks (per recruitment cycle). Community Network will provide training to volunteers to facilitate the telephone friendship groups. If an insufficient number of volunteers have been recruited by [service provider] by the end of April 2012, Age UK will approach other branches within [redacted] e.g. [redacted] or [redacted]. Similarly, if the demands of the telephone friendship groups (in the second and third wave) exceed what [service provider] can deliver, Age UK will approach other branches in [redacted]. Communication and engagement is on-going with the aim of establishing a strong collaboration between research staff and those who might assist with providing interventions for the purposes of this study and to ensure that the necessary infrastructure can be put in place to minimise the risk of insufficient numbers of volunteers to run the groups. Support has also been obtained from [redacted] PCT [redacted] Teaching Hospitals and the Local Authority with respect to participant recruitment. The approaches are varied to ensure the widest possible reach; District Nursing, Occupational Therapy and other community health and social care staff will be provided with social marketing materials to both inform them of the study and enable them to assist with the identification of appropriate and potentially interested older people (See section 8).

Intervention delivery: In accord with the existing evidence, individuals randomised to receive the intervention will be offered up to six one to one telephone conversations. These will take the format of brief friendly conversations with a trained volunteer (CRB checked) about regular every day events. The volunteer will introduce them to the concept of group telephone calls as a means of providing companionship. These initial calls may be more frequent than weekly, depending upon the preferences of the individual and will last for approximately 10 - 20 minutes. The person will then be invited to join a small telephone group of others, who may share similar interests, with an emphasis upon friendship and reciprocity. The group will be hosted by the Community Network and facilitated by an [service provider] volunteer who has been trained by them using their established programme.

Teleconferencing (group) calls will be weekly and be flexible in length; between approximately 30 minutes and 60 minutes. Each group will be supported for a period of three months. Members will be encouraged to make telephone calls to each other as well as receive them. There will be a range of needs and considerations that will have to be taken into account in the delivery of interventions, some of which will be site-contextual. For example we anticipate that some people randomised to receive the intervention may wish to continue with one-to-one calls despite being fully informed of the intervention remit. [Service provider] will have to decide whether they are willing and able to continue to deliver one-to-one calls. The individuals concerned will be included in the trial and an intention to treat analysis will be performed. One of the applicant team will advise on fidelity at the beginning of the study and at further points throughout the period of intervention delivery (MC). Challenges may include the consistency with which facilitators deliver the intervention and inconsistency in attendance levels among participants. Any issues which emerge through delivery of the intervention will be presented to the Trial Steering Committee for their independent view of what might be controlled and/or eliminated for the purposes of the trial. We will also convene a Local Implementation Group (LIG), to meet bi-monthly for the duration of the recruitment and implementation phase to ensure that methods of recruitment and delivery match the local context and that the intervention remains acceptable for longer

term roll-out in practice. The LIG will include a local older person as a lay representative and appropriate personnel from Age UK, NHS and LA.

The intervention does present some risks to the participant. The intervention may bring up painful memories. To mitigate this risk [service provider] volunteer facilitators will be trained, and give guidance, on choosing topics for discussion. One-to-one calls will explore topic choices with individual participants before group discussions commence. The volunteers will receive specialised training to monitor conversations and pick up on any distress. All participants will be contacted by the research team at baseline, six month and twelve month follow-up. In addition, we intend to contact all participants at regular intervals (see section 8) to maintain contact and help participants feel involved throughout. Participants in the intervention arm will experience more contact.

The participant may experience transient dissatisfaction. Group interventions have occasional found participants experience a level of transient dissatisfaction with the intervention. To mitigate this risk volunteer facilitators will receive training to enable them to deal with situations which may arise e.g. a participant experiencing some boredom due to the choice of topic chosen by the group. The benefits to the participant may include: tolerance of others and listening skills.

Participants in the telephone friendship groups may want to continue to have discussions over the telephone after the twelve week period has ended. In this situation, the [service provider] volunteer will discuss this with the group. It will be for the service providers to decide if they can support the groups to continue in the same way. Issues relating to sustainability of groups will also be explored in the ancillary sub-studies (see Section 10).

This trial will be conducted in compliance with the protocol, GCP and the NHS research governance framework.

2. Aims and objectives

Primary objective:

To determine whether mental wellbeing as measured by the SF-36 (mental health dimension) six months after randomisation is significantly increased in participants allocated to receive the telephone friendship group intervention compared to participants allocated to a control group (receiving only contact by card/letter or telephone at month 2, 4, 8 and 10 with no further contact other than follow up assessment). This will necessitate taking the following three factors into account: (1) participants are randomised between zero and two months before a telephone friendship group is ready for them to join; (2) the intervention may last between four and five months; (3) control arm participants get no protocol-specified intervention. The choice of six months follow-up for the primary outcome makes it likely that the intervention will have been completed, or at least will be well underway and have delivered a 'therapeutic dose'. The time point means that everyone (intervention arm, however close to start of intervention they were randomised; and, control arm) are assessed at the same point from randomisation.

Secondary objectives:

1. Identify the psychosocial and environmental factors, as well as implementation issues that may mediate or modify the effectiveness of the intervention using qualitative methods. This will include examining:
    a. voluntary sector readiness to take forward new forms of services;
    b. the best modes of delivery of telephone support/friendship;
    c. how volunteers (facilitators) can be supported and retained; and,
    d. the extent to which fidelity of the intervention is maintained within and across the participating organisations.
4. To determine if there is any lasting impact upon mental wellbeing by repeat measurement with all participants 12 months following baseline measurement
5. To examine whether there is any significant improvement on the physical dimension of the SF36 at 6 months and 12 months following baseline for the intervention arm compared with standard care.

6. To measure the extent of use of health and social care, and community facilities by participants over time to determine whether the intervention is cost effective compared with standard care.

3. Trial Design

Design

Pragmatic two arm parallel group randomised controlled trial with feasibility phase.

Endpoints

Primary outcome:

1. SF36 Mental Health (MH) dimension[32]

Secondary outcomes:

2. Other dimensions of the SF-36 to measure all aspects of health including physical health (Maruish 2011);
3. Reapplication of the PHQ9[33]
4. EQ-5D (for health economic analysis[34]
5. General Perceived Self Efficacy (GSE) Scale[35]
6. de Jong Gierveld loneliness scale[36]
7. A health and social care resource use questionnaire to collect participants' use of health, social care and community services for health economic analysis.

Design measures to avoid bias

The allocation schedule will be concealed through the use of a centralised web-based randomisation service. The trial steering committee (TSC) and trial management group (TMG), including their statisticians will be blind to treatment allocation whilst the trial is ongoing, but the trial manager and participants will not be blinded. Analysis will be by intention-to-treat. Where individuals are lost to follow-up or data is missing, imputation methods will be employed, which will be described in the statistical analysis plan.

Duration

The total duration of the trial, including three recruitment waves and 12 months post randomisation follow-up is three years and one month. The expected duration of involvement of each participant is 12 months.

Feasibility assessment

After the initial set up period of seven months we will run the first wave of recruitment as an internal pilot trial to assess the feasibility of both trial recruitment plans and the proposed intervention. It is assumed that one quarter of potential candidates will be eligible and willing to be randomised. Three phased mail shots will be sent from [redacted] GPs. Based on previous HTA-funded public health research we anticipate 250 respondents (a 5% response rate) out of this strategy. Other recruitment strategies will be instigated alongside the mail shots. We anticipate 90 respondents recruited in the feasibility phase, will be eligible and willing to be randomised. Assuming a 20% loss to follow-up this will allow outcome measurement in 72 individuals to estimate a standard deviation for the primary outcome, SF-36 mental health score, at six months after randomization, the correlation between baseline and six month score and the intra cluster correlation (ICC).

The main risks to trial success to be examined through the feasibility phase are:

1. Insufficient eligible individuals consenting to participate in the trial.

2. The study intervention (telephone friendship groups) will not be delivered effectively due to local implementation issues or inadequate acceptability by participants.

Stopping rules

The TSC will assess the feasibility of the trial seven months after recruitment has commenced, with both recruitment and retention being considered. We will need to recruit 248 people in total to account for an anticipated 20% loss to follow-up at six months (primary outcome assessment time point), giving us 80% power to detect a difference between befriending (n=100) and control (n=100). Because we believe we will be able to accommodate up to 45 befrienders in each cycle, we anticipate recruiting up to 90 participants in total during each cycle (45 in the intervention and 45 in the control).

If the first cycle does not recruit 68 participants, then there is no possibility of reaching our accrual target of 248 in three cycles. So, we propose a minimum of 68 participants with at least 55 people (80%) contributing outcome data at six months after randomisation for continuation. Similarly, if [service provider] cannot identify sufficient volunteers to facilitate telephone groups then there is no possibility of delivering the intervention.

On the basis of the pilot primary outcome data collected during the feasibility phase, the sample size for the main trial will be re-calculated, using the standard deviation, correlation and ICC from the pilot phase data and the minimum important difference of 8 points in mean SF-36 mental health scores used in the original sample size calculation. The sample size will either stay the same (if the SD of the primary outcome is less than 20 points; correlation more than 0.50 and ICC less than 0.04) or increase (if the SD is more than 20 points; correlation less than 0.50, ICC more than 0.04). This will be done seven months after randomisation of the first cohort. Assuming the protocol and intervention remain unchanged, the participants recruited during the feasibility phase will be included in the full trial

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population. Processes will be included to try and identify the reasons for non-response and numbers that were excluded due to factors such as language challenges.

5. Selection and withdrawal of participants

Inclusion criteria

1. Aged 75 years or over;
2. Good cognitive function, defined as Six Cognitive Impairment Test[122] score of 7 or under;
3. Living independently (including those who are co-resident with others) or in sheltered/ extra care housing;
4. Able to understand and converse in English.

Exclusion criteria

1. Unable to use a telephone effectively with appropriate assistive technology;
2. In residential/ nursing care homes;
3. Already receiving telephone interventions.

Participants may withdraw from active participation in the study on request. Individuals removed from active participation in the intervention will not be replaced and will be followed up for all outcome information.

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6. Randomisation and enrolment

Eligible participants will be randomised to one of the two arms by the trial manager or research assistant after receiving the consent form, via a centralised web based randomisation service provided through the Clinical Trials Research Unit (CTRU). The trial manager or research assistant will inform the individual and their general practitioner on the treatment allocation. The randomisation sequence will be generated in advance by the trial statistician. There will be no stratification factors in the randomisation sequence.

7. Trial treatment

The two arms of the trial are:-

(1) Telephone friendship groups provided through the voluntary (charitable) sector

(2) Usual health and social care.

Telephone friendship group intervention: This involves older people receiving befriending from their peers or from volunteers (who may also be older people) through phone calls which they receive in their own homes. Participants will be introduced to one-to-one telephone contact over a period of 6 short one-to-one calls with this being followed by facilitated telephone friendship groups. The support for telephone friendship groups is to be provided through study partners the Community Network. In this model older people are networked together through a teleconferencing system with assistance from an [service provider] volunteer facilitator. The Community Network has committed to providing training for facilitators and is able to host the teleconferences. The group of older people to be linked through teleconferencing may have a focus; for example a book club or knitting group but this will not be necessarily the case. During the one-to-one calls the volunteers will introduce the concept of group discussions and explore preferences for the type of topics they might want to discuss in the groups. The Community Network will provide access to their telephone lines for weekly calls which will extend over a maximum of three months per recruitment cycle. The host charities will determine whether groups can continue after completion of the trial treatment with feasibility issues explored in the qualitative sub-studies (Section 10). Available evidence suggests that almost all older people have a landline telephone. There are potential issues regarding loss of hearing and the subsequent capacity of individuals to be able to use telephone friendship services effectively. We will screen for deafness in the initial interviews by observation at the screening visit and asking candidates about any equipment need. We will liaise with Action on Hearing Loss (formerly, Royal National Institute for the Deaf) to ensure that potential participants obtain appropriate assistive technology if they get randomised to receive the telephone friendship groups intervention. We will also ensure that any participant randomised to receive the intervention with sight loss, obtains assistance from the Royal National Institute for the Blind to enable them to take part.

Treatment as usual: Participants randomised to the control arm will not be receiving any study intervention. However they will participate in baseline and outcome measurement and the extent of their health and social care service usage will be assessed (as for all participants) by a health and social care resource use questionnaire designed for the study by the health economist. The resource use questionnaire will serve to check the comparability of services received by the control group across different study sites.

Management of co-morbidity: any unanticipated illness or risk situation that is observed in participant's and their homes at baseline or follow up will be managed in the following way:-
a. In situations where accident, injury or other unforeseen occurrence is encountered the RA will alert the emergency services.
b. In other non-emergency situations, the RA will report the observed problem to the Chief Investigator (GM) or their delegate (LG) who will take appropriate action (likely to involve encouraging the person to contact their GP).

Consent will be obtained from participants to share their information with The NHS Health and Social Care Information Centre and other central UK NHS bodies. This will alert the research team to a participant's health status and help to minimise the risk of telephoning or writing to participants who have died prior to follow-up.

Loss to follow up: A certain amount of attrition is inevitable during the period of intervention delivery which has been accounted for in the calculation of the target numbers for recruitment. Recruitment targets also anticipate a loss to follow up of 20%. Rigorous record keeping by the trials manager will ensure that loss to follow up will not occur due to administrative error.

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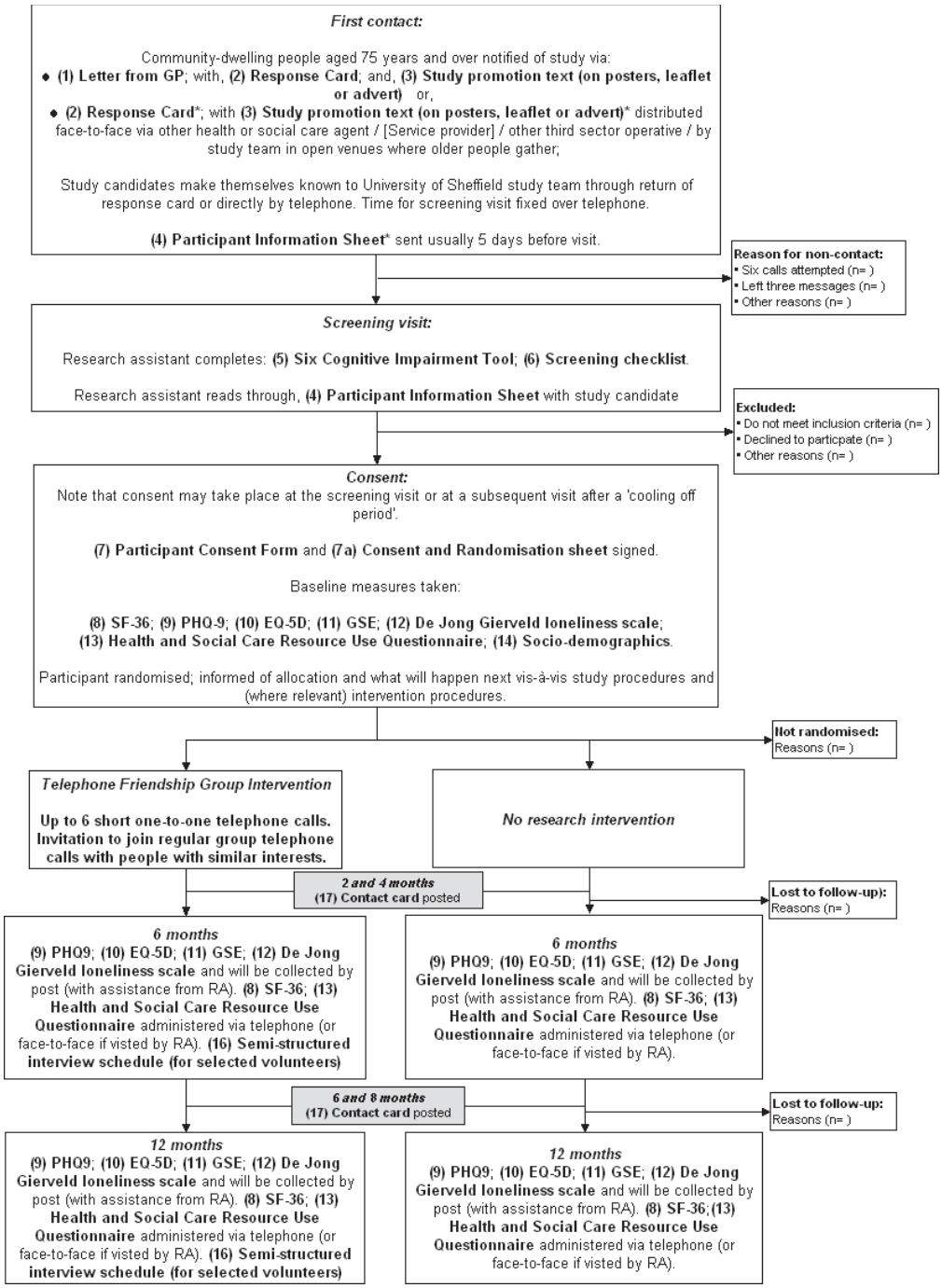
8. Assessments and procedures

Figure 1 Participant flow



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Procedures (and numbers provided in parenthesis) described below relate to the documentation outlined in Figure 1.

Procedures required at first contact

A letter from **GP (1)** will be sent to community dwelling older people aged 75 and over. A **Response card (2)** will be included inviting the person to complete their contact details and return to the research team.

The research team will receive the completed **Response card (2)** and make contact with the candidate by telephone. The team will arrange for a suitable time for a RA to conduct a screening visit. During the initial telephone call the RA will inform the candidate that a **Participant Information Sheet (4)** will be sent to their home address which provides information about the study and that they may want to read it in advance of the visit. On request, the RA will send the Participant Information Sheet via email.

The research team will make concerted efforts to make first contact with those who express an interest in participating from the information received on the **Response card (2)**. At least three telephone messages will be left and a minimum of six calls will be made to candidates where there is no facility to leave a message. If the candidate has provided an email address, the research team will also attempt to make contact via this method; including, where no telephone number has been provided on the response card. Reasons for non-contact will be recorded and may include:

- Still trying to contact
- No usable contact information
- Language requests other than English
- No facility to leave messages (min 6 calls attempted)
- Left 3 or more messages, no further follow-up.

Due to the nature of the study population, supplementary recruitment methods will also be employed to initiate first contact (see Figure 2). Third sector and other partner organisations will be given study information to enable them to discuss the study with candidates. Other 'referrers' may also be District Nurses, Occupational Therapists or other (allied) health or social care professionals. Additionally, **study promotion text (6)** displayed on posters, leaflets or adverts will be distributed by partner organisations to individuals who may be interested in finding out more about the study. Candidates

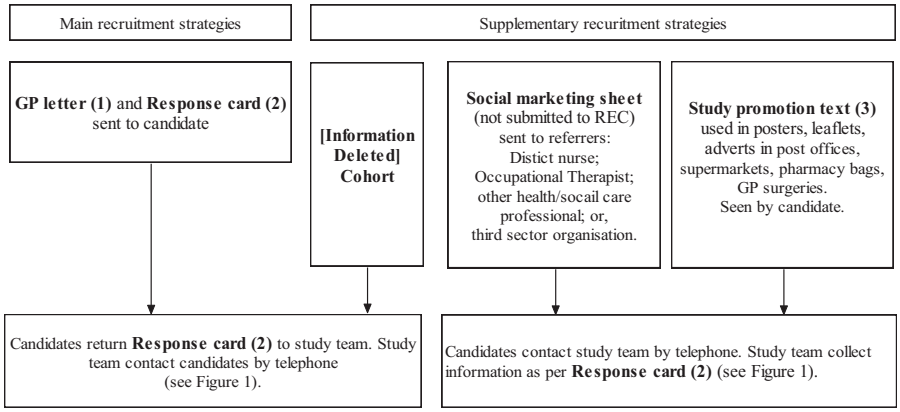
will be given contact details for the research team so they can make first contact. The research team will receive enquires and record the same information about the candidate on the **First Contact form (2a)** which records the same information as the **Response card (2)**. This will enable a screening visit to be arranged in the same way as with other recruitment strategies. The method of referral and attempts made to contact the candidate will be recorded in order to inform the feasibility assessment (see Section 3). The **First Contact form (2a)** will also record why eligible candidates chose not to take part (the option not to specify a reason will be offered).

Further to this, members of the [redacted] Cohort ([redacted]) may be used to identify candidates, subject to approval by [redacted] REC which oversees the [redacted].

Recruitment strategies

Figure 2 Describes recruitment strategies used in the study.

Figure 2. Methods of recruitment



The Participant Information Sheet will be sent to potential participants at their home (or via email, if requested), immediately after first telephone contact, which will usually be 5 days prior to the screening visit, to allow time for their consideration (see Figure 1 above).

Procedures required at screening visit

A RA will visit the potential participant at home and will read through the **Participant Information Sheet (4)**, answer questions and administer:

- **Six Cognitive Impairment Test (5)**
- **Screening Checklist (6)**

The research team will record reasons of ineligibility and for non-participation will be invited (with the option to not specify) using the **Screening Checklist (6)**. These documents (5 and 6) are combined within the **Eligibility form** (submitted to REC). Recording reasons of ineligibility will aid the recruitment strategy as the trial progresses. Basic details (age, sex, reason for exclusion/non-participation) will be collected to allow completion of the revised CONSORT diagram (Schultz et al, 2010)[123] – see appendix 1.

If a candidate is found not eligible, following a score of 8 or more on the **6CIT (5)** the following procedure will apply. The RA will thank the individual and inform them that a member of the research team will be in touch shortly. The Chief Investigator (GM) or their delegate (LG) will make direct contact with the candidate to discuss the 6CIT score and encourage the person to contact their GP.

If the candidate cannot be contacted within approximately one week of the original eligibility interview, a **6CIT non-eligible candidate letter** will be sent to the candidate. This will include an explanation of why it is not appropriate for them to participate in the study; and, advise that they should take the letter (which will include their score) to their GP. The letter will also include contact details should they wish to discuss the content of the letter further. The reason for non-eligibility will be recorded.

Procedures required before randomisation

A member of the research team will meet and consent the candidate at home **Participant Consent Form (7)**. Candidates will be offered as much time as they need to consider their decision however; consent will be permitted at the screening visit if requested by the candidate. Participants will be randomised by the research team. This will be recorded on the **Consent and Randomisation sheet (7a)** which will also capture reasons for non-consent. At this point the research team will capture information about any assistance required to participate in the study e.g. sight/ hearing loss or manual dexterity.

Baseline measurement will be administered face-to-face following consent and before randomisation by the research team and includes:

- **SF-36 plus ONS wellbeing and telephone service cost questions (8)**
- **Patient Health Questionnaire (PHQ-9) (9)**
- **EQ-5D (10)**
- **General Self Efficacy Scale– GSE (11)**
- **de Jong Loneliness Scale (12)**
- **Health and Social Care Resource Use Questionnaire(13)**
- **Socio-demographics (14)**

Procedures required after randomisation (Intervention arm only)

Participants randomised to receive the research intervention will be sent **Telephone Friendship Group Questions & Answers** by post; or, via email upon requested). The information will answer some of the practical questions participants may have about how they will receive calls and what to expect.

Study reminder (2 and 4 months)

All participants will receive a **Contact card (17)** by post from the research team, at 2 and 4 months. The brief card will thank the participant, provide an update on progress and a reminder that we will be in touch again in another 2 months.

Procedures required at six month follow-up

Six month follow-up data will be collected by the Research Assistant (RA) via telephone. Follow up data will involve completion of the following;

- **SF-36 plus ONS wellbeing and telephone service cost questions (8)**
- **PHQ-9 (9)**
- **EQ-5D (10)**
- **GSE (11)**
- **de Jong Loneliness Scale (12)**
- **Health and Social Care Resource Use Questionnaire (13)**
- **SAE Checklist (17)**

We anticipate that 20% of participants will require assistance face-to-face. In these cases the RA will seek permission to visit the participant at home to administer the questionnaire (**essential documents 8-13** and **17**) face-to-face. Approximately 4 (5%) telephone calls (in each recruitment wave) will be recorded, with consent, for researcher training and monitoring purposes.

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Some participants in the intervention arm will be invited to participate in a **semi-structured interview (16)** as part of the qualitative sub-study (see Section 10 below). An RA will ask permission to either visit the participants' home, or to telephone them to conduct the interview.

Study reminder (8 and 10 months)

All participants will receive a **Contact card (17)** by post from the research team, at 8 and 10 months. The brief card will thank the participant, provide an update on progress and a reminder that we will be in touch again in another 2 months.

Procedures required at twelve month follow-up

Twelve month follow-up data will be collected by the Research Assistant (RA) via telephone. Follow up data will involve completion of the following;

- **SF-36 plus ONS wellbeing and telephone service cost questions (8)**
- **PHQ-9 (9)**
- **EQ-5D (10)**
- **GSE (11)**
- **de Jong Loneliness Scale (12)**
- **Health and Social Care Resource Use Questionnaire (13)**
- **SAE Checklist (17)**

We anticipate that 20% of participants will require assistance face-to-face. In these cases the RA will seek permission to visit the participant at home to administer the questionnaire (**essential documents 8-13** and **17**) face-to-face. Approximately 4 (5%) telephone calls (in each recruitment wave) will be recorded, with consent, for researcher training and monitoring purposes.

Procedures for withdrawal from the trial treatment or from the study

The participant will inform the research team (or the facilitator of the group) if they want to discontinue with the telephone friendship intervention. Follow-up will continue unless the participant explicitly withdraws their consent for follow-up. Data collected up to this point will be included and anonymised.

The research team will record reasons for withdrawal from the study where possible. The participant will be informed that they do not have to give a reason.

Procedures for attempted follow-up of participants "lost to follow-up"

Participants will be considered lost-to-follow-up if they fail to respond to three telephone messages and one reminder letter. A minimum of six calls will be made to candidates where there is no facility to leave a message. If the candidate has provided an email address, the research team will also attempt to make contact via this method. For those participants previously identified (at earlier points in the study) as requiring assistance, an additional telephone call will be made. There are no procedures for further follow-up.

Procedures required when closing a trial (premature or planned).

At the point at which all questionnaires have been collected (or participants have failed to respond despite reminders) and all data have been entered and cleaned, the management group will approve closure of the database. Further details will be presented in the **data management and monitoring plan** (not submitted to REC).

Procedures required to record (serious) adverse events

In line with previous studies which deliver interventions to promote self-efficacy, we do not anticipate adverse events associated with the research interventions. Four categories of serious adverse events (SAEs) will be recorded during follow-up: results in death; is life-threatening; requires hospitalisation (initial or prolonged); results in persistent or significant disability or incapacity. The collection and reporting of SAE data will be governed by [redacted] CTRU standard operating procedures.

At each follow-up (as described above), participants will be asked if they have experienced any event or illness in the last six months which:

- has required unscheduled hospitalisation; or,
- has resulted in persistent or significant disability / incapacity (see appendix 2).

Information obtained from the NHS Health and Social Care Information Centre will be used to inform the collection and reporting of SAEs, where appropriate.

It is the Chief Investigator's responsibility:

1. To follow the procedure outlined in the study protocol for the reporting of SAEs;
2. To assess each event for causality and AE category;
3. To provide the Dean of ScHARR and the University Research Office (in their capacity as representatives of the sponsor) with details of all SAEs identified within agreed timeframes;
4. To notify the Trial Steering Committee and Data Monitoring and Ethics Committee of any SAEs where appropriate; and,
5. To submit the annual safety report to the REC.

9. Statistics

Sample Size

For the purposes of sample size estimation the primary outcome will be the mean SF-36 mental health (MH) dimension score at six-months post randomisation. The SF-36 mental health dimension is scored on a 0 (poor) to 100 (good health) scale. A previous general population survey of [redacted] residents has demonstrated that the SF-36 can successfully be used as an outcome measure for community dwelling residents aged 75 or more where a response rate of 82% was achieved[39]. From this general population survey of 3,084 [redacted] community residents, the mean SF-36 mental health score was 68.3 with a standard deviation of 19.9[39].

The developers of the SF-36 have suggested that differences between groups of between 5 and 10 points on the 100-point scale can be regarded as "clinically and socially relevant"[40]. If we assume a standard deviation of 20 points for the SF-36 Mental health score at six months post randomisation and that a mean difference in MH scores between the intervention and control group of 8 or more points is the smallest difference that can be regarded as clinically and practically important. We are going to analyse the six-month outcome data with a multiple regression/analysis of covariance model (ANCOVA) model with baseline score as a covariate. We shall assume a correlation of 0.50 between the baseline and six-month mental health score. Then to have an 90% power of detecting this 8-point mean difference in MH scores at six months between the Intervention and controls as statistically significant at the 5% (two-sided) level will require 99 patients per group (2 x 99 = 198 in total).

However, the telephone befriending intervention is a group or facilitator-led intervention. Therefore the success of the intervention may depend on the facilitator delivering it so that the outcomes of the participants in the same group with the same facilitator may be clustered. If we assume an average cluster size of 6 subjects per telephone befriending group and an intra cluster correlation (ICC) of 0.04, then the design effect is 1.28. With these assumptions and 99 subjects per group the power of the analysis is reduced to 80% to detect a mean difference of eight points in six-month MH scores. If 20% of participants drop out and are lost to follow-up then we will need to recruit and randomise 124 per group (248 in total).

Statistical criteria to terminate the trial

There are no statistical criteria for stopping the trial early; as the intervention is considered low risk. Decisions to stop the trial early on grounds of safety or futility will be made by the Trial Steering Committee or funding body on the basis of advice from the DMEC.

Procedure for accounting for missing data

The primary analysis will be an intention-to-treat (ITT) analysis with participants with complete SF-36 data at six months post-randomisation. A sensitivity analysis will be undertaken to impute missing SF-36 and EQ-5D data using baseline and follow-up data from the group of patients with valid data from both measures at six-month post-randomisation. As this is an ITT analysis, withdrawals and protocol violations will be analysed in their groups as randomised.

Analysis of primary objective

As the trial is a pragmatic randomised, with a usual (control) treatment arm, data will be reported and presented according to the revised CONSORT 2010 statement[123]. The

statistical analysis will be performed on an intention-to-treat-basis. All statistical exploratory tests will be two-tailed with alpha = 0.05. Baseline demographic (age, gender) and person reported outcome measures (PROM) data (SF-36, PHQ-9, EQ-5D, GSE, de Jong Loneliness Scale, 6CIT) will be assessed for comparability between the groups.

The aim of the analysis will be to establish firstly whether there are benefits from a telephone friendship intervention compared with the control group. Since the intervention, the telephone friendship group, is a group or therapist based intervention, there may be clustering or correlation of the participants' outcomes within a telephone befriending group. Therefore to make allowance for this the primary analysis will compare mean SF-36 Mental Health dimension scores at six months between the intervention group and control group using a marginal general linear model (GLM), with robust standard errors, and an exchangeable correlation[46]. The marginal model will use Generalised Estimating equations (GEE) to estimate the regression coefficients. Participants in the control group will be treated as clusters of size one in the analysis. The exchangeable correlation assumes that participant outcomes within each cluster (telephone befriending group) have the same correlation. A 95% confidence interval (CI) for the treatment group coefficient, the difference in SF-36 mental health dimension scores between the intervention and control group, will also be calculated. An adjusted analysis will also be performed alongside this unadjusted analysis which will include baseline covariates, such as age, gender and baseline SF-36 mental health score in the marginal general linear model.

For the primary outcome, the SF-36 Mental Health dimension score at six months follow-up, missing data will be imputed through a variety of methods, including Last Observation Carried Forward (LOCF), regression and multiple imputations.

Analysis of secondary outcomes

Secondary outcomes such as the other dimensions of the SF-36, PHQ-9, de Jong Loneliness Scale, General Perceived Self Efficacy at six months follow-up will be compared between groups again using a marginal general linear model both with and without adjustment for covariates. A 95% confidence interval (CI) for the mean difference in this parameter between the treatment groups will also be calculated.

Participants are to be followed up for up to 12 months post randomisation. Mean SF-36, other dimensions of the SF36, PHQ-9, de Jong Loneliness Scale and General Perceived Self Efficacy dimension scores at 12 months follow-up will be compared between groups again using a marginal general linear model with and without adjustment for covariates. A 95% confidence interval (CI) for the mean difference in this parameter between the treatment groups will also be calculated.

The Sheffield CTRU will oversee randomisation, undertake data management and analysis and ensure the trial is undertaken according to Good Clinical Practice Guidelines and CTRU standard operating procedures.

Economic analysis

Following the feasibility phase, in which the data collection instruments will be tested for this population, in the main trial and from a societal perspective[52;124-127], the health economists will: cost the telephone friendship intervention; ask older adults through a (telephone) interviewer administered questionnaire about their primary and secondary care health service use, social care use, and voluntary and private sector service use. A primary cost-effectiveness analysis will be conducted using the SF-6D (derived from SF36) as our utility measure with EQ5D as a methodological comparator. We will undertake a secondary cost-

utility analysis using both utility scores as the measure of utility in the calculation of Quality Adjusted Life Years (QALYs)[34]. The two health related quality of life measures are used to explore their use in older populations and ensure methodological robustness QALY calculation. The cost-utility ratio i.e. cost per QALY will be compared with the NICE threshold of £30,000 per QALY, and cost effectiveness acceptability curves (CEACs) will be used using bootstrap resampling methods to convey to health and social care policy makers the probability that this intervention is cost-effective at a range of payer thresholds[128]. Sub-group analysis and sensitivity analysis will be carried out in order to inform policy makers of where the intervention might be best targeted.

10. Ancillary sub-studies

10.1 Introduction to the ancillary sub-studies

There are two ancillary sub-studies: (1) a fidelity assessment; and, (2) qualitative research. Each sub-study involves the collection and analysis of data from both participants who receive the research intervention and from those involved in delivering the intervention (facilitators). For clarity, it is important to state that some data collection tools, such as **semi-structured interview (16)** schedules, collect data for both sub-studies. The data collection tools which are only intended for those who receive the intervention have formed part of the submission to the NHS or Social Care Research Ethics Committees. The tools which are only intended for those who deliver the intervention (facilitators) have not been submitted and are clearly marked.

10.2 Fidelity assessment sub-study (facilitators)

The fidelity assessment will assess how well the telephone friendship intervention is delivered according to the intervention protocol (see Section 7). An intervention fidelity framework based on that identified by the Behaviour Change Consortium[54] has been developed (Table 1). The framework sets out the parameters by which quality and fidelity will be measured according to study design, training, delivery, receipt and enactment.

Facilitator attendance at facilitator training sessions will be monitored by a **training attendance register** (not submitted to REC) taken by a single trainer (Sarah Harwood, Community Network) who will train all facilitators to measure 'treatment dose'. The trial manager (RG-W) and content expert (MC) will observe a sample of training sessions (at least one per cycle) and use a **training content checklist** (not submitted to REC) to assure consistency of materials and practice by the trainer as well as to confirm facilitator skill acquisition.

Attendance at group befriending sessions will be monitored by the use of **participant attendance registers** (not submitted to REC) taken by the facilitators at every session during both the one-to-one and group phases.

A random sample of thirteen (5%) audio recordings of group sessions will be taken. Permission to audio record group sessions will be obtained via the **Participant Consent Form (7)** and again at the

start of a group session that has been selected. The trial manager (RG-W) and content expert (MC) will use a **facilitator checklist** (not submitted to REC) to assess:

- The match with the intervention protocol, in terms of the content and techniques delivered;
- The extent to which facilitators have enabled choice and decision-making;,
- “Drift" in facilitation skills and intervention delivery (for those facilitating groups across successive waves / cycles) with information on adherence being fed back to facilitators as necessary.

The group facilitation skills of individual volunteer facilitators will be self-assessed, with facilitators recording any difficulties with the delivery of the intervention protocol in a **facilitator diary** (not submitted to REC).

The **General Perceived Self Efficacy (GSE) Scale (11)** and **de Jong Gierveld Loneliness Scale (12)** will be used to test the extent to which baseline loneliness and self-efficacy affect all outcomes at follow-up.

The trial manager (RG-W) and content expert (MC) will use a **semi-structured interview schedule** (not submitted to REC) to explore the receipt, delivery and enactment of the intervention, the challenges of implementation and barriers to uptake with a convenience sample of facilitators. The trial manager (RG-W) and/or content expert (MC) will use a **semi-structured interview schedule (16)** to explore the receipt, delivery and enactment of the intervention with a sample of participants who received the research intervention (see Section 10.3 Qualitative research).

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Table 1. Fidelity assessment strategies

Goal	Description	Strategies
Design		
Comparable treatment dose	Adequate description of the intervention dose to ensure that variation in dose is recorded.	• Set minimum/maximum number of one-to-one telephone contacts • Set minimum/maximum duration of one-to-one telephone contacts • Set frequency of one-to-one telephone contacts • Set minimum/maximum number of group telephone contacts • Set minimum/maximum duration of group telephone contacts • Set frequency of group telephone contacts • A feasibility phase within the design
Minimise the risk to implementation	Plan for foreseeable setbacks to successful implementation	• A number of recruitment strategies • Three recruitment cycles helping to match capacity with recruitment • Alternative provider of telephone conferencing technology • Alternative sources for the recruitment of volunteers (facilitators)
Training		
Standardised training	Attendance Use of standardised materials (and same trainer) Use of standardised practice	• Register by Trainer • Observed by Trial Manager Content checklist used by Trial Manager& Content Expert on an sample of sessions
Provider skill acquisition		• Observed by Trial manager • Content checklist used by Trial Manager& Content Expert on an sample of sessions
Minimise "drift" in skills/delivery (if facilitators are working across three cycles)	Adherence to training content/ delivery techniques	• Content checklist used by Trial Manager& Content Expert on an sample of sessions (during recruitment cycle 2 and 3 delivery)
Delivery		
Ensure delivery as intended	Attendance 6 one-to-one sessions Group sessions (12 weeks) Group facilitation skills Development of enabling choice and decision-making	• One-to-one register • Group register • Week 1-6 Content checklist used by Trial Manager & Content Expert on an sample of recorded sessions (audio recording) • Reflexive facilitator self-report • Checklist used by Trial Manager& Content expert Observed sample on an sample of recorded sessions (audio recording) • Semi-structured interview - Facilitators • Semi-structured interview - Participants
Receipt & Enactment		
	Impact on participant's: Wellbeing / self-efficacy / loneliness	• PROMS • Semi-structured interview – Facilitators • Semi-structured interview – Participants

Based on Bellg et al, 2004. Enhancing Treatment Fidelity in Health Behaviour Change Studies: Best Practices and Recommendations from the NIH Behaviour Change Consortium. Health Psychology, Vol 23, 5: p443-51

10.3 Qualitative research sub-study (participants only)

The purpose of the qualitative sub-study is to evaluate the impact of telephone friendship groups for older people as well as their perceived advantages and disadvantages. The objective is an assessment of the acceptability and appropriateness of the intervention in preventing loneliness and maintaining good mental health. Some aspects of the fidelity assessment (for instance views on the receipt and enactment of the intervention) will also be evaluated (see above, Section 10.2). The sub-study will also explore, as part of the feasibility assessment, the burden on participants from the completion of questionnaires.

Methods

To provide depth as well as breadth to the findings, an in-depth **semi-structured interview schedule (16)** will be used with older people to explore to what extent they considered telephone friendship groups to have made an impact on their wellbeing. Interview themes will include: the befriending process; the value of befriending for older people; the needs of older people in relation to the befriending service; the impact of the befriending service on the physical and emotional health of older people; the effect of the befriending service on social interaction amongst older people and older peoples' self-defined general well-being. Interviews will be conducted face-to-face with selected volunteers at the six month follow-up, with no fewer than 10% of trial participants allocated to the intervention (n=12). A purposive sample will be used to ensure a balanced representation of respondents in terms of both demographic characteristics. We anticipate undertaking approximately 15-20 interviews across the three recruitment waves however, interviews will continue until data saturation occurs. By convention, this is defined as being when no new themes occur in the data. We will seek to follow up a small number of participants who were randomised to receive the intervention but were non-adherent to explore the reasons why the intervention was unacceptable or inappropriate.

The interviews will be conducted either in people's homes or in a convenient place locally, if this is preferred and will last about 1 hour. A written and verbal explanation for the study will be given and confidentiality assured (**Participation Information Sheet (4)**; **Participant Consent Sheet (7)**). The interviews will be recorded with the participants' consent. Because of the sensitivity of the subject, a protocol has been devised on how to deal with issues of concern should they arise.

Analysis

The analysis of the data will commence during the data collection period with interviews, transcription and analysis forming a cyclical, continuous process where interviews inform analysis and analysis informs the interviews. Interviews will be digitally recorded and transcribed verbatim. Data analysis of transcripts will be conducted in NVivo using a constant comparative method to identify themes. Analysis and interpretation will follow 'Framework Analysis', a case-by-theme approach, a practical and effective way of managing, summarising and synthesising complex qualitative data[129]. Framework analysis will focus on the participants' views of the appropriateness and acceptability of the intervention.

First transcripts will be read to become familiarised with the data with notes made relating to initial themes based on the research question and information that emerges from the interviews. Second the transcripts and notes will be re-read independently by the Trial Manager (RG-W) and Content Expert (MC) for the participant and facilitator interviews. Using the Framework Analysis staged structure, transcripts will be systematically coded according to the themes that emerge and these will be grouped according to sub-headings within a framework structure. We will actively seek 'deviant' or 'negative' cases and modify

emerging themes accordingly[130]. Framework Analysis allows for the emergence of themes which have not been previously identified as important to the research question[48;49]. Sub-headings will be collapsed into key themes, which capture the essence of the interviews. Results will be used to explore potential explanations for the quantitative findings and identify if there are other emerging issues or factors influencing uptake and impact of the interventions that have not been previously documented[25;50]. The final outcome will be a synthesis of coded data, sub-themes and key themes.

11. Trial supervision

The University of Sheffield will act as sponsor for the trial. Three committees will be established to govern the conduct of this study: the Trial Steering Committee (TSC), the Data Monitoring and Ethics Committee (DMEC) and the Trial Management Group (TMG). These committees will function in accordance with Sheffield CTRU standard operating procedures.

The TSC will consist of an independent chair with clinical and research expertise in the topic area, and two other topic experts as the sponsor sees fit and as agreed by the grant awarding body. The TSC will meet every 6 months from the start of the trial. The DMEC will consist of a neutral chair with research expertise, an independent statistician and an independent content expert. The DMEC will meet once before recruitment commences and every 6 months from the start of the recruitment. The DMEC can recommend premature closure of the trial to the TSC in accordance with Standard Operating Procedure GOV003.

A full time Trial Manager will contact the Chief Investigator and meet with the Assistant Director of the CTRU at weekly intervals while co-ordinating the trial. The TMG will meet at least at three-month intervals and will consist of: the Chief Investigator, the trial manager, the study statistician and a lay representative (from [redacted] Expert Elders or a similar organisation).

A Local Implementation Group will meet every two months and involve all local stakeholders, including members of the academic study team as well as representatives from charities, the NHS and the lay community.

12. Data handling and record keeping

Data management will be provided by the University of Sheffield Clinical Trials Research Unit (CTRU) who adhere to their own Standard Operating Procedures (SOPs) relating to all aspects of data management including data protection and archiving. A separate data management and monitoring plan (DMMP) will detail data management activities for the study in accordance with SOP (Shef/CTRU/DM009).

For the duration of the study, all consent forms, data collection forms and interview transcripts will be kept in a locked filing cabinet in a secured area within the CTRU.

Archiving

Data from the study will be stored in accordance with the Directive 2005/28/EC Article 17 and the CTRU Archiving Standard Operating Procedure (Shef/CTRU/DM002) for at least 5 years following completion. It will be stored in on-site archive facilities; or in a commercial archive with overall responsibility being retained by the Sponsor. Access will be restricted to the sponsor and regulatory authorities. Archived documents will be logged on a register which will also record items retrieved, by named individuals, from the archive. Electronic data will be stored in an 'archive' area of the secure CTRU server for a minimum of five years to ensure that access is future-proofed against changes in technology. Electronic data may also be stored (e.g. on a compact disc) with the paper files.

Health economic analysis (Bangor University)

To facilitate health economic analysis, anonymised data will be downloaded from the secure CTRU web site hosted by a named researcher at the Centre for Health Economics and Medicines Evaluation (CHEME) at Bangor University. Alternatively, the data may be pre-processed and formatted in Sheffield, and then sent encrypted by email.

13. Data access and quality assurance

The study will use the CTRU's in-house data management system (Prospect) for the capture and storage of participant data. Prospect stores all data in a PostgreSQL database on virtual servers hosted by Corporate Information and Computing Services (CiCS) at the University of Sheffield. Prospect uses industry standard techniques to provide security, including password authentication and encryption using SSL/TLS. Access to Prospect is controlled by usernames and encrypted passwords, and a comprehensive privilege management feature can be used to ensure that users have access to only the minimum amount of data required to complete their tasks. This can be used to restrict access to personal identifiable data.

Participant confidentiality will be respected at all times. Candidate/participant names and contact details will be collected and entered on the database. Access to these personal details will be restricted to users with appropriate privileges. All other data will be anonymised and will only be identifiable by participant ID number, and no patient identifiable data will be transferred from the database to the statistician. The CRF/questionnaires will collect demographic details, some of which will be used to indicate the participant's socio-economic status.

Prospect provides validation and verification features which will be used to monitor study data quality, in line with CTRU SOPs and the DMMP. Error reports will be generated where data clarification is required.

Health economic analysis (Bangor University)

For all research projects, CHEME adheres to the Data Protection Act 1998. Files containing electronic data will be password protected, stored on a secure network where security of the data is centrally protected. All electronic data is centrally backed up on a secure server. All university laptops are encrypted. Workstations in CHEME are locked if the user leaves the computer unattended. Any electronic files which are saved in folders on a shared network, will be restricted to authorised CHEME health economists who have been allocated a password to allow access to the data. One copy of the electronic database will be write protected, to ensure a clean copy of the data. A further copy will not be write protected. This

will aid future research in this area by allowing additions and reanalysis of the data. Any unnecessary or duplicate information will be deleted on study completion.

When handling electronic files with any direct identifiers, specifically postcode only, the following will be observed:

Files containing direct identifiers will be available separately from other trial data and saved in a folder with access only to individuals who strictly need to see it for the purposes of one part of the economic evaluation

Files containing direct identifiers will remain in only one location in a secure area of the server and not be copied and saved elsewhere.

Files containing direct identifiers will not be transferred via email or by other means unless encrypted. No data, including patients' identifiable data will be stored on home computers, personal laptops or unencrypted memory sticks.

14. Publication

Dissemination will be undertaken through peer reviewed scientific journals and clinical and academic conferences. We will also ensure regular dissemination to the third sector and older people's advocacy groups through regular project bulletins.

The study team are obliged, by the terms of its contract, to notify the PHR programme of any intention to publish the results of PHR-funded work at least 28 days in advance of publication in a journal. This also applies to public oral and poster presentations, for which the team will advise the PHR programme 28 days before submission of abstract to organisers of an "event". In this case, the notification form provided on the PHR website's 'Project outputs' page.

15. Finance

The trial has been financed by the NIHR PHR and details have been drawn up in a separate agreement.

16. Ethics and research governance approval

The trial will be submitted to a Research Ethics Committee (REC) through the IRAS central allocation system. The approval letter from the ethics committee and copy of approved patient information leaflet, consent forms, CRF's and questionnaires will be sent to the CTRU before initiation of the study and participant recruitment.

The trial will be submitted for NHS and Local Authority research governance approval.

17. Indemnity / Compensation / Insurance

The University of Sheffield has in place insurance against liabilities for which it may be legally liable and this cover includes any such liabilities arising out of this research project.

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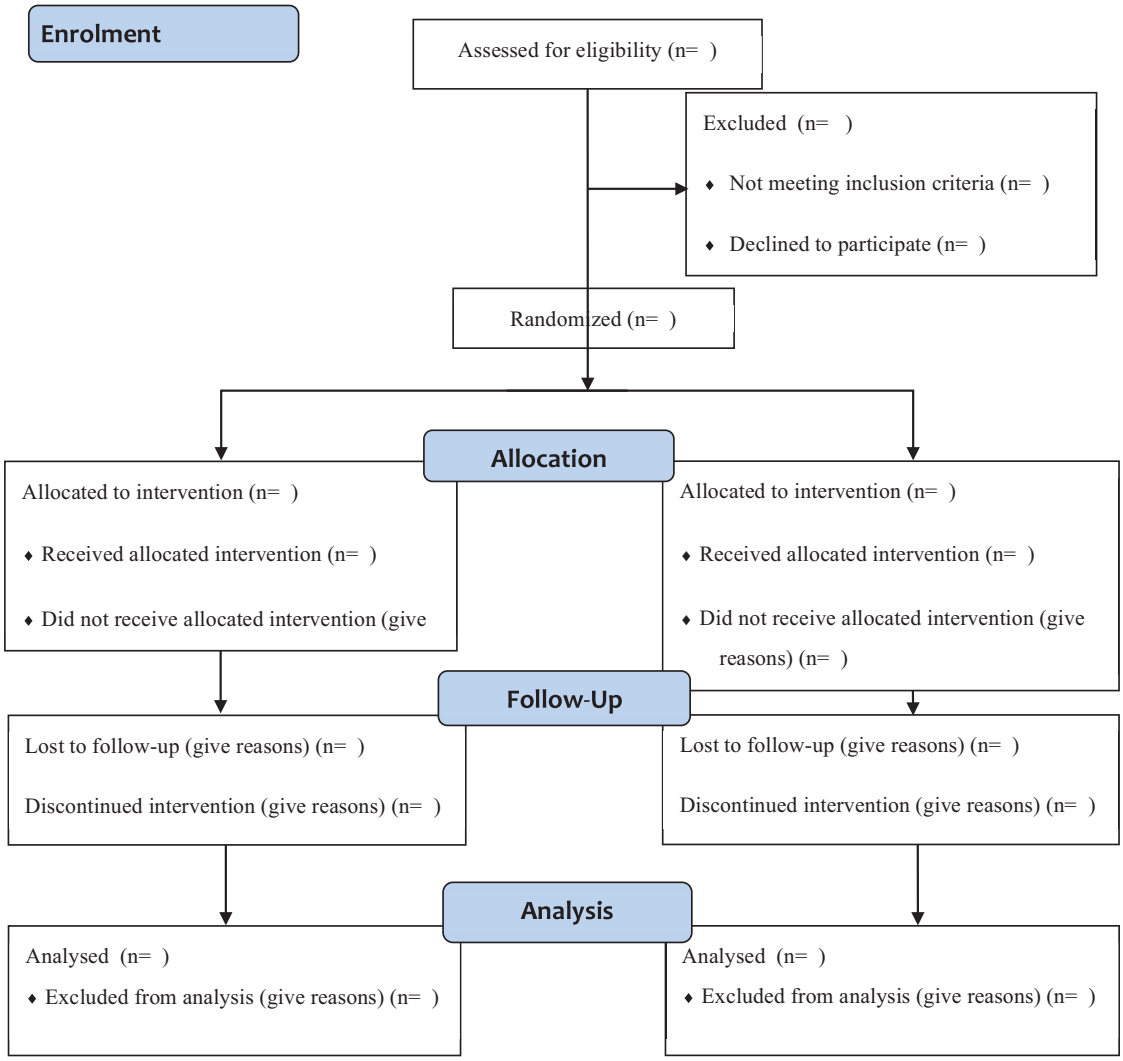
Appendix 1: Revised CONSORT 2010 Flow Diagram



[09-3004-01] [Mountain] protocol version: [4.0] [30.10.2012]

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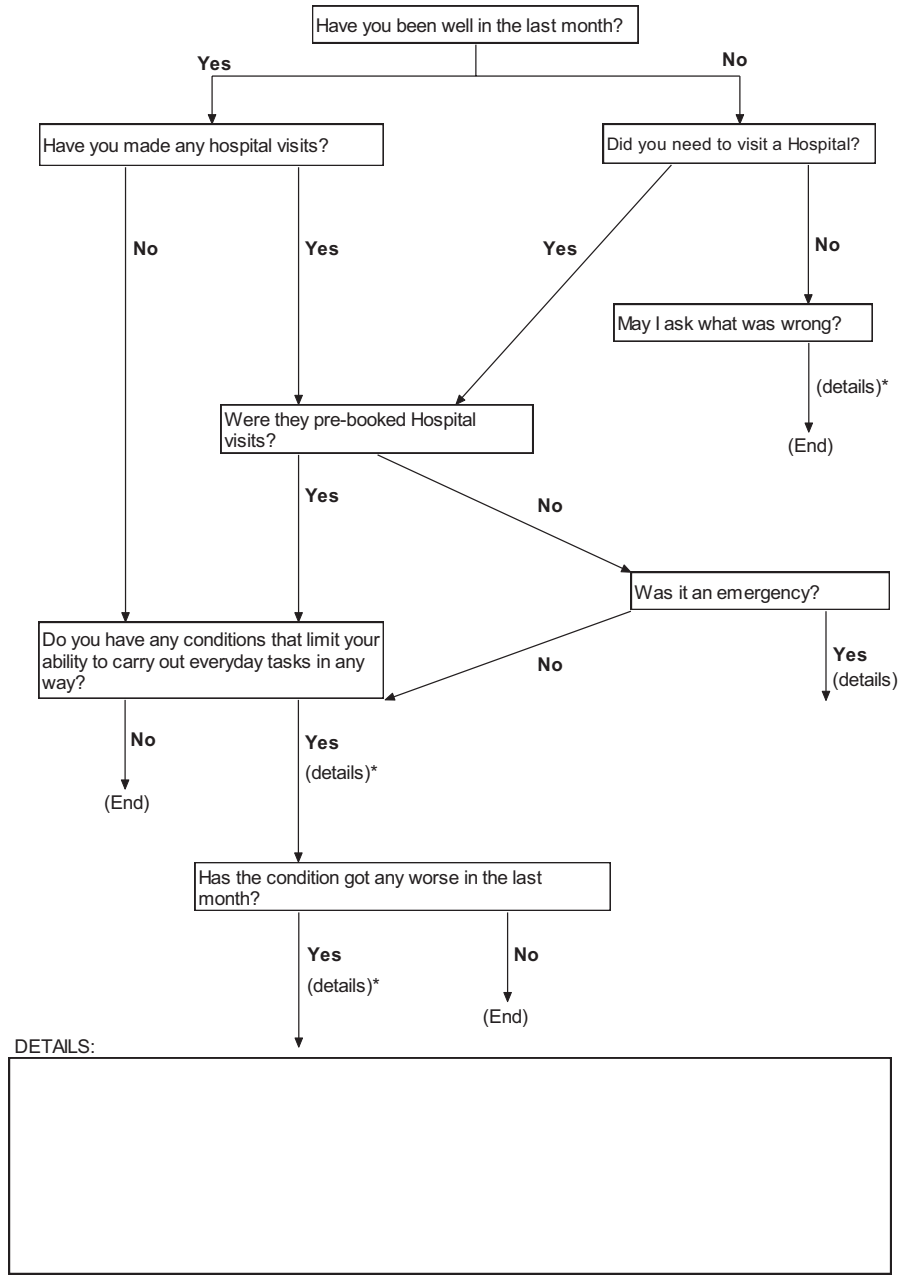
Appendix 2: Serious Adverse Event Checklist (6 month and 12 month follow-up)



* If details are unclear was permission granted to contact GP for varification and/or confirmation?

Yes ☐ No ☐

[09-3004-01] [Mountain] protocol version: [4.0] [30.10.2012]

TABLE 33 Changes to the protocol

Change to protocol	Progress report	Date	Approved by
Protocol version 2.0 (7 February 2012) approved following request by the REC to complete 6 and 12 month follow-up by telephone (rather than post). Version 1.0 was therefore never approved by the REC	1	17 February 2012	South Yorkshire REC
Protocol version 3.0 (10 April 2012) added an additional document, 'Telephone Friendship Group Questions and Answers', for participants allocated to the intervention arm; added an additional procedure to send letters to candidates not eligible due to cognitive impairment; removed partner logos and changed to funder's template; ISRCTN reference and DMC members added following registration; telephone version of EQ-5D-3L; clarification that 6CIT and screening checklist formed the 'Eligibility form' (approved by the REC); and Appendix 2: SAE Checklist (and page 21) changed to '. . . last 6 months'. Minor changes to First Contact Form, Response card, General Self–efficacy scale and resource use questionnaires were also included	2	19 April 2012	South Yorkshire REC
Protocol version 4.0 (30 October 2012) added a procedure for sending a letter/e-mail to candidates returning a response card without a telephone number. Use of e-mail for sending Participant Information Sheet and Q&A document and/or making initial contact when no telephone number provided. Added a 'Contact Card' for use at end of recruitment; and a minimum of three messages (six calls when no answerphone service is available) and a reminder letter in order to attempt the 6/12 month follow-up. Minor spelling and typographical errors corrected	Not reported (report no. 3 not required)	21 November 2012	South Yorkshire REC

DMC, Data Monitoring and Ethics Committee; SAE, serious adverse event.

Appendix 2 Participant telephone friendship group: questions and answers

Putting Life IN Years (PLINY): Telephone friendship groups research study

Introduction to telephone friendship groups

As you know, the purpose of the research is trying to find out whether telephone friendship groups can be beneficial for older people aged 75 and over and if so, how. You have been allocated at random to take part in telephone friendship groups. A trained [service provider] volunteer will be contacting you by telephone. We have talked to you about what happens during the study however, we have provided some additional information below to help answer some questions you may have about the one-to-one and group telephone calls.

We have provided you will a sheet at the end which you might like to use to make a note of the name of your [service provider] volunteer/facilitator. You can also note down the times when they have arranged to call you.

About the telephone conversions

The [service provider] volunteer will contact you using the telephone number you provided. They will chat to you for about 20 minutes each week for up to six weeks. You can talk with the volunteer about anything you like. They will tell you more about the group telephone discussions and arrange future dates/ times for them to call you. During the one-to-one calls the volunteer will establish the date/time of the group telephone conversations. It is better if these are held at the same time each week.

The group will join together on the telephone for about one hour for 12 weeks. An Operator from a charity we are working with, called Community Network, will connect you to others by your usual telephone at home. This is sometimes called a teleconference.

The [service provider] volunteer is trained to facilitate group telephone discussions and they will make sure everyone has a turn. The volunteer will keep a note of the date/time of the telephone calls with all participants and note some of the topics discussed. This will be used to inform the research study.

Q What happens if I have not heard from a volunteer?

A It can take several weeks for the one-to-one calls to start. A volunteer will contact you as soon as possible.

Q What happens if I do not answer when the volunteer facilitator phones me at the prearranged time?

A The [service provider] volunteer (your group facilitator) will inform the [service provider] Volunteer Co-ordinator that they were unable to make contact with you at the time arranged. The Co-ordinator will try to contact you by telephone to make sure that you are okay.

Q What should I do if I am unable to participant in one of the group conversations?

A If you know in advance, please tell the volunteer facilitator that you will not be available on that day. You can tell them at the start or end of

the group discussion. If you are unwell or your circumstances have changed please telephone [telephone number] to let Community Network know you will not be participating in this week's group conversation.

Q **Can I make my own calls, to other members of the group, in between group telephone discussions?**

A We do not recommend sharing your telephone number during group conversations. If you do want to share your telephone number to make calls outside the group, the volunteer facilitator will refer you to [service provider]'s Volunteer Co-ordinator who will ask you to give written permission to share your telephone number with another participant.

The volunteer facilitator will remind all participants that sharing personal information is for each individual to decide. They will also remind participants that any calls outside of the group telephone discussions are not part of the research study i.e. you will have to pay for such calls yourself.

[service provider] and Community Network will not pass on your telephone number to anyone else without your express permission

Q **What happens if I need help with my health?**

A You are free to talk about anything you like in the group; however, the group is a friendship group and not able to offer medical advice. If you are worried about your health you should contact your GP.

Q **What happens if I am accidentally disconnected or have to leave for part of the telephone conversation?**

A The volunteer facilitator will let alert the Community Network Operator who will call you back. If you have any problems you can dial [telephone number] and press the '#' (hash) key on your telephone keypad. The Community Network Operator will help return you to the group call.

Q **Can I increase the volume?**

A Yes! Press ***6** on your telephone keypad to increase the volume of the earpiece. A list of other telephone keypad options is provided below. You may find these helpful as you become more familiar with the calls. If you have any problems speak to your facilitator or press '#' (hash) to speak to the Community Network Operator.

Q **Will I have to speak and make a contribution?**

A Everyone gets an opportunity to speak, but you can simply listen until you feel ready to talk.

Q **I like the idea, but am a bit worried about taking part.**

A Telephone friendship groups are very informal. Most people will be taking part for the first time. The volunteer facilitator (Chairperson) will try to make everyone feel welcome and at ease.

Q **Surely everyone will be talking over each other?**

A Perhaps surprisingly, this doesn't happen. People usually wait for a

natural pause before talking. The volunteer facilitator will help to advise who is speaking and let everyone have a chance to take part.

Q Who do I ring to link me into the call?

A You don't. Community Network will call you on the phone number you have provided. We pay for the prearranged calls.

Q What can you discuss in a telephone friendship group?

A Anything! The choice of subject is up to you. Once you've started, the facilitator will help everyone to keep to the agreed topic and help the group think about other topics to discuss.

Q Will group telephone conversations be confidential?

A It is up to you to decide how much information you tell people about yourself. You do not have to tell people anything about you that you do not want them to know. The volunteer facilitator will abide by [service provider] policies and procedures for maintaining confidentiality. This means they will not talk about the group conversations outside the group.

Q What if the group call is being recorded?

A We will record a small number of group calls. We are recording the calls for research purposes to make sure that the volunteers run the groups in the way that they have been trained to. You will hear an automated message at the start of the call if it is being recorded.

Q Can I stop taking part in a telephone friendship group?

A Yes, you can decide to withdraw at any time and, if necessary, let the research team know if you no longer want to be contacted. If you do wish to drop out, you do not have to give a reason. Please tell the volunteer facilitator or contact the research team.

Key contacts

Community Network Operator: [telephone number]
[Service provider] – [Customer Engagement Manager]: [telephone number]
PLINY Research Team (University of Sheffield):
Louise Newbould [telephone number]; or
Rosie Duncan *[*telephone number*]*

Telephone Keypad - Options

Press	Action
# (hash)	for Operator Assistance
*1	Mute or un-mute self
*4	Decrease earpiece volume (press 8 to exit menu)
*6	Increase earpiece volume (press 8 to exit menu)
*7	Decrease mouthpiece volume (press 8 to exit menu)
8	Exit menu and return to the call
*9	Increase mouthpiece volume (press 8 to exit menu)
*0	Roll call of participants (only you will hear the list of participants in the group)
e.g. To mute/un-mute, press *1 ['*' accesses menu, '1' mutes/un-mutes]	

Volunteer facilitator Name:	

One-to-one calls

Date	Time

Group calls (telephone friendship group)

Week	Date	Time
1		
2		
3		
4		
5		
6		

Week	Date	Time
7		
8		
9		
10		
11		
12		

My telephone friendship group…

Name

Appendix 3 Putting Life in Years intervention design

Theoretical underpinning

Social isolation and loneliness

The intervention draws on de Jong Gierveld's loneliness model,[28] which is based on a cognitive theoretical approach to loneliness. Characteristic of this approach to loneliness is the emphasis on the discrepancy between what one wants in terms of interpersonal affection and intimacy and what one has; the greater the discrepancy, the greater the loneliness. Importantly, it differentiates between social loneliness and emotional loneliness. Social loneliness refers to the absence of a broader engaging social network of friends and acquaintances, whereas emotional loneliness relates to the absence of an intimate companion.

See http://home.fsw.vu.nl/TG.van.Tilburg/manual_loneliness_scale_1999.htm (accessed 20 June 2013).

Some recent literature distinguishes two aspects of isolation: 'social disconnectedness' – a lack of contacts with others and indicated by situational factors, for example small network sizes – and 'perceived isolation' – the subjective experience of a shortfall in one's social resources, for example companionship and support.

The intervention will impact on social and emotional loneliness by reducing the discrepancy between the older person's relationship expectations (or standards) and his or her cognitive evaluation of the (mis)match between the quality and quantity of existing relationships.[55] The intervention will reduce perceived isolation by improving perceptions of companionship and support.

Self-efficacy refers to the ability to gain and maintain a belief in personal competence or control in achieving various aspects of well-being. The higher a person's self-efficacy is with respect to obtaining external resources, the more likely it is that the person will undertake those activities and apply the effort needed to do so.[14] A low sense of self-efficacy has been shown to indicate low self-esteem and the potential for depression and feelings of anxiety and helplessness, whereas high levels of self-efficacy will encourage more investment in terms of individual effort and persistence and, ultimately, generate improvements in quality of life.

A declining sense of self-efficacy may often stem more from disuse and negative cultural expectations than from biological ageing and can set in motion self-perpetuating processes that result in lower cognitive and behavioural functioning. Monotonous environments that require little independent thought or judgement diminish the quality of functioning, whereas intellectually challenging ones enhance it (Bandura, 1993).[131] Research suggests that there is a strong association between high self-efficacy and less feelings of loneliness.[14]

Bandura's theory of self efficacy[29] describes individuals' self-belief in coping with adversity in various domains of functioning, such as persistence in the face of barriers and recovery from setbacks, and involves four main approaches: mastery, vicarious (observed) experience, verbal persuasion and perception of affective and physiological states.

Social learning theory states that people's perceptions of their capabilities (i.e. self-efficacy) affect their behaviour, thinking and emotional reactions in stressful situations. It has been suggested that social learning theory can inform interpretations of behaviour and cognitive change in support/self-help groups. Other people, viewed as role models, can elicit and enhance experiential knowledge based on first-hand experience (p. 51).[132] Social learning theory suggests that there are four requirements for people to learn and adapt behaviour: attention, retention (remembering what one observed), reproduction (ability to

reproduce the behaviour) and motivation (good reason) to want to adopt the behaviour. Although the aim of the intervention is to reduce feelings of loneliness, which may be linked to self-efficacy, it is unlikely that we will be able to measure sustainable changes in self-efficacy over the study period. We should also be clear that the purpose of the group discussions on the telephone is not about setting and achieving goals or major behaviour change but about reducing loneliness and social isolation and improving participants' sense of confidence and mental well-being (in some cases reducing depression).

Intervention components

Before the conversations start

The outline of the six weekly conversations (the intervention) will be described to the potential participants and they will be offered the opportunity to ask questions, raise concerns and make comments. Older people who may benefit from this intervention are recruited through GP practices in [redacted]. *As far as possible*, volunteers (befrienders) will be matched to the participants on the basis of common interests and any particular wishes made by the participants. However, befrienders are trained to facilitate conversations such that the older person's interests are always prioritised. This will avoid any delay in establishing the one-to-one intervention.

The first stage: detail

The first stage, six one-to-one telephone conversations, will take the format of brief (10–20 minutes) friendly conversations about regular everyday events. Three stages are suggested, which will support the older person and also prepare them for the group conversations. The three stages are (1) familiarisation – getting to know each other's interests and the older person's expectations; (2) everyday conversation – recent events, sharing experiences, focusing on the positives, but also allowing space for 'chat' about the older person's health, feelings, worries, etc.; and (3) everyday conversation continues with added focus on developing specific conversation topics, such as resources and accessing services, current affairs, television programmes, grandparenting, special interests (gardening, music, etc.). The older person will be encouraged to raise these topics in the ensuing group sessions.

The one-to-one sessions are not intended as professional counselling sessions. Should this need become apparent (expressed by the older person), the volunteer will, without breaking confidentiality, raise it with the volunteer co-ordinator and an individualised solution will be proposed (referring him or her back to the recruiting charity, providing him or her with a named contact for support).

It is important that the older person who is the recipient of the telephone call is in control of the topics discussed. However, the befriending volunteer will guide the conversations through the three stages, which may not always happen neatly in this sequence but are likely to be covered over the six sessions.

At the end of each conversation, the volunteer and the older person agree the time and date when the next conversation will take place.

Should an individual not wish to move on to participate in group conversations, the host charity will be asked if it has the capacity to continue providing a one-to-one befriending service for the individual. This option will not be offered at the start of the programme as an alternative to the group conversation. It will be considered only in those situations in which an individual expressly states that he or she does not wish to continue in a group.

Week 1

The volunteer introduces her/himself and the participant also introduces her/himself.

The volunteer ensures that the older person understands the purpose of the telephone conversation and asks about his or her expectations. Ground rules, for example confidentiality, boundaries about what is/is not discussed, what happens if the need for professional help is expressed, and the right to withdraw from the study are agreed. The time scale of the conversations and the ensuing group conversations is explained.

The volunteer facilitates an open conversation to 'get to know each other' (this could be talking about memories) and to find common interests. The befriender may encourage the older person to talk about his or her aspirations for this intervention and what he or she is hoping to get out of it. The befriender may also explore any concerns or fears that the older person may have and discuss how these might be overcome.

The conversation is concluded by the volunteer preparing the older person for the 'finish' and reminding him or her of the next 'date'.

Week 2

Following greetings the volunteer enquires about the participant's health and any events during the past week.

The volunteer encourages the older person to talk further about interests, memories, worries (could be health, family, neighbourhood, etc.) and also shares some of his or her memories, interests, etc. Encouragement and support is given to achievements (from the older person's perspective) since the last conversation.

The volunteer reminds the participant that topics discussed are confidential (especially if asking questions about health) and offers reassurance that it is okay to have boundaries for what they do/do not discuss.

Weeks 3 and 4: everyday conversations

Following greetings, the volunteer opens up the conversation to discussion about recent events, health, family and feelings. The volunteer should facilitate the conversations in such a way that the older person feels and is in control of what is talked about and develops a stronger sense of confidence in him- or herself.

The volunteer can refer to issues/topics from week 2 (and/or week 3) if appropriate.

Week 5

The conversation follows a similar pattern to weeks 3 and 4. When possible the volunteer places greater emphasis on developing specific conversation topics. This may be about hobbies, current affairs, family or television programmes. The older person will, however, continue to be in control of the conversation so that, if, for example, he or she has had 'a bad night' and wishes to talk about his or her worries, he or she should be able to do so.

The volunteer reminds the older person that the following week is the final week of one-to-one conversations, which will be followed by group discussions. The volunteer also suggests that the older person might want to think about what he or she would like to talk about in the group and what he or she hopes to get out of it.

Week 6

Following greetings the volunteer will start by reminding the older person that this is the last week of their conversations. The conversation then follows a similar pattern to that of week 5. Towards the end of the conversation the volunteer will discuss the ensuing group conversations with the participant and encourage him or her to raise topics and interests in the group. At this stage, if the older person expresses a reluctance to participate in a group, other options will have to be explored.

If an older person expresses concern about joining a group, the volunteer could explore these concerns and barriers with him or her, which would link into mastery and planning for how to cope with barriers.

Stage 2

The second stage consists of one group conversation per week over 12 weeks. Older people who have taken part in six one-to-one conversations are ideally allocated to groups in which, on the basis of the previous conversations, they are most likely to have common interests. The size of the groups will range from six to eight individuals and the sessions will last between 30 and 60 minutes.

The trained facilitator will be provided with a handbook on group facilitation. The role of the facilitator will be to make it easy for the group to achieve its purpose. He or she will do this by:

- creating and maintaining a safe and stimulating space for discussion
- enabling the group to listen and respond to other members of the group
- ensuring the interests of one or two individuals do not dominate the group
- ensuring that all participants have an opportunity to contribute
- ensuring that the discussions are not 'destructive' or damaging to individuals in the group and
- constantly monitoring and fostering the purpose of the group as well as the relationships and individuals within it.

Before the meetings start, the facilitator will communicate with the participants to determine a mutually agreeable time for the meetings. Conversations should ideally take place on the same day of the week and at the same time. Participants will receive written information about teleconferencing and:

- what to do if they are unable to participate in one conversation
- what happens if they do not answer when the facilitator phones
- the acceptability of initiating between-call contact with other participants
- the confidentiality of what is discussed in the group
- boundaries between what is/is not discussed
- what happens if a group member expresses the need for help with regard to his or her health
- how the facilitator will manage disagreements during the conversations
- what happens if there are technical problems, such as how to reconnect if they are accidentally disconnected or have to leave for part of the meeting
- key contacts
- the right to withdraw from the study.

These points will be discussed with the group during the first meeting. Depending on the composition of the group, the conversation session structure may develop in one of two ways:

1. as a subject interest group (e.g. current affairs, local history, music), who will discuss the same subject matter each time or
2. a friendship support group, in which members agree the topic to be discussed at each session.

Cattan *et al.*'s[23] systematic review suggests that both types of group (subject interest and friendship support) may be effective. The review also highlighted that improving self-esteem and internal locus of control (elements of self-efficacy) could enhance the effectiveness of an intervention to reduce feelings of loneliness.

Week 1

The trained volunteer facilitator will facilitate the introduction of group members to each other, draw attention to the purpose of the conversations and discuss the ground rules of teleconferencing with the participants (as in the written information). Participants will be given time to raise any technical/practical/safeguarding problems that require attention by the research team.

In the first meeting, the facilitator will encourage participants to introduce topics and interests to the group to be discussed over the 12 weeks. The facilitation of this first step will depend on the composition of the group and the methods used to select participants for the group.

Towards the end of the allocated/agreed time, the facilitator will draw the discussion to an end and remind members of the day/date and time of the next group discussion.

Weeks 2–10

The facilitator calls the participants. Participants introduce themselves and are reminded of basic ground rules.

The facilitator encourages the group to recap on the previous conversation and invites participants to comment on the week that has passed (have they initiated calls outside the group conversation, taken part in some external activity, requested information about, for example, becoming a volunteer, etc.).

Participants are encouraged to make suggestions for that day's and the following weeks' discussions, to share information and to contribute to the discussion.

Towards the end of the allocated/agreed time, the facilitator will draw the discussion to an end and remind members of the day/date and time of the next group discussion.

Week 11

The group call in week 11 follows the same format as in weeks 2–10. In addition, the facilitator reminds participants that the following week is the last conversation that they have signed up for. Participants are asked to think about what they plan to do following the end of these conversations.

Week 12

The group call in week 12 follows the same format as in weeks 2–10. However, more emphasis is put on participants discussing their plans following the end of the group conversations. The facilitator concludes the discussion, giving everyone a chance to say goodbye.

The changes in self-efficacy are likely to be small. The most likely improvements are an increase in self-confidence and increased feelings of competence and self-control. These improvements may be observed through increased information exchange, participants wanting to initiate/or initiating calls outside the group, participants feeling able to suggest a particular topic for discussion and participants wanting to become/or becoming volunteers.

Intervention development

In May 2005, Help the Aged and Zurich Community Trust launched a 2-year national programme called A Call in Time, intended to provide low-level support and telephone befriending services to older people who are lonely, isolated or vulnerable. Eight projects were funded across the UK. A service mapping exercise described the content of these projects.[24] A Delphi survey was conducted with the project co-ordinators of all eight projects to reach a consensus view about a 'model of best practice'.[24] The consensus was for 'a telephone befriending model to be based on a combination of telephone calls and peer-to-peer support, where all members are encouraged to make telephone calls as well as receive them, thereby developing "telephone clubs" ' (p. 50).[24] Concurrent qualitative research with older people who received telephone befriending services, including those involved in telephone clubs, confirmed the value of this model.[24,25]

Between October 2011 and January 2012, following the commission of the PLINY project by the National Institute for Health Research, the manual for the one-to-one calls was drawn up by Mima Cattan and Rebecca Gossage-Worrall, with input from the PLINY service provider and the TMG public representative. The manual for the group calls was based on the standard Community Network manual and was drawn up by the same individuals with additional input from a professional group facilitation trainer. The content of both the one-to-one manual and the group manuals drew on material from manuals reviewed by Mima Cattan as part of her service mapping exercise[24] and was reviewed by the first wave of volunteer facilitators in March 2011. These volunteers requested clarification on many issues in the one-to-one and group manuals and this consultation resulted in changes to the manuals and the insertion of the 'Questions and Answers for Participants' section.

Appendix 4 Training materials

Putting Life In Years (PLINY): Telephone friendship groups research study

One-to-one calls manual

Introducing participants to group telephone discussions through one-to-one calls

What are telephone friendship groups?

Approximately 6 – 8 people joined together over the telephone which is sometimes called a teleconference. The trained volunteer facilitates the group discussions which take place for about 1 hour for 12 weeks.

Purpose of the one-to-one telephone calls

There are a lot of people who may never have been involved in a telephone conversation with more than one person. As a volunteer facilitator you will help introduce each person to the idea of group telephone discussions by calling them for a brief friendly one-to-one telephone conversation. The calls will be made through the Community Network. This will not cost you anything and this guide will tell you what to do.

Discussions over the telephone can take place with more than two people. This type of group conversation is called a tele-conference. A number of people can join the same telephone call and talk together from any location.

Tele-conferences are often used by businesses to enable colleagues and partners to 'meet' without the need for long distance travel. There are also a number of friendship or support services which are delivered to individuals, and groups of people, over the telephone.

Group discussions are led by a trained facilitator. The facilitator's role is to monitor the discussion, support individuals to contribute to the conversation and help the group fulfil its purpose.

One-to-one telephone calls

The one-to-one telephone calls should last for approximately 10-20 minutes. You can call the participant up to six times before the participant joins a telephone friendship group. The brief friendly conversations are confidential and should include:

1) *familiarisation* – getting to know each other, the participant's expectations;
2) *every day conversation* – recent events, sharing experiences about everyday life, focusing on the positives, but also allowing space for 'chat' about the older person's health, feelings, worries etc;
3) *developing specific conversation topics* - current affairs, TV programmes, grand parenting, interests and hobbies (gardening, music, books) and accessing services. These topics may be something they want to talk about in the telephone friendship group.

08.10.2012; Version 1.3

Putting Life In Years (PLINY): Telephone friendship groups research study

Guide to one-to-one telephone discussions

Not all participants will need six one-to-one discussions to enable them to understand how the group discussions work or for them to feel able to join a group. If the person is ready for a group after only three or four one-to-one telephone calls, you can discuss this with the person and agree to make fewer calls.

If a group is not available or there are not sufficient numbers to start a group then it may help to keep the participant engaged by maintaining contact via telephone for the full six calls, until the group starts.

INSTRUCTIONS

Guidance for making calls through Community Network

Step 1: Dial Community Network on [telephone number].

Step 2: Enter your Chairperson code _____.

Step 3: Record an owner name (*this name will be heard by the participant when they join the call*).

If you need to re-record the name at any stage just re-dial, enter the Chairperson Code and press *(star) as soon as the owner message starts; and, follow the instructions.

NOTE: Participants can only be called during [service provider] office hours 9am – 5pm.

Initially contacting participants' directly to arrange the first one- to- one call

Step 1: Dial Community Network on [telephone number].

Step 2: Enter your Chairperson code _____.

Step 3: Press 'star' (*).

Step 4: Press '9', followed immediately by the participants number. The phone will ring and be answered in the usual fashion. Once you have spoken and wish to introduce the individual to the conference call, simply press 'star' (*).

See Appendix D for further guidance.

All one-to-one calls can be made using this procedure. If the time and date of the one-to-one (or group) calls are known in advance, these can be booked for you by the Community Network Operator. Dial [telephone number] and **press the #** (hash) key on your telephone key pad. The Operator will book the session and call you and your participant at the pre-arranged time of the call. You can also email [email].

08.10.2012; Version 1.3

Operator Assistance is available Monday-Friday 08:30 - 21:00 by calling [telephone number] and pressing # (hash) on your phone keypad. A list of functions is included in Appendix E which may be helpful during the one-to-one or group calls.

Things you will need before each one-to-one call:

- A pen
- Your One-to-one calls register (Appendix C)
- A watch or clock which you can see comfortably from your telephone
    - keep a note of the start time and when the call is due to end
- A note of the date and time of the next call using the next weeks One-to-one calls register.

First one-to-one call (Week 1)

1) introduce yourself to the participant and inform them that you are a volunteer working for [service provider]
2) ask them how they would like to be addressed
3) remind them that this is part of a research study and they have agreed to take part
4) explain the purpose of the telephone call is to get know them and to induce them to group telephone conversations. During the first call let them know:
    a. the calls will last approximately 20 minutes;
    b. conversations are confidential;
    c. if they do not want to talk about something they do have to;
    d. what happens if the need for professional help is expressed
    e. they have the right to withdraw from the study.

The first conversation should be open and help you 'get to know each other' (this could be talking about memories) and to find common interests. You may want to encourage the participant to talk about what they are hoping to get out of being involved in a telephone friendship group. If the participant talks about any concerns you may want to explore these and discuss how these might be overcome.

Time - remind the participant that there is about 5 minutes left and begin to draw the conversation to a close. Confirm the date and time of the next telephone call before you end the call.

Notes – Record on the One-to-one calls register that the person took part in this session. Write a brief summary of the session e.g. topics discussed, expectations, general observations.

Week 2:

Greet the participant and enquire about their health and any events since the last telephone call.

Encourage the participant to talk further about interests, memories, worries (could be health, family, neighbourhood etc) and also shares some of their memories, interests etc. Encouragement

and support is given to accomplishments (from the older person's perspective) since the last conversation.

Reminds the participant that topics discussed are confidential (especially if asking questions about health). Provide reassurance that it is okay to have boundaries for what they do/don't discuss.

Time - remind the participant that there is about 5 minutes left and begin to draw the conversation to a close. Confirm the date and time of the next telephone call before you end the call.

Notes – Record on the One-to-one calls register that the person took part in this session. Write a brief summary of the session e.g. topics discussed, general observations.

Weeks 3 and 4: 'Every day conversations'

Greet the participant and begin the conversation by talking about recent events, health, family and feelings. You may want to enquire about something they mentioned during a previous discussion.

Enable the older person to take control of the conversation. Encourage them to suggest and lead on topics they want to talk about.

Time - remind the participant that there is about 5 minutes left and begin to draw the conversation to a close. Confirm the date and time of the next telephone call before you end the call.

Notes – Record on the One-to-one calls register that the person took part in this session. Write a brief summary of the session e.g. topics discussed, general observations.

Week 5:

The conversation should follow a similar pattern to weeks 3 and 4. Where possible place greater emphasis on developing specific conversation topics. This may be about hobbies, current affairs, family, TV programmes. The person should be in control of the conversation so that if, for example, they have had 'a bad night' and wish to talk about their worries, then they should be able to do so.

Remind the person that the following week is the final week of one to one conversation and the group discussions start on _____. You might also want to ask the person to think about what they would like to talk about in the group and what they hope to get out of it.

Time - remind the participant that there is about 5 minutes left and begin to draw the conversation to a close. You may want remind the person how many one-to-one calls are left and tell the person that you can talk about the group a little more next week. Confirm the date and time of the next telephone call before you end the call.

Notes – Record on the One-to-one calls register that the person took part in this session. Write a brief summary of the session e.g. topics discussed, any concerns or positive comments about joining the group, general observations.

Week 6:

Following greetings, start by reminding the person that this is the last week of their one-to-one conversations. You may want to ask them about things you have discussed in previous weeks.

Begin to talk to the participant about the group conversations and encourage them to raise topics and interests in the group. At this stage if the participant expresses a reluctance to participate in a group, explore these concerns with them.

The conversation is concluded by reminding them of the date and time of the first group discussion.

Notes – Record on the One-to-one calls register that the person took part in this session. Write a brief summary of the session e.g. topics discussed, any concerns or positive comments about joining the group, general observations.

Will everyone need six one-to-one calls?

Some people will be more willing and/ or able to join a group than others and may not need all six one-to-one calls to help build their confidence. This should be discussed with the person. If you do progress more quickly through the guidance for the six one-to-one calls it is important that, as a minimum, the participant is:

- made aware that the one-to-one conversations are confidential;
- reminded about the purpose of the one-to-one calls and that they are brief conversations of up to 20 minutes;
- invited to talk about anything they like;
- invited to consider the topics or type of group they might like to join;
- reminded that there may be people in the group who have different interests or experiences;
- reminded that a telephone friendship group will be starting for them to join
- told about the 'ground rules' for the group.

When will one-to-one calls take place?

One-to-one calls should be made between the hours of 9am and 5pm. During the first call discuss with the participant a suitable time to call them again next week. You may want discuss with the participant that you will call them on the same day and time for the one-to-one calls. At the end of each conversation, agree (or remind them of) the time and date when the next conversation will take place.

Ground rules for participants

Part of your role as a telephone friendship group facilitator will be to make sure that the group works well. To help you to do this, there are a number of ground rules everyone in the group should follow. Your will learn more about ground rules and how to agree rules with the group, during your

facilitator training. However, you can discuss these with participants during the one-to-one sessions. These may include:

- Confidentiality – discussions taking place in the group are confidential, unless agreed by all participants

REMEMBER: During one-to-one calls the participants you speak to are likely to join the same telephone friendship group but they do not know each other. It is important to keep the one-to-one discussions confidential.

- Not talking over other people in the group
- Respect for each other.

What to do if you are concerned about a participant or need advice?

The one to one telephone calls are not intended as counselling sessions. If a participant expresses a need to speak to someone about how they feel, you should, without breaking confidentiality, raise it with the volunteer coordinator. They will provide advice on what to do next.

What happens if one of the participants does not want to join a group?

If an individual tells you that they do not wish to move on to group conversations contact your volunteer co-ordinator for advice. The service is one-to-one calls followed by group discussions for 12 weeks. It will be up to [service provider] to decide what happens next. This option will not be offered at the start of the programme as an alternative to the group conversations. It will only be considered in those situations where an individual expressly states that they do not wish to continue in a group.

Example 1: *I don't have anything to talk about*?
You might ask the participant if he/she reads a newspaper; have they read anything interesting.

Example 2: "I don't want to talk to people I don't know about X, Y, Z"
Remind the participant that they don't have to tell the group anything they don't want to.
You might like to ask the participant what they would like to talk about; or, what they might like to ask other people in the group (e.g. interests/ hobbies).

What should you do if one of the participants does not want to take part in the study anymore?

If an individual tells you that they do **not** want to continue to take part in the study….

1) Contact the volunteer co-ordinator for advice.

2) Discuss any concerns with the participants and if they want to stop taking part in telephone conversations (one-to-one or group), tell the participant that you will inform the volunteer co-

ordinator. If the participant provides a reason for not wanting to continue make a note of this on the calls register. Tell the participant that the research team will still contact them.

Contacts:

[Service provider] (9am – 5pm)
[Community Network]
[PLINY Research Team]

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Appendix C: One-to-one calls register

PHR 09/3004/01

Intervention

One-to-one calls register (weekly)

Week number ☐ of 6

Volunteer / facilitator name

Do you normally call these participants? ☐ Yes ☐ No, I am standing in for another volunteer

#	Participant ID	Participant name	Date and time of call	Call successful?	Reason for unsuccessful call*	Comments
1	R☐/☐☐☐		d d m m y y h h m m	☐ Y ☐ N		
2	R☐/☐☐☐		d d m m y y h h m m	☐ Y ☐ N		
3	R☐/☐☐☐		d d m m y y h h m m	☐ Y ☐ N		
4	R☐/☐☐☐		d d m m y y h h m m	☐ Y ☐ N		
5	R☐/☐☐☐		d d m m y y h h m m	☐ Y ☐ N		
6	R☐/☐☐☐		d d m m y y h h m m	☐ Y ☐ N		
7	R☐/☐☐☐		d d m m y y h h m m	☐ Y ☐ N		
8	R☐/☐☐☐		d d m m y y h h m m	☐ Y ☐ N		
9	R☐/☐☐☐		d d m m y y h h m m	☐ Y ☐ N		

*Reason for unsuccessful call:
1 Not answered (or line engaged / not working)§
2 Partial call
3 Unable to join the call (e.g. visitor, busy, unwell)
4 No longer wants to participate in telephone calls/discussion§
5 Deceased§
6 Other, specify
§Inform the volunteer co-ordinator

17/04/2012 v1.0

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Appendix D: One-to-one telephone call – Step By Step Instructions

You are the 'Chairperson' for the one-to-one call.

Joining as the Chairperson for the first time:

To activate your codes, you will need to record a **conference owner name** which will heard by participants when they dial in. Use the organisation name [service provider].

1. Dial the Conference Phone Number [telephone number]. You will hear — "*Welcome to the Community Network MeetnTalk conference line, please enter your conference code followed by the hash (#) key or just press hash (#) to speak to an operator*"

2. After entering your 5-digit Chairperson Code [_____], you will then hear — "*The system does not yet have a recording of the conference owner's name. Please speak the conference owner's name and then press the hash (#) key"*

3. After saying the name and pressing hash, you will hear — "*Press 1 to accept the recording, 2 to review, 3 to record again, 9 to discard*"

4. Press 1 to accept the recording, you will hear — *"Recording saved."* Then hang up.

Initially contacting participants' directly to arrange the first one- to- one call:

1. Dial into the system using the Freephone number [telephone number]. You will hear — "*Welcome to the Community Network MeetnTalk conference line, please enter your conference code followed by the hash (#) key or just press hash (#) to speak to an operator". E*nter your Chair Code followed by the hash (#) key.

   If the code is correct, you will hear — "Code accepted. This conference is owned by — (pre-recorded message). After the tone, say your name and then press the hash (#) key". Your name will then be recorded for this session.

2. You will then hear — *"Would you like to record this call? Enter 1 for yes or 0 for no."* The system will continue to prompt you to respond; if no key press is made, the conference will not be recorded. **Press '0' (zero) for no**.

3. After this, you will also be asked to provide your own name again, for the introduction played to other participants whenever you enter, or exit the conference.

4. You should now have entered the conference. You are now able to dial-out to bring a participant into the call (although there are only two of you for the one-to-one calls the system still calls it a 'conference' call).

5. Press '9', followed immediately by the participants' number. The phone will ring in the usual way. Once you have spoken and wish to introduce the individual to the conference, simply press 'star' (*). They will then be brought into the conference.

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If the time and date of the one-to-one (or group) calls are known in advance, these can be booked for you by the Community Network Operator. Dial [telephone number] and **press the #** (hash) key on your telephone key pad. The Operator will book the session and call you and your participant/s at the time of the call.

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Appendix E: Telephone Key Press Options

Please use these commands to help you get the most out of your conferencing experience:

Press	Action
# (hash)	for Operator Assistance
*1	Mute or un-mute self
*2	Lock or unlock the conference. A locked conference does not allow anyone else to join (Chairperson only)
*3	Eject the last user who joined the conference (Chairperson only)
*4	Decrease earpiece volume (8 exit menu)
*5	Pause/restart recording (Chairperson only)
*6	Increase earpiece volume (8 exit menu)
*7	Decrease mouthpiece volume (8 exit menu)
8	Exit menu and return to conference
*9	Increase mouthpiece volume (8 exit menu)
*0	Roll call of participants (this is played only to the requester, not to the conference)
e.g. To mute/un-mute, press *1 ['*' accesses menu, '1' mutes/un-mutes]	

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Community Network Facilitator Handbook

FACILITATOR'S HANDBOOK©

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1. SECTION ONE: INTRODUCTION

Facilitation literally means 'making things easy'. A facilitator makes it easy for the group to achieve what it sets out to do. That means that your job as a facilitator is to:

- Be clear about the purpose of your group
- Have the skills to help them achieve their purpose
- Have the tools to help effectively
- Understand how groups work
- Work in a way that makes it easy for them

The training is designed to help you practise some of the tools and skills you will need many of which you are likely to have already. In this handbook we offer some extra material that will help you to reflect and build on your existing skills as well as to reinforce what is covered in the training.

Section Two explores the role of the facilitator and the different elements of the role that a facilitator may use during the group sessions. There is also some information on the different styles you may adopt as a facilitator.

Section Three explains how groups work and how they develop. You will find this useful to refer to as the group changes during the time you are working with them.

Section Four concentrates on three of the core skills you will use as a facilitator: listening, questioning and responding to difficult behaviour. There is also a skills checklist for you to assess your own skills against.

Section Five is very practical and will provide useful information about how to prepare for your first session, how to run a session and how to close off.

Section Six contains additional material that you may find helpful. Before you begin the training you may find it helpful to assess how ready you feel for the role. There is a brief questionnaire to help you do this in this section. There is also another questionnaire for you to complete after the training. This will help you to assess how far the training has prepared you for the role.

2. SECTION TWO: THE ROLE OF THE FACILITATOR

1.1 The Role

The facilitator is there to ensure that the group session is effective and achieves what its members set out to do. Your job might range from helping the group members to find common ground for discussion, to share common experience, to discuss the latest world events or bestselling book or just to enjoy each other's company.

The role of the facilitator therefore is to ensure that the group works as a constructive and cohesive unit to a common purpose. The facilitator has a role within the group which combines the three following elements:

As a **Leader** the facilitator will:

- **FOCUS** To provide a focus for the group's cohesion and discussion
- **STIMULATE** To encourage constructive debate between group members.
- **SUPPORT** To bring out information from introverted members of the group and to allow new ideas to be submitted.
- **PARTICIPATE** When the group is interacting poorly or in the wrong direction the facilitator must be willing to promote new discussion.
- **TEAM BUILD** To form a cohesive, interactive, motivated and productive group.

As a **Referee** the facilitator will:

- **REGULATE** To maintain order of the group discussion, discouraging participants from talking at the same time, or dominating the floor.
- **PROTECT MEMBERS** To ensure that all contributions to the discussion are treated equally and that no-one is rebuffed for their input.
- **DEAL WITH PROBLEMS** To control problem people within the group allowing everyone to participate freely.
- **ACT AS TIMEKEEPER** To adhere to the meeting timetable thus ensuring completion of the agenda.

As a **Mediator** the facilitator will:

- **BE NEUTRAL** The facilitator must be neutral in the discussion, taking a pragmatic view of all points raised. This frees the facilitator to concentrate on the group rather than the content of the discussion so that they can ask pertinent and stimulating questions.
- **BE PRAGMATIC** To take a detached look at the discussion viewing each point on its merits.
- **ENCOURAGE FEEDBACK** To promote discussion of each point raised, by all members of the group.

YOU DON'T NEED TO BE THERE TO SOLVE PROBLEMS

Beware of feeling that your role is to provide answers or solutions to problems. Others may have suggestions or signpost people to organisations. Remember you are neutral and your role is to facilitate, not to provide answers.

1.2 Four Facilitation Styles

A facilitator will not play a single role throughout any facilitation process. Instead, she or he will change their style according to the circumstances. Below are four of the most common styles you might use and the kinds of situations each one is best suited to. Health warning: no two groups are the same and you may find that you use different styles in the same circumstances. Your primary role is to be alert to the dynamics of the group and the demands of the task and to alter your role and style accordingly.

LEADING	**BEING PART OF**

• When the group lacks direction
• When the group dries up
• When the subject is technical
• Where there is a lot of dispute in the group
• Where you need a definite outcome
• If the group lacks experience
  • of the subject/process
  • of working as a group
• Where they don't know each other very well
• At the beginning of a course
• At the conclusion of facilitation
• To ensure that a decision is made - if needed
• Where the subject is contentious
	• Getting started
	• If the group is hostile
	• If there are sensitive issues (you do not wish to overemphasise your ownership)
	• When you have expert knowledge (also acting as adviser)
	• When developing skills in the group
	• When the group is on a roll
	• When there are guest speakers
	• When one of the participants is presenting to the group
	• When the group are not communicating/gelling

MONITORING	**ABSENT**
• After a settling in period • To provide clarification - ensure task is understood • To capture ideas for later use • If you are facilitating as an outsider • If you need to follow progress without being involved • Full time 'fly on the wall' • To be available for use as a resource • To assess the climate of the group • As a co-facilitator (supportive)	• When group discussion is flowing • After task has been given and initial discussion takes place • When your presence is not required by group (at their request) • Informal setting/meeting • Central co-ordination • When the group needs to establish own identity first • After confrontation • When own opinion may be a hindrance

1.3 The Facilitation Spectrum

Your style will range along the following spectrum according to the circumstances.

CHARACTERISTICS OF EACH STYLE	YOUR STYLE MIGHT RANGE FROM
	Gentle intervention
Doing nothing Silence Support Questions to clarify	Supportive ⇓
Questions to change Questions to move Suggesting choices Suggesting paths Sharing ideas Suggesting action	Persuasive ⇓
Guidance Choosing for group Directing	Directive ⇓
	TO
	Forceful intervention

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3. SECTION THREE: ABOUT GROUPS

3.1 Purpose of the Group

As noted above, your job is to help the group achieve its purpose so it is important to be clear about this from the start. The group may want to think about the group's purpose in the first session.

- Are you sharing experiences and learning from each other?
- Are you offering social contact and emotional support?
- Are you building a network where people can get in touch with each other again?

Sometimes groups change their purpose as they evolve. If that is the case you need to check with the group and clarify it for them.

3.2 How Groups Work

All groups of people who work together tend to go through different stages. The sequence is not always the same nor is the time that different groups might spend at each stage. In fact groups may go back to earlier stages when a group has been apart for a while or someone new joins, for example. Groups can 'meet' in a room together or over the telephone. The circumstances and the way the group works may vary slightly depending on the purpose of the group and the chosen format. The most typical sequence is as follows:

Stage 1. CONFUSION

When the group first comes together there is an initial period of confusion. Individuals may be unsure as to where they stand in relation to others or they may be uncertain about what is required. Typical emotions include anxiety and excitement. Typical behaviours include tentativeness, superficial politeness, questions about what will happen and when, and either holding back or searching for someone to talk with. The group are generally looking for a structure or a framework of authority in which to function.

Useful action for facilitators at this stage is to be welcoming, to set the right tone, to clarify the programme or agenda, to agree any ground rules, to get people talking to each other and to encourage everyone to speak in the group early on. Too much freedom too soon can exaggerate or extend the period of confusion unless it is managed very well.

Stage 2. DEPENDENCE

Individuals are reliant on the facilitator and they seek to stay within their comfort zone. For some it is still too early to take big risks at their own choosing; the trust has not built up enough yet. People stick to their strengths, their roles and even their chairs. Authority may be embodied in the facilitator (personal), a set of rules or procedures (structural), or in a task that has been set (external). In the group the pursuance of, and reliance on, this authority may overshadow the needs and opinions of individuals.

Facilitators need to be aware of their power at this stage and not encourage the group to become overly dependent on them. Weaning the group off this dependence may require gentleness and firmness. Encouraging and demonstrating support, clarity in delegating tasks and empowering individuals may help.

Stage 3. FIGHT/FLIGHT

At its inception this stage can be about bids for power. However, it is also where the group recognises other problems or opportunities but is not ready to deal with them. Instead, it may either attack or withdraw from the situation. Individuals may mentally, or physically leave. Alternatively, they may challenge the programme, the facilitator or others in the group. Sometimes this quickly transforms itself into high energy, creativity, collaboration and direction. Unfortunately, it can sometimes result in "an atmosphere", unhealthy competition and misdirected anger.

There can be a temptation for facilitators to ignore what is happening so they do not have to deal with what is happening. Alternatively, as part of the group, they may be drawn into the maelstrom and attempt to deal with the issues at face value.

Generally speaking it is best to plan in activities that are likely to promote stimulation, support and success. Where there are difficulties, it is generally better to surface them and deal with them calmly, maturely and openly; encourage listening and feedback, without blame or guilt, and respond positively by taking action (or encouraging the group to take action) based on the expressed needs of individuals and the group as a whole.

Stage 4. PAIRING

People by now are beginning to get to know each other. Individuals are making choices, including who they like and want to spend time with. Friendliness with one another can lead fairly quickly to the formation of sub-groups. The appearance of pairing is frequently a signal that the group culture is crystallising. At its worst this can mean the emergence of exclusive cliques, more positively it can mean the development of fluid, permeable sub-groups that work (or socialise) closely and intensively for periods of time. Group norms that emerge may be enabling or they may be limiting.

Working on tasks of a more personal nature, disclosure, collaboration and coming down off your pedestal are all useful options. Avoid your own preferences turning into favouritism. Where group norms are limiting or oppressive they may need to be challenged.

Stage 5. MATURITY

This is where the group is more adult. As well as working together effectively, they are able to handle difficult problems, including emotional ones, without threatening the group's stability. Confusion, dependence and conflict may continue from time to time but in a more healthy and controlled manner. There is a cohesive culture and a spirit in the group. It is now working as a team: there is high morale, group loyalty and individuals are accepted for what they are. Individuals may find it hard to leave the group and when the group dissolves there can be a period of readjustment and even mourning.

At this stage the group can be virtually autonomous if required. The facilitator is regarded more as an equal than as a formal leader. The role may now have changed to one of being a resource to the group, an observer/interpreter, a consultant, or being just one of the group. However, as the group reaches the time for disbanding they may mentally start the process of leaving. This may mean that the facilitator needs to once again pick up the reins and prepare people for departure.

4. SECTION FOUR: FACILITATION SKILLS

You will already be aware of the range of skills that a facilitator needs. As you know these include:

- **Communication**
  The ability to put over points using all the techniques available both verbal and non-verbal, receptive listening is also an important tool.
- **Planning**
  To arrange the discussion and to set it up in such a way that all barriers are removed between facilitator and participants. The time allocation to the meeting has to include time for discussions and feedback sessions.
- **Leadership**
  To forge a co-operative group of individuals through motivation and empowerment of the individuals - knowing when to stand back and let the group members take the initiative
- **Problem Identification**
  Knowing that there is a problem is not enough you have to be able to get to its root cause and use your skills to solve it.

Three of the key **communication** skills that we will be practising during the training are:

- Listening
- Questioning
- Responding to difficult behaviour

4.1 Active listening

When you listen actively, you will:

- **Listen For The Total Meaning**

Any message usually consists of two components

a) The content of the message
b) The feeling or attitude underlying this content

It is the total meaning of the message that we must try to understand.

e.g. “I’ve fixed that appointment”
“Well, I’ve finally got that wretched appointment”

Although the content is the same, the total message has changed. Extra sensitivity to the total meaning can transform an average working climate into a good one.

- **Respond To Feelings**
  In some instances, the content is far less important than the feeling which underlies it. Each time the listener must ask
  “What is she trying to tell me?”
  “What does this mean to him?”
  “How does she see this situation?”
- **Note All Clues**
  Active and sensitive listening requires us to be aware of all aspects of communication. Hesitation in speaking, the inflection of a person’s voice, the points

that are stressed, are all clues about how the person is feeling. We should also note expressions, hand and eye movements.

- **What We Communicate by Listening**
  By constantly listening to the speaker, you are conveying the idea that you are interested in him as a person and that what he feels is important; that you respect his ideas; that you want him to know he can talk openly and honestly without being snubbed.
- **Testing For Understanding**
  It is important to constantly test your ability to see things in the same way the speaker sees them. You can do this by reflecting in your own words what the speaker seems to mean by her words and actions. Her response will tell you whether or not you have understood.

Active listening is not an easy skill to acquire, it demands practice. Perhaps more importantly, it may require changes in our attitude and behaviour towards each other.

We are also very good at putting up **barriers to our own listening.** Nine of the most common barriers are listed below. How many do you recognise?

(1) Scoring Points

Relating everything you hear to your own experience.

- Saying ....“Oh that’s nothing, you should have seen what happened to me last week”
- Thinking.... “Mm! My kids are so much more intelligent than that!”

(2) Mind Reading

Predicting what the other person is really thinking.

- Saying to yourself.... “I bet that’s not the real reason he left that company”

(3) Rehearsing

Practising your next lines in your head.

- Preparing your next “clever” remark or question and missing what the other person is saying.

(4) Cherry Picking

Listening for a key piece of information - then switching off.

- Checking that an interviewee has had particular experience in a particular field but not listening to the proof.
- Listening out for a trigger for you to tell your side of things rather than hearing them out.

(5) Daydreaming

- You can think 4 - 6 times faster than people can talk. The temptation is to use the “spare” time to daydream.

(6) Labelling

Putting the other person into a category before hearing all the evidence.

- Quickly dubbing someone as a “typical” accountant/salesperson etc.
- Not listening to someone you have decided is a rambler etc.

(7) Counselling

Being unable to resist interrupting and giving advice.

- Saying... "Why don't you try...." or "In my experience, the best ....."

(8) Duelling

Continually countering any remarks with parries and thrusts of your own.

- Saying ... "Well at least *I* am never in debt"
- Saying ... "You won't find people in *my* group acting like that!"

(9) Side stepping sentiment

Countering expressions of emotion with jokes or hollow cliches.

- Saying.... "Well it's not the end of the world is it ?"
- Saying.... "Stiff upper lip. Tomorrow's another day!"

4.2 The Power of Questions

As you probably know, there are two types of questions:

- **Open** Questions – those which are genuinely exploratory and curious
- **Closed** Questions – those which expect a one-word answer

Generally speaking, open questions are more useful than closed questions. Typically open questions start with words such as:

- How...?
- What...?
- When...?
- Where...?
- Why...?

Closed questions are useful for checking for understanding or agreement and summarising. However they often close off a discussion so use them carefully.
Asking questions can:

- Open new possibilities
- Gather information
- Build new relationships
- Help you think objectively
- Create innovations
- Resolve breakdowns
- Support you in making decisions
- Help you and your group learn and develop
- Support you to manage change in the group
- Make unprecedented things happen

Questions cause new opening for thought and discussion whereas statements and opinions may not.

4.3 Responding to difficult behaviour

From time to time you may find that members of the group behave in ways that you find difficult. This may depend on the stage that the group is at (see section two) as well as

the particular dynamic within the group or how an individual is feeling on the day. Whatever the cause you need to be able to respond effectively. Below are a few examples of behaviour that you might find challenging along with some ideas on how to respond.

Calming down a heated discussion
If the discussion is getting heated or contributions are overlong be prepared to step in and curtail it. Be polite but firm. For example:
• *"Hold on – there are several people speaking at once! Right John first, then Sue."*

Negative attitude
- For example, a team member who always points out difficulties
- Ask them to suggest a solution to the difficulty they have identified
- View them as a resource against whom to bounce ideas and suggestions
- Be prepared for the negative – and use it to improve an idea
- Regard the statement of difficulty as an invitation to build, not as an obstacle

An "expert"
- Don't react defensively – respect what they can offer
- Use the person's expertise – but set limits
- Encourage the expert to listen
- Invite the expert to present formally
- Give the expert an official role in answering people's questions

The cynic ("I've heard it all before")
- Don't get defensive or angry
- Find some merit in what they are saying
- Encourage them to concentrate on the positive
- Use the rest of the group to give different viewpoints
- If you feel their behaviour is disrupting the group you may want to have a word with them, outside the group, to find out if anything is upsetting or annoying them.• You can also talk to the [service provider] Co-ordinator if you are concerned.

Conflict between two team members
- Don't intervene too early
- Emphasise points of agreement, minimise points of disagreement
- Direct the individual's attention to the objectives of the meeting
- Park the issue for the moment
- Draw others into the discussion to reduce the one-to-one element
- Depersonalise the issue from the individuals

There are some situations that may arise which are not appropriate to discuss as a group. If this happens, you might like to suggest to the person concerned that you will speak to the [service provider] Co-ordinator for advice. If it is a very emotional situation, you may wish to deal with it instantly by talking to the participant alone. You and the participant can be taken out of the group, by a Community Network operator, to discuss the problem privately and then be returned to the group.

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4.5 Self Assessment

Evaluate and assess your own facilitation skills (score yourself)

Score yourself 1 to 5: 5=Good 1=Poor

- I am able to defuse emotionally charged situations
- I am sensitive to the emotional 'undercurrents' within a group
- I am able to use a range of questions to promote open discussion and clarify issues
- I am able to summarise and reflect back what's being said accurately
- I use active listening effectively
- I can communicate instructions and requirements clearly and confidently to the group
- I am able to introduce a session effectively and establish a positive climate right from the beginning
- I am aware of the different facilitation styles and am able to adapt my style to suit the occasion
- I can close effectively
- I can use a range of tools/techniques to maintain pace and introduce variety
- I can give good quality feedback to individuals and the group
- I can deal with disruptive or over-talkative members of the group
- I am able to draw out quieter members of the group
- I can handle conflict between the members of group effectively

5. SECTION FIVE: THE FACILITATION PROCESS

5.1 Before You Start

There are several things to consider when you are preparing to facilitate a new group.

- Time and date of calls - You will have arranged the first group session with participants during the one-to-one calls. It is preferable to arrange the weekly group calls for the same time and day each week.
- Purpose of the group - The group has been established as part of the research study examining whether telephone friendship groups improve wellbeing for people aged 75 and over. This is not the purpose of the individual group but it is important that participants are aware they can leave the study at any time. The purpose of the group is to bring older people together, via telephone, to share experiences and talk about hobbies and interests. The group can decide if they would like to focus on a specific subject (e.g current affairs, local history, music) or agree topic/s to be discussed each week.

Each telephone friendship group should include approximately 6 to 8 participants. The call should last between 30 minutes and 1 hour. The ideal length of time is 1 hour to allow for everyone to contribute to the discussion.

Using the Group calls register you will need to make a note of the date and time of each session and note the participants who join the call. If someone does not join a session and you know the reason why, write this on the Group calls register
The Community Network Operator will call you first; and 'connect' each participant into the same telephone call. You need to check the following before you start:

- Do participants know the date and time of the session?
- Have you filled in each participant's name in the Group calls register
- Do you have everyone's contact details?

Ensure your participants understand what a telephone conference is and what the benefits are in taking part. **Written information will be available to participants (see Section Six).**

Take your telephone conference in a quiet room and have your Group calls register in front of you.

It is a good idea to have something to lean on to make it easier to take notes during the call. The Group calls register should be used to record the name of the participants who are part of the group and who joined the group as planned. The form can also be used to note your summary of the session and any observations, for example, what were the positives?; were any topics agreed for next week? etc.

5.2 During the Conference

Getting going
As a facilitator, you will be called first so that you can greet each member of the group as they join.

Provided everyone is by his or her phone, it will only take a few minutes to get everyone on line. It is a good idea to make a little small talk while waiting for everyone to be connected.

Once the group is all together and you have welcomed everyone, spend a little time introducing yourself, and then ask everyone in turn to say a little bit about themselves. Confirm with them the future times and dates of the next meetings.

If there are any questions about the research, inform the participant that you will feed this back to the volunteer co-ordinator (who will contact the research team).
Encourage participants to introduce topics and interests to the group, to be discussed over the 12 weeks. You may want to try an icebreaker to help the group feel more settled. Examples include: describe what you can see out of your window; name two famous people you would like to invite to tea; or what essential items you would bring to a desert island. From these simple questions, you will find out a great deal about your group's interests and activities.

Keep the Community Network page (see Section Six) to hand when you are facilitating to remind you how to call the operator, or how participants can increase the ear volume etc.

Week 2 – Week 10

- Remind participants of basic ground rules
- Encourage the group to recap on the previous conversation
- Encourage participants to make suggestions for that day's and following weeks' discussions; to share information; contribute to the discussion
- Invite participants to comment on the week that has passed; have they initiated calls outside the group conversation, taken part in some external activity, requested information about for example becoming a volunteer.

Week 11

- Continue facilitating the group as in weeks 2 – 10 (above)
- In addition, remind participants that this is week 11 (of 12) and the following week is the last conversation.
- Encourage participants to think about what they plan to do following the end of these conversations.

Week 12
Continue facilitating the group as in weeks 2 – 10 (above) however, place more emphasis on participants discussing their plans following the end of the group conversations.

The facilitator concludes the discussion, giving everyone a chance to say goodbye

DATA PROTECTION
Beware of circulating telephone numbers unless participants have agreed this beforehand or you will be breaking the Data Protection Act.

Ensure ALL participants get a chance to speak
Remember to **ask each person to say their first name before they start speaking as** this helps you build up a picture of participants' contributions. Complete the Group Calls Register after each session to keep a record of the participants who joined the

conversation. You can use the Group calls register to monitor who is contributing to the conversation.

Explain that if someone wishes to interrupt or get a point over they should say their name i.e. 'this is Janet. I think...'. After a time the group will be able to recognise each other's voices and this won't be necessary. But to begin with you will need to know who is talking.

During the conference you may want to direct a question or bring in a participant who has not been involved much, but don't put people on the spot. This way you can make sure that everyone has had a chance to contribute and bring people into the discussion if they have not had a chance to speak, but you must also remember that some people simply want to listen to what others have to say.

It is important to emphasise the fact that this time is for the participants to air their views and to raise important points that they feel need discussing. It is their time.

Remember:

- Do they know how to contact you if their circumstances change and they cannot take part?

Avoid focussing on individual issues

It is easy to get drawn into a discussion with an individual about their own personal issues. Of course, feel free to talk to each person individually but try not to get into too much of an in-depth conversation.

- Take control constructively
- Thank the individual, restate pertinent points and move on

Examples
• "I understand there are issues here but we need to give John a chance to air his views too."
• "Does anyone else have something they would like to contribute to the discussion."

Make sure there are no distractions

- Ask your group (if possible) to take their telephone conference in a quiet room. Any background noises will be played to the rest of the meeting.
- Ask someone to speak up if they are becoming faint.
- Ask participants to put their hand over the mouthpiece if you can hear background noises.

Keep the discussion going

If the discussion dries up try bringing in a question for participants and encourage those who are not speaking much but don't put pressure on the participant. Instead:

- Acknowledge their contributions every time they speak
- Ask them if they agree with what's being said
- Capitalise on their knowledge and personality

Examples
• "There are several people who have not had a chance to say something."
• "Tell me how you are feeling at this moment."
• "Why have you always done it this way…?"
• "What if you were to…?"

- Ask for any other issues relating to the topic people want to talk about

(It is useful to prepare a number of questions in advance in case this happens. Equally, making a note of who has made good points can help to remind you of who to bring in to the discussion and when.)

Examples
• "I think we need to give Kate's point more consideration"
• "Building on John's idea, what if we were to…?"

Body language. As there is no body language to see on the phone, it is necessary for people to say whom they are when interrupting, etc. Look out for those participants who have not said very much. Try to bring them into the conference. Initially it can be useful to put a tick by the name of those who have spoken, to help monitor the conversational flow. You can use the Group Calls Register but ensure the record of attendance and comments are legible.

Silences. These can feel awkward, but sometimes it may be necessary for reflection. Have a number of potential topics written down, which could be used to restart conversations that have stopped.

Things to remember

- Keep the discussion informal and friendly – put people at ease
- Tell them it is *their hour* to talk about the issues they feel are important or interesting
- Use first names and introduce everyone but ask them to say hello and one thing about themselves so that each person can hear each other
- Read out who is there
- Can they hear you OK?
- Keep a pen and the Group Calls Register handy so you can tick who is speaking and note down any topics/ observations.
- Remember your introduction (i.e. some calls may be recorded – in this case there will be an automated message, the SOS number etc.) Let people speak when they want to – don't be too forceful at the beginning
- Don't precede questions with participants' names to avoid 'putting people on the spot'
- Use Community Network facilities if you need to (calling operator, line problems, disconnection, background noise)

5.3 FINISHING UP

Summing Up and drawing things to a close
Keep your eye on the clock – telephone conferences usually last for one hour and the operator will interrupt you when you have five minutes left. Allow time for yourself to make some summing up comments, and/or you can ask the group for some final thoughts and remind them of the next scheduled date.

Examples
• "We have talked about some interesting issues but need to draw things to a close now."
• "We have to draw the discussion to a close but perhaps the group would like to pick up this discussion at next week's session?"

In the first few sessions, you may feel it would be helpful to ask participants their views on how they find the group discussion over the telephone.

- It may help the group to share their expectations and experience of the group
- Did other participants have a different experience of the first session?

Saying Goodbye
Bring the discussion to a close and allow everyone time to say a GROUP 'goodbye' – it helps to synchronise a farewell and then hang up the phone. Sometimes the phone lines are tied up for a short while after the conference whilst the digital link is disconnected. It is worth mentioning this before everyone says goodbye so that there is no confusion.

Remember to fill in your **Group Calls Register** for the week's session.

Evaluate the experience from the participants' point of view
Use the last 5 minutes to sum up and find out what people thought of the session.
If time permits, ask

- *Are there subjects you would like to talk about in the future – will you tell others about this experience?*

Learn from it and make changes.

ADDITIONAL FEATURES:

a) **Help.** If you need to attract an operator press **#** on your handset. This will take you out of the conference and you will be able to speak directly to a Community Network operator.

b) **Self-Mute.** If there is an unavoidable noise (for example, building work, a chiming clock, etc.) coming from one of the lines, ask the participant to press ***1**, which will mute the line. This will allow the participant to listen without the rest of the group hearing the noise! Explain that by pressing ***1** again this will un-mute their line.

Please see the 'Top Tips' guide from Community Network for the full list of function keys. Please be aware that most of these functions are for more business type meetings so you will be unlikely to need or use them.

DOCUMENTATION:

Group Calls Register

Fill in the **Group Calls Register** with the names of the participants in the group. Each week ensure you record the participants who joined the conversation and any reason for a participants' non-attendance (e.g. sickness, family etc). A space for your comments is provided to note any problems that have occurred with participants or points you may want to check later. Make a note of any observations, positive experiences and topics, suggested by the group, for next week's discussion.

A brief information sheet with all the relevant information regarding the group will be sent it to each participant by [service provider]. It includes:

- ✓ Contact number for the [service provider] co-ordinator to let them know if they cannot take part;
- ✓ The operator number for during the conference, if they are disconnected or late for the meeting they can dial back into the conference. This number will be [telephone number];
- ✓ All the dates/times of the group meetings (or space for this to be added)
- ✓ Space for the first names of the other participants should they want to make note. Ask the participants to keep it near their phone as it also may act as a reminder.

CONFIDENTIALITY:

The Volunteer Co-ordinator may also ask facilitators that host a group to sign a confidentiality bond: ensure that what is said in the group remains in the group. It may also be necessary in relation to the organisation/project's objectives. All Community Network employees sign a confidentiality agreement as a term of their employment.

Continuing contact after the group has finished …

Some people wish to stay in touch with some members of the group. It is for the participants to decide if they wish to share their telephone number with one or more members of the group. If they do this they will need to sign a consent form to comply with Data Protection requirements.

Remember: you must not give out telephone numbers, as this could be a breach of confidentiality.

5.4 TOP TIPS FOR FACILITATORS

1. Demystify your role, explain what you are doing and why.
2. Reflect back to the group their need to take responsibility wherever this is practical or helpful.
3. Don't use your power to fulfil your own needs.
4. Don't manipulate the group, however subtly, with charm. A charming manipulator, especially those that are friendly and well-meaning, can get away with far more than an aggressive forceful leader. Remember you are not there to manipulate.
5. Don't try and be a psychotherapist. Some people reach out, either directly or indirectly, with their emotional needs. This is more a commentary on people's problems than a compliment to your skills.
6. Don't expect to meet your emotional needs when facilitating (e.g. your needs for attention, respect, power, making friends, finding lovers). Pursue this in your own time.

7. Be clear about the purpose of the group and don't confuse it with your own goals.

8. Negotiate any ground rules or boundaries with the group. If any are mandatory (such as confidentiality or respect for each other), state them at the outset.

9. Model the behaviours you hope to see displayed by the group.

10. Listen to what is really happening in the group.

11. Generally trust your intuition - but remember it is fallible.

12. Encourage feedback. Receive criticism and praise with equal gratitude. Give feedback to the group as well as to individuals.

13. Don't panic. Fear will de-skill you more than any problem.

14. Act simply. Complex theory often masks simple solutions.

15. Be supportive. In particular support those with strong feelings, including anger.

16. Laugh with the group. Inoffensive humour brings people together, engenders warmth and dissipates anxiety.

17. Encourage equality.

18. Remember the culture and the organisational environment you are working in. Aspire to be practical and people oriented.

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SECTION SIX: ADDITIONAL MATERIALS

- Pre-Training Questionnaire
- Post-Training Questionnaire
- Checklist: Facilitating a telephone friendship group
- Guidelines and Frequently Asked Questions
- Confidentiality bond
- Group calls register (weekly)

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The Pre-Training Questionnaire

In this section we would like you to reflect on your own experiences as part of or running a group and assess how ready you feel you are to become a facilitator. We have designed a number of questions to elicit your views and feelings.

Taking in question in turn, work your way through the questionnaire, drawing on your own experiences. What you write is for your eyes only. **You don't have to write a lot, and there are no "right answers" - the most important part is the thinking.**

Q1. What kind of groups have you been part of? What were you best at in each?

Groups I have been part of	My strengths in the group

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Q2. Do you have any experience of managing or leading groups?

Yes ☐ No ☐

If *yes*, go to question 3. If *no*, go to question 4.

Q3. What kind of groups have you led? What were you best at in each?

Groups I have been part of	My strengths in the group

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Q4. What skills do you think a facilitator needs? How would you rate yourself for each? Give yourself a rating out of 10.

Skills a facilitator needs	Rating (out of 10)

Q5. What areas do you want to focus on in the training workshop?

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The section below is intended to you to summarise your thoughts and identify your key priorities for the training so that you can make the most of it.

My objectives for the training:

My concerns:

The skills/knowledge/abilities I would most like to develop:

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POST TRAINING QUESTIONNAIRE

Q1. What skills do you think a facilitator needs? How would you rate yourself for each? Give yourself a rating out of 10.

Skills a facilitator needs	Rating (out of 10)

Q2. What aspects of facilitating a group are you likely to find most easy or difficult and most or least satisfying?

Easiest aspects:	**Most difficult aspects:**
Most satisfying aspects?	**Least satisfying aspects**

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Q3. What makes you feel ready to be a facilitator?

Q4. What do you feel unprepared for?

Q5. What are your hopes for the programme?

Q6. What do you personally hope to gain from it?

Q7. What could you do to make sure that you achieve your hopes?

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Q8. What anxieties do you have about it?

Q9. What could you do to prevent these fears being realised?

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CHECKLIST

FACILITATING A TELEPHONE FRIENSHIP GROUP

Use this list when you are facilitating a telephone friendship group. Have your Group calls register ready. Fill in the, date, time and list of those who are in the group. Record any absence with reasons if known.

Before the telephone friendship group begins

- ☐ Welcome everyone to the group
- ☐ Ask if anyone has problems hearing clearly
- ☐ Tell everyone the SOS number [telephone number]
- ☐ Introduce Yourself
- ☐ Mention the conference is being taped (if it is their will be an automated message) and reason (that it is for training and monitoring purposes as part of the research study).
- ☐ Ask participants to introduce themselves (reassure that first names are fine)
- ☐ Following the guidance in section 5 for the weekly sessions, open the discussion to everyone.

At the end – around 5 minutes before the end (there will be a time check by the operator

- ☐ Remind everyone there is 5 minutes left
- ☐ Offer an opportunity for any last burning issues
- ☐ Thank everyone for their contributions
- ☐ Remind people about the day and time of the next telephone group discussion
- ☐ Remind people the line might be unavailable for a few seconds
- ☐ Group goodbye

MENTION THIS:
Press # on your keypad to attract the operator's attention – the operator is NOT listening in throughout the conference.

Press *1 to mute out background noise (you need to press it again to speak otherwise no-one will hear you)
Keep the telephone keypad function list to hand about other facilities that are available to participants during the conference.

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Confidentiality bond

COMMUNITY NETWORK | [SERVICE PROVIDER] | UNIVERSITY OF SHEFFIELD

CONFIDENTIALITY BOND

As a 'host' of a **Community Network** telephone group I agree that:

- I accept and understand the scope of my role as a host in accordance with the training given.
- I recognise that I am not acting as a counsellor or therapist and will not seek to offer such opinions.
- I will not reveal the identity of any caller to anyone outside Community Network without the express permission from the Community Network Chief Executive, Social Inclusion Project Officer or a senior staff member of [service provider].
- I will not reveal details of any conference session to anyone outside the conference or Community Network without express permission from the Community Network Chief Executive, Social Inclusion Project Officer or a senior staff member of [service provider].
- I will not arrange to meet with any caller without the express permission from the Community Network Chief Executive, Social Inclusion Project Officer or a senior staff member of [service provider].
- I will not record any of the conference sessions without prior permission of the Community Network Chief Executive, Social Inclusion Project Officer, or a senior staff member of [service provider].
- I will accept the instructions and guidance of the Community Network Chief Executive, Social Inclusion Project Officer or a senior staff member of [service provider] in relation to my role as a 'host' of a telephone group.
- I understand that a number of telephone conferences will be recorded and that staff at Community Network will have access to the digital audio files; and, will pass on the files to the PLINY study team for research purposes. Consent has been obtained from participants as part of them agreeing to take part in the study.

Name (Please Print)_____

Signed_____

Dated_____

Please read, sign, date & return this form to.
[service provider]

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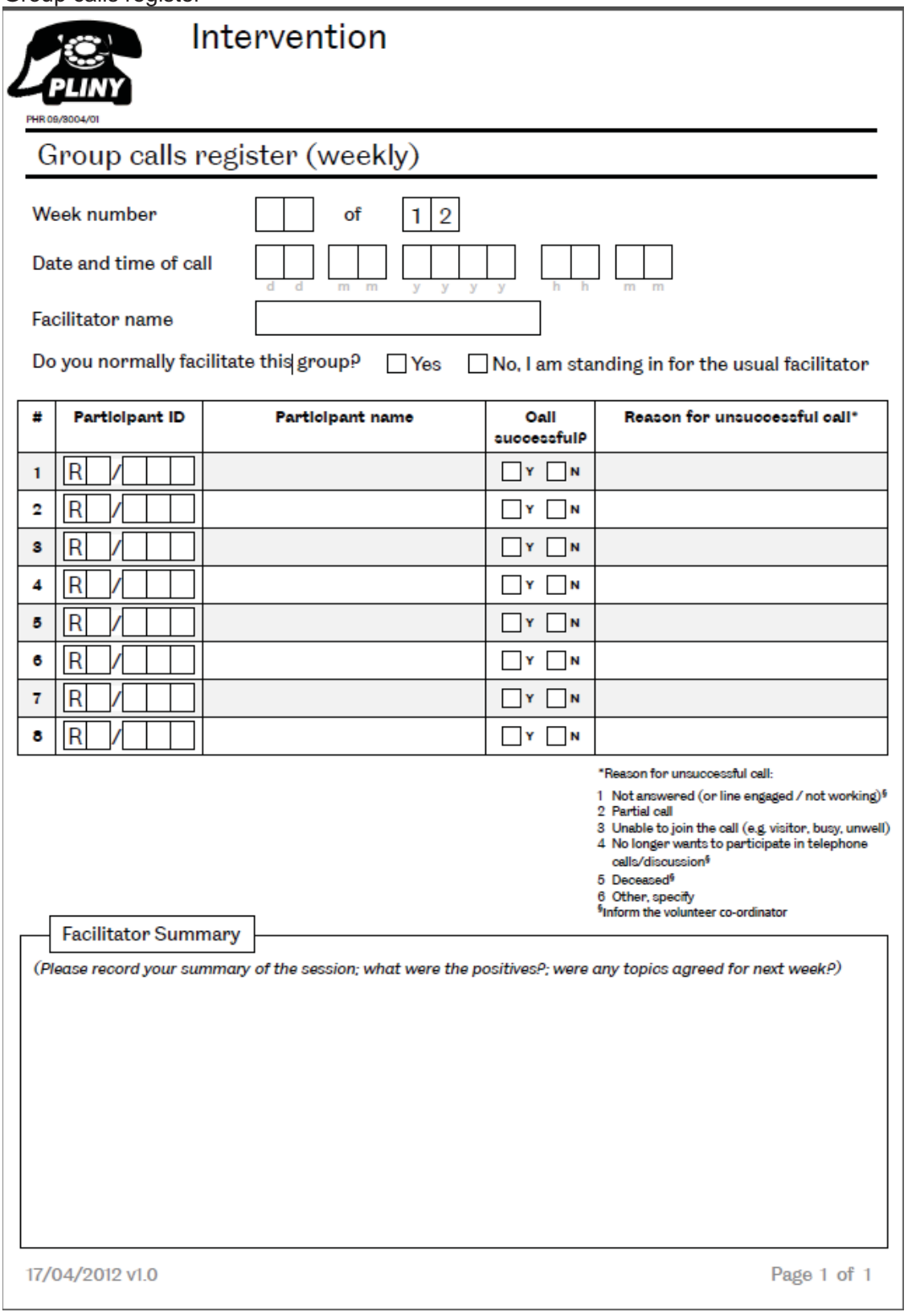
Group calls register



PLINY

PHR 09/3004/01

Intervention

Group calls register (weekly)

Week number ☐☐ of 12

Date and time of call ☐☐ ☐☐ ☐☐☐☐ ☐☐ ☐☐
d d m m y y y y h h m m

Facilitator name ☐

Do you normally facilitate this group? ☐ Yes ☐ No, I am standing in for the usual facilitator

#	Participant ID	Participant name	Call successful?	Reason for unsuccessful call*
1	R☐/☐☐☐		☐ Y ☐ N	
2	R☐/☐☐☐		☐ Y ☐ N	
3	R☐/☐☐☐		☐ Y ☐ N	
4	R☐/☐☐☐		☐ Y ☐ N	
5	R☐/☐☐☐		☐ Y ☐ N	
6	R☐/☐☐☐		☐ Y ☐ N	
7	R☐/☐☐☐		☐ Y ☐ N	
8	R☐/☐☐☐		☐ Y ☐ N	

*Reason for unsuccessful call:

1 Not answered (or line engaged / not working)§
2 Partial call
3 Unable to join the call (e.g. visitor, busy, unwell)
4 No longer wants to participate in telephone calls/discussion§
5 Deceased§
6 Other, specify

§Inform the volunteer co-ordinator

Facilitator Summary

(Please record your summary of the session; what were the positives?; were any topics agreed for next week?)

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Training session content (sessions 1-4)

SESSION ONE

Topic	Content	Time: min

Welcome & Introduction	Welcome
	Overview of the course
	• Workbook has some theory; course will be practical and experiential
	• Opportunity to practice; will ask each of you to facilitate a short session
	• Content
	  ○ Session one: Role and Listening Skills
	  ○ Session two: Groups and Using Questions
	  ○ Session three: Handling Conflict
	  ○ Session four: Practical, Professional and Ethical issues
	Groundrules for these sessions:
	• Say your name first
	• Join in – listen, contribute, ask questions (no question is stupid)
	• Stop when I ask
	• Respect for each other
	Introductions – name and whether you've run groups before over the phone or face-to-face – any similar experiences
		10

Role of the Facilitator	Definition: to make the group's work easy (from the latin)
	Flexible role – many different aspects depending on the changing needs of the group
	Discussion (1)
	• What role(s) might a facilitator inhabit? If participants struggle with this, ask 'What might a facilitator do'?
	• *Some examples*:
	  ○ *Leader*
	  ○ *Neutral*
	  ○ *Monitor*
	  ○ *Referee*
	  ○ *Stimulator*
	  ○ *Summarise*
	  ○ *Signpost (to help/advice/support/information etc.)*
	  ○ *Problem solver*
	  ○ *Validator and supporter of the group*
	  ○ *Providing boundaries and safety*
	  ○ *Guardian of the groundrules*
	  ○ *(Very rarely) expert or adviser – challenge this*
	Discussion (2)
	• Go through each aspect of the role – when might you use this one?
	• *For example:*
	  ○ *Directive at the beginning or if the group is in trouble/needs structure*
	  ○ *Monitoring – when the group is working well*
	Emphasise that the facilitator's main task is to respond to the group NOT to lead it.
		30

Listening	Listening is key to good facilitation. Discussion: 'What makes a good listener? E.g. • *Be interested/curious* • *Concentration* • *No distractions* • *Attention to tone of voice, hesitations and silences as well as the words*	**15**

	• *React to what you've heard* • *Check understanding* • *Validate/acknowledge* • *Reflect/repeat* • *Don't interrupt* • *Don't plan what you're going to say next* • *Allow silence* Stress two key points: • Good listening depends on having your attention on the speaker • Listening gets blocked by assumptions/preconceptions – check your assumptions Exercise (if time) (a) Give the group a topic to discuss. At various points the trainer says stop at which point the next one in line must continue the last delegate's sentence, starting with their last few words. Once they've got the hang of it, then you can begin to name people out of sequence, forcing them to listen all the time rather than just to the person before them. (b) Play 'Just a minute'. Give the participants a topic to discuss and one person starts. If they repeat, hesitate or go off the topic, then someone else can interrupt and have a go. The person speaking at the end of the minute is the 'winner'.	
Finish	Any questions/thoughts? Thing(s) you most remember from this session?	**5**

SESSION TWO

Select 1 participant to facilitate part of the discussion. Set up the task, hand over to the facilitator and monitor their performance. After 5 – 10 minutes, stop the discussion and offer feedback. Suitable topics:

- ***Groups: 'what kind of group maintenance practices?'***

Topic	Content	Time: min
Recap	Welcome Recap of Session 1	**10**

Groups: how they work	Understanding the Group Process
	• Any group has three levels of need
	  ○ Task needs
	  ○ Group maintenance needs
	  ○ Individual needs
	• All three functions must be balanced in any group
	Discussion exercise:
	• Think of a group of friends dining out together.
	  ○ What is their task? e.g.
	  ▪ *To share experiences*
	  ▪ *To share food/drink*
	  ▪ *To catch up and reinforce/develop friendship*
	  ○ What kind of group maintenance practices might they need to keep the group together? e.g.
	  ▪ *Inclusion*
	  ▪ *Communication*
	  ▪ *Reaching out*
	  ▪ *Protecting*
	  ▪ *Sharing food/drink*
	  ▪ *Bonding & friendship*
	  ▪ *Boundaries*
	  ▪ *Safe environment*
	  ▪ *Practical stuff (time to meet, transport, etc. etc.)*
	  ▪ *Respect & courtesy*
	  ▪ *Relaxation*
	  ▪ *Time to think*
	  ○ What kind of individual needs might the group be expected to meet?
	• A facilitator must always be attentive to the three levels of need; continually striking a continuing balance between the needs of the task, the needs of the group and the needs of the individuals within it.
		25

Groups: how they develop	Give a brief overview of the stages that a group may go through • Forming (group is new; uncertain, even suspicious, wary and very polite) • Norming (boundaries and conventions are formed, both explicit (such as the groundrules) or implicit) • Storming (the group begin to test the norms and 'act out' – like an adolescent – this is a sign the group is beginning to mature) • Performing (group is mature and gets on with what is formed to do while treating each other with respect) The group may pass through these very quickly or slowly. They may also go through them out of order or return to earlier stages (for example when someone new joins the group. It is useful for the facilitator to be aware of what stage their group is in and help them if they get stuck. Also be aware that this development is normal and natural and not to hold themselves responsible or to blame (for example in storming stage). Keep a sense of perspective and help the group to move on. Discussion:	**10**

	• How might you help a group which had got stuck in a particular stage.	
Using Questions	Explain that there are two types of questions. Ask the group to: • define the difference between 'open' and 'closed' questions. • give examples of each. • discuss when you might use them: o *Open questions – use these most frequently to open things up and explore/deepen issues. Being with 'who'; 'what'; 'where'; when' and 'why'. Use 'why' questions sparingly as they can sound interrogative and focus on the past.* o *Closed questions – use rarely to confirm something.* Stress that good facilitators use questions rather than statements and prefer open questions to closed. Other examples of other types of questions to avoid: • Multiple questions • Leading questions	**10**
Finish	Any questions/thoughts? Thing(s) you most remember from this session?	**5**

SESSION THREE

Select 1 – 2 participants to facilitate part of the discussion. Set up the task, hand over to the facilitator and monitor their performance. After 5 – 10 minutes, stop the discussion and offer feedback. Suitable topics:

- ***Signs that conflict is developing***
- ***How would you intervene?***
- ***Conflict exercise***

Topic	Content	Time: min
Recap	Welcome Recap of Session 2	**10**

Handling Conflict	**Discussion:** What signs might suggest that the group is moving towards conflict?
	• *Constant disagreement*
	• *Raised voices*
	• *Increasing lack of respect*
	• *Pregnant silences*
	• *Negative public statements*
	• *Over-generalisations*
	• *Lack of honesty*
	• *Poor communication*
	• *Hanging up/disappearing*
	
	Explain that conflict can healthy unless the group gets stuck in it. There are four key triggers when a facilitator will need to intervene:
	• If the group is splintering and a sub-group or just two participants are engaged in a debate/conflict
	• If the debate has become personal
	• If the groundrules are being broken
	• If the group is stuck in the same old argument
	
	Discussion: If you do decide to intervene, how would you do it?
	
	<u>Trainer Input:</u>
	Explain that there is no hard and fast rule to how to resolve conflict but there are some guidelines:
	• Acknowledge the conflict
	  ○ Be honest
	  ○ Notice it's getting heated
	• If the groundrules have been broken, remind the group of the relevant one(s)
	• Acknowledge everyone's contributions (without agreeing/disagreeing with anyone)
	• Get the group to take responsibility for resolving the issue ('how can we resolve this?' 'how shall we move forward?'
	• Keep everyone involved
	
	Ultimately you want to give the group some breathing space and then give the issue back to the group and trust them to resolve it with your support. Importantly,
	• Don't make it personal – focus on the issues not the person
	• If necessary, try and give the group some distance on it (questions such as 'how would you feel about this in 5 years' time?' 'what would you think about it if you were in Australia right now?'
	• Help the group to stand in each other's shoes (ask individuals to consider the benefits or disadvantages of the notion they are proposing)
		35

	• Try and understand the underlying motivations of someone who is continually provoking conflict (do they have needs that aren't being met by the group? How can you handle that?) • Be aware of your own tolerance for conflict – are you intervening when you feel uncomfortable rather than when the group needs support? • It can be healthy to disagree. Finally, remind everyone of the groundrules. Managing conflict does not necessarily mean resolving it. There are many situations which cannot be easily or immediately resolved. Conflict can even be constructive, if handled correctly; it can result in the clarification of important issues and lead to better communication. It can build greater communication, co-operation and understanding between team members who will learn more about each other through the conflict resolution process. In addition, it can help individuals within the team to enhance their communication and leadership skills. Remember that conflict can develop because of poor communication, lack of openness and weak leadership/facilitation. Facilitators need to be self-aware as to whether there is anything they are (not) doing which is contributing to the situation.	
	Exercise: Role Play (5 mins) **2 group members begin to argue and speak disrespectfully** **Choose a volunteer to act as facilitator to manage the situation** **Give feedback on the exercise. (5 mins)**	**10**
Finish	Any questions/thoughts? Thing(s) you most remember from this session?	**5**

SESSION FOUR

Select 1 – 2 participants to facilitate part of the discussion. Set up the task, hand over to the facilitator and monitor their performance. After 5 – 10 minutes, stop the discussion and offer feedback. Suitable topics:

- ***Equal Opportunities***

Topic	Content	Time: min
Recap	Welcome Recap of Session 3	**5**
Professional and ethical practice	Explain that there are a number of key practical and ethical issues that arise from facilitating telephone groups. There are also two areas of legislation that touch on our work. As this is the final session there will also be plenty of time to answer any questions or issues that anyone is concerned about. The first statutory area is **Data Protection** and the related ethical issue of **confidentiality.** **Discussion:** How might data protection and confidentiality affect our work? • *Data Protection* ○ *Group members must not share personal information or contact details without giving written permission* ○ *If they do want to, seek guidance from the [service provider] Co-ordinator who will provide a consent form* ○ *Do not allow sharing of information until consent form is signed by everyone.* ○ *It is not recommended practice* ○ *CN/[Service provider] complies with legal requirements including all civil rights legislation and guidance, therefore facilitators must comply* ○ *If group wants to record their teleconference or do anything else extra they must again get written consent* • *Confidentiality* ○ *Make it one of the groundrules* ○ *Allow plenty of discussion as to what it means* ○ *Be realistic – it is easy for a group to leak unintentionally* ○ *If very personal or sensitive information is disclosed during a session, remind group of the groundrule.* The second statutory area is **Equal Opportunities** **Discussion:** How might Equal Opportunities affect our work? • *Treat everyone with respect and courtesy* • *Make sure everyone is included* • *Stay neutral* • *Check your own assumptions and preconceptions* • *Inclusion issues might include:* ○ *Ensuring that everyone can hold a handset for the whole length of the session or is provided with a headset.* A more practical issue is **record keeping and notetaking.** **Discussion**: What do you feel about record keeping and notetaking given everything we've said so far? • *Record keeping* ○ *All our projects are sponsored and sponsors may require records to be kept.*	**40**

	○ *This project is part of a research study which also requires records to be kept regarding attendance (call registers).* ○ *Participants will be informed that you will make a note of calls and topics discussed etc. for research purposes.* ○ *Use the Calls register to record the participants that joined the telephone call. Use the space provided to provide a summary of the session. e.g. Did anyone do something which they wouldn't have done a few weeks ago?; What topics were discussed?; Did anyone suggest a topic for next week? etc.* • *Note-keeping* ○ *This is for yourself only.* ○ *Be cautious about taking notes during the session as it will distract from your listening.* ○ *Suggested format:* ▪ *3 levels of need:* • *What **task** was the group engaged in?* • *How did the **group** perform as a group?* • *Any particular **individual** needs?* ▪ *Self-assessment of your performance as a facilitator (WW/WD/DD)* Finally, **timekeeping:** • Allow time beforehand to clear your mind and time afterwards to write up your notes • During the session, make sure you can see a clock/watch so that you always know how much time is left • Ensure that contribution time is balanced – curtail those who are hogging the airtime • There will always be a 5 minute warning – keep this time for tying off loose ends, reminding everyone of the next session and saying goodbye. **<u>Exercise</u>** **Discuss, experiment and agree ways of giving a time check whilst a participant is talking.**	
Q&A	Allow time for questions If there are none, *either:* • Ask the group to compile a list of tips for a teleconference facilitator, *or* • Ask the group to list the benefits and difficulties of facilitating teleconferences and how they might overcome these.	**10**
Finish	The most important thing you will take away from this training. Farewells and next steps.	**5**

Putting Life IN Years (PLINY): Telephone friendship groups research study

Introduction to telephone friendship groups

As you know, the purpose of the research is trying to find out whether telephone friendship groups can be beneficial for older people aged 75 and over and if so, how. You have been allocated at random to take part in telephone friendship groups. A trained [redacted] volunteer will be contacting you by telephone. We have talked to you about what happens during the study however, we have provided some additional information below to help answer some questions you may have about the one-to-one and group telephone calls.

We have provided you will a sheet at the end which you might like to use to make a note of the name of your [redacted] volunteer/facilitator. You can also note down the times when they have arranged to call you.

About the telephone conversions

The [redacted] volunteer will contact you using the telephone number you provided. They will chat to you for about 20 minutes each week for up to six weeks. You can talk with the volunteer about anything you like. They will tell you more about the group telephone discussions and arrange future dates/ times for them to call you. During the one-to-one calls the volunteer will establish the date/time of the group telephone conversations. It is better if these are held at the same time each week.

The group will join together on the telephone for about one hour for 12 weeks. An Operator from a charity we are working with, called Community Network, will connect you to others by your usual telephone at home. This is sometimes called a teleconference.

The [redacted] volunteer is trained to facilitate group telephone discussions and they will make sure everyone has a turn. The volunteer will keep a note of the date/time of the telephone calls with all participants and note some of the topics discussed. This will be used to inform the research study.

Q **What happens if I have not heard from a volunteer?**

A It can take several weeks for the one-to-one calls to start. A volunteer will contact you as soon as possible.

Q **What happens if I do not answer when the volunteer facilitator phones me at the prearranged time?**

A The [redacted] volunteer (your group facilitator) will inform the [redacted] Volunteer Co-ordinator that they were unable to make contact with you at the time arranged. The Co-ordinator will try to contact you by telephone to make sure that you are okay.

Q **What should I do if I am unable to participant in one of the group conversations?**

A If you know in advance, please tell the volunteer facilitator that you will not be available on that day. You can tell them at the start or end of the group discussion. If you are unwell or your circumstances have changed please telephone [telephone number] to let Community Network know you will not be participating in this week's group conversation.

Q **Can I make my own calls, to other members of the group, in between group telephone discussions?**

A We do not recommend sharing your telephone number during group conversations. If you do want to share your telephone number to make calls outside the group, the volunteer facilitator will refer you to [redacted]'s Volunteer Co-ordinator who will ask you to give written permission to share your telephone number with another participant.

The volunteer facilitator will remind all participants that sharing personal information is for each individual to decide. They will also remind participants that any calls outside of the group telephone discussions are not part of the research study i.e. you will have to pay for such calls yourself.

[redacted] and Community Network will not pass on your telephone number to anyone else without your express permission

Q What happens if I need help with my health?

A You are free to talk about anything you like in the group; however, the group is a friendship group and not able to offer medical advice. If you are worried about your health you should contact your GP.

Q What happens if I am accidentally disconnected or have to leave for part of the telephone conversation?

A The volunteer facilitator will let alert the Community Network Operator who will call you back. If you have any problems you can dial [telephone number] and press the '#' (hash) key on your telephone keypad. The Community Network Operator will help return you to the group call.

Q Can I increase the volume?

A Yes! Press ***6** on your telephone keypad to increase the volume of the earpiece. A list of other telephone keypad options is provided below. You may find these helpful as you become more familiar with the calls. If you have any problems speak to your facilitator or press '#' (hash) to speak to the Community Network Operator.

Q Will I have to speak and make a contribution?

A Everyone gets an opportunity to speak, but you can simply listen until you feel ready to talk.

Q I like the idea, but am a bit worried about taking part.

A Telephone friendship groups are very informal. Most people will be taking part for the first time. The volunteer facilitator (Chairperson) will try to make everyone feel welcome and at ease.

Q Surely everyone will be talking over each other?

A Perhaps surprisingly, this doesn't happen. People usually wait for a natural pause before talking. The volunteer facilitator will help to advise who is speaking and let everyone have a chance to take part.

Q Who do I ring to link me into the call?

A You don't. Community Network will call you on the phone number you have provided. We pay for the prearranged calls.**Q What can you discuss in a telephone friendship group?**

A Anything! The choice of subject is up to you. Once you've started, the facilitator will help everyone to keep to the agreed topic and help the group think about other topics to discuss.

Q Will group telephone conversations be confidential?

A It is up to you to decide how much information you tell people about yourself. You do not have to tell people anything about you that you do not want them to know. The volunteer facilitator will abide by [redacted] policies and procedures for maintaining confidentiality. This means they will not talk about the group conversations outside the group.

Q What if the group call is being recorded?

A We will record a small number of group calls. We are recording the calls for research purposes to make sure that the volunteers run the groups in the way that they have been trained to. You will hear an automated message at the start of the call if it is being recorded.

Q Can I stop taking part in a telephone friendship group?

A Yes, you can decide to withdraw at any time and, if necessary, let the research team know if you no longer want to be contacted. If you do wish to drop out, you do not have to give a reason. Please tell the volunteer facilitator or contact the research team.

Key contacts

Community Network Operator: [telephone number] (remember we will call you)
[SERVICE PROVIDER Volunteer Co-ordinator]

PLINY Research Team (University of Sheffield):
[RESEARCH ASSISTANT]; or,
[RESEARCH ASSISTANT]

Appendix 5 Questionnaire booklet for participants at baseline

Putting Life In Years (PLINY): Telephone friendship groups research study

PHR 09/3004/01

FOR OFFICE USE ONLY

R / Randomisation number Interviewer ID

PLINY
Questionnaire booklet

08.10.2012; Version 1.3

PLINY

PHR 09/3004/01

Randomisation number R / | | |

Socio-demographics

Date of completion | | / | | / | | | | (d d / m m / y y y y)

Basic information

Sex ☐ Male ☐ Female

Date of birth | | / | | / | | | | | | (d d / m m / y y y y)

Live with others ☐ Yes ☐ No

Live with… *tick all that apply*
☐ Spouse/partner ☐ Child/children ☐ Parent(s)
☐ Other _____ *specify*

Tenure
☐ Owned outright ☐ Mortgage/loan ☐ Shared ownership (part rented / part mortgage) ☐ Rented
☐ Live rent-free (friend / relative's property) ☐ Other _____ *specify*

Ethnic group

White
☐ English / Welsh / Scottish / Northern Irish / British
☐ Irish
☐ Gypsy or Irish Traveller
☐ Any other White background
specify _____

Mixed / multiple ethnic groups
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other Mixed / multiple ethnic background
specify _____

Asian / Asian British
☐ Indian
☐ Pakistani
Bangladeshi
☐ Chinese
☐ Any other Asian background
specify _____

Black / African / Caribbean / Black British
☐ African
☐ Caribbean
Any other Black / African / Caribbean background
specify _____

Other ethnic group
☐ Arab
☐ Any other ethnic group
specify _____

☐ **Prefer not to say**

08.10.2012; Version 1.3

PLINY

Randomisation number R __ / __ __ __

PHR 09/3004/01

Socio-demographics

Education

- ☐ 1 - 4 O levels/CSEs/GCSEs any grades
- ☐ 5+ O levels (passes) / CSEs (grade 1) / GCSEs (grades A*- C) School Certificate,
- ☐ 1 A level / 2 - 3 AS levels
- ☐ 2+ A levels / VCEs, 4+ AS levels, Higher School Certificate
- ☐ Degree (e.g. BA, BSc)
- ☐ Higher degree (e.g. MA, PhD, PGCE)
- ☐ Professional qualifications (e.g. teaching, nursing, accountancy)
- ☐ NVQ Level 1 Foundation GNVQ
- ☐ NVQ Level 2, Intermediate GNVQ
- ☐ NVQ Level 3, Advanced GNVQ, ONC, OND
- ☐ NVQ Level 4 - 5, HNC, HND
- ☐ Apprenticeship
- ☐ Other qualifications (e.g. City & Guilds, RSA/OCR. BTEC)

Age on leaving full time education __ __

Main activity/Occupation

- ☐ Employed or self employed →
- ☐ Retired →
- ☐ Seeking work
- ☐ Looking after home/family
- ☐ Long-term sick or disabled
- ☐ Student (Full time)
- ☐ Other ______ *specify*

- ☐ Professional
- ☐ Managerial/Technical
- ☐ Skilled (non-manual)
- ☐ Skilled (manual)
- ☐ Partly skilled
- ☐ Unskilled

What is (was) your specific job/title? ______

08.10.2012; Version 1.3

Randomisation number R / | | | |

PHR 09/3004/01

ONS Subjective Wellbeing

Date of completion | | | | | | | | |
d d m m y y y y

Subjective wellbeing

Overall, how satisfied are you with your life nowadays?

Interviewer instruction: give scale of 0 to 10, where 0 is 'not at all satisfied' and 10 is 'completely satisfied'

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

not at all satisfied — completely satisfied

13/12/2011 v1.0

Your Health and Well-Being

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.
Thank you for completing this survey!

For each of the following questions, please tick the one box that best describes your answer.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

2. <u>Compared to one year ago</u>, how would you rate your health in general <u>now</u>?

Much better now than one year ago	Somewhat better now than one year ago	About the same as one year ago	Somewhat worse now than one year ago	Much worse now than one year ago
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

3. The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	☐ 1	☐ 2	☐ 3
b Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐ 1	☐ 2	☐ 3
c Lifting or carrying groceries	☐ 1	☐ 2	☐ 3
d Climbing several flights of stairs	☐ 1	☐ 2	☐ 3
e Climbing one flight of stairs	☐ 1	☐ 2	☐ 3
f Bending, kneeling, or stooping	☐ 1	☐ 2	☐ 3
g Walking more than a mile	☐ 1	☐ 2	☐ 3
h Walking several hundred yards	☐ 1	☐ 2	☐ 3
i Walking one hundred yards	☐ 1	☐ 2	☐ 3
j Bathing or dressing yourself	☐ 1	☐ 2	☐ 3

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a Cut down on the amount of time you spent on work or other activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Accomplished less than you would like	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c Were limited in the kind of work or other activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d Had difficulty performing the work or other activities (for example, it took extra effort)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a Cut down on the amount of time you spent on work or other activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Accomplished less than you would like	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c Did work or other activities less carefully than usual	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

Not at all	Slightly	Moderately	Quite a bit	Extremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. How much bodily pain have you had during the past 4 weeks?

None	Very mild	Mild	Moderate	Severe	Very severe
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Ex tremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a Did you feel full of life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Have you been very nervous?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c Have you felt so down in the dumps that nothing could cheer you up?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d Have you felt calm and peaceful?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e Did you have a lot of energy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f Have you felt downhearted and low?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g Did you feel worn out?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
h Have you been happy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
i Did you feel tired?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

11. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a I seem to get ill more easily than other people	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b I am as healthy as anybody I know	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c I expect my health to get worse	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d My health is excellent	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Thank you for completing these questions!

Randomisation number R / | | |

PHR 09/3004/01

Telephone friendship service costs

Telephone friendship groups happen once a week and last approximately one hour. How much would you be willing to pay each week, to participate in a telephone friendship group (including the cost of calls)? **Tick one box only**

☐ Less than £3	☐ £10 – £14.99	☐ I cann ot afford to pay
☐ £3 - £4.99	☐ £15 - £19.99	☐ I would not be willing to pay
☐ £5 - £9.99	☐ £20 - £24.99	☐ Prefer not to say

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Randomisation number R / ☐☐☐

PHR 09/3004/01

Health and Social Care Resource Use Questionnaire

Hospital service use

Attended hospital in last 3 months? ☐ Yes ☐ No

Outpatient appointments ☐ Yes ☐ No → *Check A&E attendances*

	Speciality (e.g. orthopaedics, urology)	Reason for appointment	Number of appointments
1			
2			
3			

A&E attendances ☐ Yes ☐ No → *Check hospital admissions*

	Reason for attendance
1	
2	
3	

Hospital admissions (overnight stays) ☐ Yes ☐ No → *Check other hospital services*

	Reason for admission	Number of nights in…				
		Continuing care / respite ward	Medical ward	Assessment / rehab	ICU	Other
1						
2						
3						

Other hospital services ☐ Yes ☐ No

	Service used (e.g. day hospital, care home admission)	Reason for using service	Number of appointments or days
1			
2			
3			

Use of hospital-provided transport *(for any hospital attendances indicated above)* ☐ Yes ☐ No

How many journeys… by emergency ambulance? ☐ non-emergency hospital transport? ☐

17/04/2012 v2.0

Randomisation number R /

PHR 09/3004/01

Health and Social Care Resource Use Questionnaire

Community-based service use

Community services used in the last 3 months? ☐ Yes ☐ No

☐ GP
☐ Practice nurse
☐ District nurse
☐ Health visitor
☐ Community psychiatric / mental health nurse
☐ Psychologist
☐ Counsellor
☐ Community psychiatrist
☐ Physiotherapist
☐ Chiropodist
☐ Dietician
☐ Occupational therapist
☐ Home care worker
☐ Care manager
☐ Social worker
☐ Home/care assistant
☐ Home/care attendant
☐ Family support worker
☐ Sitting service
☐ Meals on wheels
☐ Other *specify in table below*

Complete the table for each of the services ticked above
(use one row for each combination of service, location and provider)

	Service (as above)	**Type of contact** home / clinic or surgery / telephone	**Provider** NHS / LA / Voluntary / Private	**Frequency** (number of visits in last 3 months)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

17/04/2012 v2.0

Randomisation number R / ☐☐☐

PHR 09/3004/01

Health and Social Care Resource Use Questionnaire

Day service use

Day services used in the last 3 months? ☐ Yes ☐ No

☐ Day care

☐ Lunch club

☐ Social club

☐ Other service or activity (e.g. exercise class / green gym)
specify in table below

Complete the table for each of the services ticked above
(use one row for each combination of service, location and provider)

	Service Day care / Lunch club / Social club / Other (specify)	**Name/location of service**	**Provider** NHS / LA / Voluntary / Private	**Frequency** (number of visits in last 3 months)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

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PLINY

Randomisation number R / | | | |

PHR 09/3004/01

Health and Social Care Resource Use Questionnaire

Medication

Medication taken in the last 3 months? ☐ Yes ☐ No

☐ Sleeping medication

☐ Medication for depression / anxiety / mood

Complete the table for each of the medications ticked above

	Medication (drug name)	**Reason** Sleeping / Depression	**Period taken** Started >3 months ago	**or** Start date	Stop date **or**	Ongoing	**Method** e.g. tablet or injection	**Strength** e.g. 10 mg or 25 mg	**Daily dose** (Number of times the medicine is taken per day)
1			☐			☐			
2			☐			☐			
3			☐			☐			
4			☐			☐			
5			☐			☐			
6			☐			☐			
7			☐			☐			
8			☐			☐			
9			☐			☐			
10			☐			☐			
11			☐			☐			
12			☐			☐			

17/04/2012 v2.0

Randomisation number R / | | | |

PHR 09/3004/01

EQ-5D

Your own health today

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today

Mobility	
- I have no problems in walking about	☐
- I have some problems in walking about	☐
- I am confined to bed	☐
Self-care	
-I have no problems with self-care	☐
-I have some problems washing or dressing myself	☐
-I am unable to wash or dress myself	☐
Usual activities (e.g. work, study, housework, family or leisure activities)	
-I have no problems with performing my usual activities	☐
-I have some problems with performing my usual activities	☐
-I am unable to perform my usual activities	☐
Pain/discomfort	
-I have no pain or discomfort	☐
-I have moderate pain or discomfort	☐
-I have extreme pain or discomfort	☐
Anxiety/Depression	
-I am not anxious or depressed	☐
-I am moderately anxious or depressed	☐
-I am extremely anxious or depressed	☐

13/12/2011 v1.0

Randomisation number R /

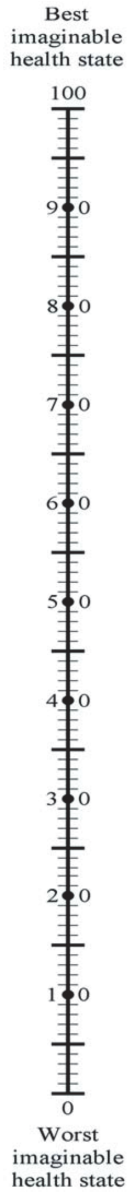
PHR 09/3004/01

EQ-5D

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Your own health state today



13/12/2011 v1.0

Randomisation number R /

PHR 09/3004/01

de Jong Gierveld Loneliness scale

Please indicate for each of the 11 statements, the extent to which they apply to your situation, the way you feel now. Please, circle the appropriate answer.

The following statement is an example:

"There is actually no one with whom I would want to share my joy or sorrow"

If you experience these feelings in exactly the same way, please circle the answer Yes as shown below:

There is actually no one with whom I would want to share my joy or sorrow	Yes	More or Less	No

1	There is always someone I can talk to about my day-to-day problems	Yes	More or Less	No
2	I miss having a really close friend	Yes	More or Less	No
3	I experience a general sense of emptiness	Yes	More or Less	No
4	There are plenty of people I can lean on when I have problems	Yes	More or Less	No
5	I miss the pleasure of the company of others	Yes	More or Less	No
6	I find my circle of friends and acquaintances too limited	Yes	More or Less	No
7	There are many people I can trust completely	Yes	More or Less	No
8	There are enough people I feel close to	Yes	More or Less	No
9	I miss having people around me	Yes	More or Less	No
10	I often feel rejected	Yes	More or Less	No
11	I can call on my friends whenever I need them	Yes	More or Less	No

13/12/2011 v1.0

PLINY

PHR 09/3004/01

Randomisation number R /

Patient Health Questionnaire - 9 (PHQ - 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use " " to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE USE ONLY 0 + ____ + ____ + ____

= Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

13/12/2011 v1.0

PHR 09/3004/01

Randomisation number R /

General Self-efficacy Scale (GSE)

		Not at all true	Hardly true	Moderately true	Exactly true
1	I can always manage to solve difficult problems if I try hard enough.				
2	If someone opposes me, I can find the means and ways to get what I want.				
3	It is easy for me to stick to my aims and accomplish my goals.				
4	I am confident that I could deal efficiently with unexpected events.				
5	Thanks to my resourcefulness, I know how to handle unforeseen situations.				
6	I can solve most problems if I invest the necessary effort.				
7	I can remain calm when facing difficulties because I can rely on my coping abilities.				
8	When I am confronted with a problem, I can usually find several solutions.				
9	If I am in trouble, I can usually think of a solution.				
10	I can usually handle whatever comes my way.				

17/04/2012 v2.0

Appendix 6 Interview topic guides

Participant interviews

[13 December 2011 Version 1.0] PHR 09-3004-01

Participant ID	
Date of Interview	
Researcher ID	

PLINY: Putting Life in Years: Telephone friendship groups qualitative sub-study

Participant semi-structured interview topic guide

The participant interviews will examine:

- the acceptability of the process of delivering telephone friendship groups
- the extent to which older people value telephone friendship groups as making an impact on their wellbeing
- the extent to which the facilitator enabled them to make choices and decisions during the telephone friendship groups
- older people's needs and the nature of the telephone friendship groups they receive
- whether older people continue to be part of a friendship group, have kept in touch with contacts or initiated their own group.

Themes and potential questions

N.B. In accordance with the design of the qualitative sub-study, the content of the topic guide may be revised in light of on-going analysis and emerging issues.

Telephone friendship groups –

Explore the **process** of the telephone friendship groups with older people in terms of:

- Acceptability – *how did you find the* telephone friendship groups*?*
- *Attrition - Did you complete the 12 weeks? If not, explore reasons why. (Prompts: facilitator, organisation of groups, group members).*
- Accessibility – *how easy was it for you to take part in the weekly telephone group sessions?*
- Group sessions – *can you talk me through the process of being involved in the group with other people? (Prompts: similar interests, length of sessions – opportunity to speak, numbers in the group, did the group have a goal or purpose). LINK TO*
- Role of the volunteer facilitator – *can you talk me through the role the volunteer facilitator played in the group? (Prompts: organisation, clear aims, instructions)*
- Barriers – *can you talk about any issues which made taking part in the group sessions, or receiving calls, difficult?*
- Receipt – *can you talk me through the things you learnt during the group sessions?*

Explore the **value** of the telephone friendship groups for older people in terms of:

- General health and wellbeing – *how important is it for you? What type of support did you receive from the* telephone friendship groups*? If the* telephone friendship groups *did not exist would it make a difference to your life?*
- Relationship with the volunteer facilitator – *can you talk me through the relationship that you had/have with your volunteer facilitator?*
- Main benefits of the telephone friendship groups – *what are the positive aspects? Are there any negative aspects? (Prompt: people they liked or didn't like, any disagreements – how these were dealt with/if any.)*

- Impact [enactment] – *can you tell me about any changes in your life as a result of the* telephone friendship groups*? (Prompts: initiate calls, new friends/staying in touch, new interest/activity, starting own group, levels of confidence with/ making new contacts).*
- Cost – *if telephone friendship groups were available but there was a cost to you (of approximately £2 - £5 per week) would you be willing to pay for this service? (Prompt: explore ability to pay, balance between cost and length of calls e.g. 30 minutes would cost less than 1 hour).*

Explore the **needs** of older people in relation to the telephone friendship groups in terms of:

- Expectations – *what did you expect the telephone friendship group to be like? Were they as you expected them to be?*
- Type of need – *what did you want from the* telephone friendship group*? Have these 'wants' been met?*
- Improvements to the telephone friendship group – *how can your experience of the* telephone friendship groups *be improved?*

Health – physical and emotional health. Explore past (pre-telephone friendship group) and present health. *Has the telephone friendship group made a difference? If so, how?*

Activities – **house related tasks**, e.g. cleaning, preparing meals, etc.; **personal care**, e.g. washing, dressing, etc.; **mobility**, e.g. bending, kneeling, lifting, etc.; **outside tasks**, e.g. shopping, walking any distance, etc. Explore whether changes have occurred and if so, how have older people's ability to perform activities changed in the last few months (i.e. since before older people joined the telephone friendship groups and whilst older people have been in receipt of the telephone friendship). Explore ability to perform these activities in relation to older people's physical and emotional health (pre- telephone friendship group and during telephone friendship group). *Has the telephone friendship group in any way affected your ability/inclination to perform these activities?*

Social interaction – occasions when older people socialise either with family, friends, neighbours or groups. Explore whether changes have occurred since receiving the telephone friendship intervention and if so, in what way has social interaction changed. Explore social interaction in relation to older people's physical and emotional health (pre-telephone friendship group and during telephone friendship group). *Has the telephone friendship group in any way affected your ability/inclination to socialise?*

General well-being – feelings and mood. Explore past (pre-befriending) and present general well-being. *How does/did it make you feel, being part of the telephone friendship group?*

Explore any **other issues** that older people have in relation to the telephone friendship groups – *is there anything else you would like to say about your experience of the telephone friendship groups?*

Finally, explore the acceptability of the questionnaires administered at baseline (face-to-face) and at follow-up (6 months).

Volunteer facilitator interviews

[Facilitator interview topic guide 5 January 2012 Version 1.0]

Facilitator ID	
Date of Interview	
Researcher ID	

PLINY: Putting Life in Years: Telephone friendship groups qualitative sub-study

Volunteer facilitator semi-structured interview topic guide

The [service provider] volunteer facilitator interviews will examine:

- the extent to which the volunteer felt able to develop the skills of participants in the telephone group (training, tools used, example observations)
- barriers to uptake (including the transition from one-to-one to group discussions)
- the challenges faced during the delivery of the intervention (issues raised by participants, technical difficulties, group dynamics)
- the challenges of implementation of telephone friendship groups
- whether older people continued to be part of a friendship group and how the group negotiated keeping in touch with contacts or starting their own group
- the extent to which they felt supported whilst delivering the intervention (monitoring).

Themes and potential questions

N.B. In accordance with the design of the qualitative sub-study, the content of the topic guide may be revised in light of on-going analysis and emerging issues.

Facilitating telephone friendship groups –

Explore the **process** of the volunteer running the telephone friendship groups with older people in terms of:

- Motivation – *can you tell me why you chose to volunteer for this role? (Prompts: what did you expect? How did this compare to the experience of running the groups?).*
- Acceptability – *can you talk me through your role running the telephone friendship groups? (Prompts: organisation, any difficulties clear aims, instructions, if applicable, did they stop running groups – if yes, explore the reasons for this?)*
- Drop out - *Did anyone miss a group discussion? If yes, explore reasons why. (Prompts: drop out, choice of topic, other group members, technical issues, organisation of meetings e.g. convenient time).*
- Accessibility – *how easy was it to organise weekly telephone discussions?*
- Group sessions – *can you talk me through the process of running a group? (Prompts: how were topics chosen, length of session, level of involvement, numbers in the group, did the group have a goal or purpose, did all members join the group at the same time – if no, how did this work?).*
- Barriers – *can you talk about any issues which made running the group discussions, or making calls to members, difficult? (Prompt: any issues which made it easier to run the groups?)*

- Perceived (participant) understanding - *can you talk me through any ideas/skills you introduced to the group? (Prompt: How did the group respond? Did you feel they understood e.g. self- confidence and wellbeing and what can improve them?)*

Explore the facilitator (study-specific) **training** delivered to volunteers in terms of:

- Relationship with the trainer – can you talk me through the training session/s? (*Prompts: opportunity to ask questions, clear guidance, manuals/instructions, opportunity to make suggestions for the programme content?*)
- Facilitation skills – can you talk me through the skills or techniques you learned as part of the facilitator training? (*Prompt: listening, ground rules, group relationships/dynamics*)
- Experience – *how prepared did you feel by the training? (Prompts: were examples useful, did issues come up during the telephone group discussion which was not covered in the training? If yes, what were these issues?*

Explore the **general issues** arising from facilitating groups in terms of:

- Relationship with the group members – *can you talk me through the relationship that you had/have with members in your group/s? (Prompt: transition from one-to-one to group sessions – were they the same individuals? If yes, explore whether this was beneficial.)*
- Main benefits of the telephone friendship groups – *can you identify ways you think the participant benefited from the discussions? What are these positive aspects? Are there any negative aspects? (Prompt: members who did not get on, any disagreements – how did you deal with this issue/if any?).*
- Impact – *can you tell me about whether you feel any members of the group changed during the course of the 12 weeks? (Prompts: initiate calls outside the group, new interest/activity, levels of confidence with/ making new contacts, new friends/staying in touch, started own group).*
- [Service provider] training – *can you tell me about the training you received from [service provider]? (Prompts: topics covered, opportunity to ask questions about the various volunteer roles and what they would involve).*
- Volunteer wellbeing – *Did you receive any support whilst running the telephone friendship groups? (Prompts: If yes, who provided support? Did any issues come up which you felt you needed support with? If yes, what kind of support did you need? Did you know who to ask if you were concerned about a member of the group?).*
- Improvements to the telephone friendship group – *From your experience of running the telephone friendship group/s, is there anything which could have been done differently or improved? (Prompt: organisation, technical issues, training or participant issues).*

Explore any other issues that the volunteer has/had in relation to the telephone friendship groups – *is there anything else you would like to say about your experience of running the telephone friendship groups?*

Appendix 7 Qualitative research framework

Theme	Subtheme	Description
Prior states[a]	1.1 Reason for participation	Motivations and factors associated with taking part
	1.2 Prior expectations	Expectations of the intervention prior to receiving one-to-one/ group calls
	1.3 Needs	Needs of participants prior to receiving the intervention, with a particular emphasis on health and well-being
Technical[a]	2.1 Accessibility	Extent to which the calls were accessible; factors that lessened or enhanced accessibility
	2.2 Acceptability	Factors that impacted on the level of acceptability to participants
	2.3 Facilitator performance	Participants' perceptions of their volunteer facilitator
Group dynamics	3.1.1 Cohesiveness	Extent to which groups 'gelled'
	3.1.2 Disclosure	Extent (and level) to which participants engaged in discussions
	3.1.3 Peers	Influence of peers within the group and the impact on participants' experiences
Value	4.1 Perceived benefits	Extent to which the intervention met the needs of participants
	4.2 Preferred alternatives	The alternative forms of 'friendship' and differing priorities from those in the delivered intervention
	4.3 Willingness to pay	Willingness (in theory) to pay for calls to take part in TF groups

a Themes and subthemes were relevant to the experiences of the volunteers.

Appendix 8 Fidelity checklists

Training content checklist

Examining: Use of standardised materials and practice by training provider

Date of audio recording | | Group no. | | Observer/s | 1.

Trainer | | Cycle | 1 | | 2.

Tick session/s included | 1 | 2 | 3 | 4 |

	Goal	Observed +/-		N/A	Observer notes
	Standardised training	**Yes**	**No**		
TRAINER N/A	Same Trainer	+	-		
	Pre-course: Facilitator's Handbook provided	+	-		
	Pre-course: Training Outline provided	+	-		
	Trainees trained together (Min. 4 – Max. 5)	+	-		
	Total of 4 hours *(delivered in 1 hour sessions)* training	+	-		
	General	**Yes**	**No**	**N/A**	**Observer notes**
TRAINER ALL	Reminds trainees of the distinction between role during 1:1 and group calls (e.g. suggest 'role of facilitator' is an early topic for the group)	+	-		
	Provides encouragement and builds confidence	+	-		
	Provides constructive feedback	+	-		
	Listens actively and responds to trainees' self-reflection	+	-		
	Models facilitator behaviours during discussions and encourages trainees to reflect and build on these	+	-		
	Core Content	**Yes**	**No**	**N/A**	**Observer notes**
TRAINER Session 1	Introduction and the Role of facilitator • Introduces group to each other and outlines purpose and outline of the training content • Ground rules - Minimum (confidentiality; respect etc) • Group can agree their own (good early topic) • Offers definition of the facilitator role and instigates discussion of the behaviours involved	+ + + +	- - -		

		Communication skills – Listening • Facilitates group discussion of key listening skills • Emphasises two key components of listening: attention and setting aside assumptions • Clearly explains two types of 'listener' 1) talk to think; 2) think to talk.	 + + +	 - - -		
		Core Content	**Yes**	**No**	**N/A**	**Observer notes**
	Session 1	• Explains the impact each type can have in a group and suggests making space for this e.g. *"that is fascinating; let us take a moment to think and then hear from someone that's not spoken yet".* • Suggests encouraging people to speak early on (e.g. roll call) • Active listening (e.g. vocal gestures "mm", "uh-huh").	+ + +	- - -		
	Session 2	Groups – How they work • Three levels of need: 1) Task - Purpose of the group; 2) Group; 3) Individual • Links facilitator role to responding to and balancing levels of need. • Explores examples where the three levels may conflict or compete (e.g. an individual's crisis v planned topic).	 + + +	 - - -		
		Groups – How they develop • Explains that groups develop over time and generally experience four stages of development: o Forming; norming; storming; performing. • Reassures trainees the stages can indicate the group is progressing towards performing well. • Encourages group to reflect on how this fits their own experience	 + + +	 - - -		
		Communications skills – Questions • Explores types of questions (open/closed) and appropriate use	 +	 -		
	Session 3	Handling conflict • Experiencing conflict can be healthy for the group. • Asks trainees for signs of conflict. • Describes the four triggers when the facilitator MUST intervene: 1) Group is breaking up; 2) Comments are personal; 3) Ground rules are being broken; 4) The group is stuck (same argument). • Describes the framework for intervening (e.g. acknowledge the conflict; remind about ground rules; acknowledge groups' contributions then hand it back to them to decide how to take it forwards).	 + + + +	 - - - -		

	Session 4	Professional and ethical practice • Getting going ('icebreakers') and finishing up (time keeping; saying goodbye) • Equal Opportunities – discuss issues of recruitment, access and inclusion • Data Protection – People shouldn't share their personal details. Only at the end in writing. (e.g. exchanging telephone numbers) • Confidentiality (e.g. leakage during conversations; Exceptions) • Documentation (i.e. different types – recording keeping and note-taking) • Allows time for exploring trainees' concerns and issues	+ + + + + +	- - - - - -		
		Tailoring	**Yes**	**No**	**N/A**	**Observer notes**
TRAINER	**ALL**	Training is tailored in response to observed needs by trainer; or, specific questions from trainees.	+	-		
		Trainer checks understanding. Provides a recap; feeds back on suggestions/ questions and fills knowledge gaps e.g. **Q**. what if the conversation dries up? **A**. take it back to the group – *"things have dried up does anyone have any suggestions"* or *"would the group like me to make a suggestion?"*).	+	-		
		'Provider skill acquisition'	**Yes**	**Yes**	**N/A**	**Observer notes**
TRAINER	**S1**	Invites trainees to talk about existing skills and experience of groups and builds on it	+	-		
		Refers trainees to pre-/post-training exercises within Handbook	+	-		
	ALL	Each Trainee is asked to practice facilitation skills (approx. 10 mins during a session) with a topic provided by trainer.	+	-		
		Trainee invited to reflect on practice session and peers invited to give feedback.	+	-		
		Trainer gives constructive feedback (e.g. suggest what they might have done differently; positive affirmation/ encouragement).	+	-		
		Provider Self-awareness	**Yes**	**No**	**N/A**	**Observer notes**
TRAINEE	**ALL**	Reflects on and discusses their own style of communication.	+	-		
		Demonstrates awareness of how their 'style' may impact on the group in relation to the information delivered by the trainer.	+	-		
		Reflects on what they have learned and how they feel about facilitating a telephone group.	+	-		
		Total +				
		Total + or -				
		Percentage correct = items scored + / Total items scored				

Additional notes:

Intervention delivery checklist

Examining: Adherence to content as intended

Date of audio recording | Group no/ cycle | Observer 1:

Volunteer Facilitator | Completion date | Observer 2:

Session:

	Goal	Observed +/-			Observer notes
	Attendance	**Yes**	**No**	**N/A**	
Facilitator	Completes Group Calls Register	+	-		
	Checks everyone is still on the call (e.g. roll call exercise) at intervals	+	-		
	Asks participants to let him/her know if they need to leave the call; reminding that they don't have to give a reason.	+	-		
	Session One Only				
Facilitator	Sets group at ease	+	-		
	Gives practical information about how sessions will work, timekeeping, Community Network's role etc.	+	-		
	Allows the group to introduce themselves	+	-		
	Agrees ground rules with the group (suggests and discusses 'core' ground rules and invites other suggestions). Minimum:- i) confidentiality; ii) say name before speaking; iii) stop talking when asked; iv) respect for each other – maximum 5 – 6.	+	-		
	Gets everyone talking early	+	-		
	Models core facilitator behaviour from the beginning – gives group responsibility for leading discussion (e.g. says name before speaking; allows pauses)	+	-		
	For All Sessions				
	Introduction to group call	**Yes**	**No**	**N/A**	**Observer notes**
Facilitator	Initiates exchange of greetings	+	-		
	Brings people in smoothly	+	-		
	Reminds the group about the ground rules (as necessary in later sessions)	+	-		
	Checks the purpose of the session (or specific topic agreed) with the group	+	-		
	Reminds the group about time limits (e.g. one hour; and Community network time	+	-		

	check - *not applicable for later sessions*).				
	Group content / Facilitation skills	**Yes**	**No**	**N/A**	**Observer notes**
	Builds capacity and resources of the group throughout				
Facilitator	Uses active listening techniques: • Pays attention and responds to what is said • Does not lead or steer unless necessary • Gives responsibility to the group wherever possible • Does not intervene unnecessarily • Offers appropriate reassurance e.g. "mm"; "uh-huh" when a participant is talking • Repeats/rephrases to prompt discussion • Uses open questions • Uses summarising statements if appropriate (e.g. transition between topics)	+ + + + + + + +	- - - - - - - -		
	Encourages quieter participants to join the discussion. e.g. "that is fascinating; let us take a moment to think and then hear from someone who's not spoken yet".	+	-		
	Asks the group's permission before making any suggestions e.g. *(would it help if I suggested something or has someone else got an idea?)*	+	-		
	Balances the three levels of need (task/group/individual) e.g. individual needs don't dominate group discussion or the wider purpose (task) of the group.	+	-		
	Tailors level of 'facilitation input' to the needs of the group.	+	-		
	Invites the group to respond to questions and uses questions rather than statements	+	-		
	Acts as the guardian of the ground rules	+	-		
	Respects emotional boundaries	+	-		
	Creates a safe environment for sharing, mutual support and learning from others' experiences	+	-		
	Encourages communication and connection	+	-		
	Challenges difficult behaviour	+	-		
	Conveys respect	+	-		
	Helps the group to expand their perspectives and explore alternative choices	+	-		
	Addresses faulty beliefs	+	-		
	Supports good practice and positive beliefs	+	-		
	Acknowledges achievements	+	-		
	Is tactful and supportive over disappointments	+	-		
	Handling conflict	**Yes**	**No**	**N/A**	**Observer notes**
	Allows the group to experience conflict (if it arises) and encourages them to resolve it	+	-		

	Intervenes in any of the following scenarios: • group starts to break up (e.g. taking sides) • ground rule/s is broken • it gets personal • the group is stuck (in the same argument)	+	-		
	Is open/ honest and follows a clear process: • acknowledges the conflict • reminds the group of the ground rules • acknowledges everyone's contributions • gets the group to decide how to move forward • keeps everyone involved e.g. "I notice that things are getting heated/ *the group seems to be stuck; we need to remember the 'respect' ground rule; thank you all for your contributions, how do you want to take this forward? Let's take a moment and hear from someone who hasn't spoken for a while."*	+	-		
	Session close	**Yes**	**No**	**N/A**	**Observer notes**
	Reminds the group the session is coming to a close e.g. time check	+	-		
	Summarises the session (including any points/topics for next week)	+	-		
	Provides an opportunity for 'final thoughts'.	+	-		
	Reminds the group of the date and time of the next session	+	-		
	Invites a group "goodbye"	+	-		
	Total +				
	Total + or -				
	Percentage correct = items scored + / Total items scored				

	Participants (extent to which the group is 'performing' well)	**0 = Never; 1 =seldom; 2 = Sometimes; 3 = Often**				**Observer notes**
		0	**1**	**2**	**3**	
Participant	Participants observe the ground rules e.g. stop when instructed; say their name before speaking					
	Participant/s introduce their own topic/s					
	Participants show mutual support e.g. making suggestions; resolving disagreements themselves; jointly agreeing topics for discussion; offering engagement/support					
	Participants are committed to the group e.g. attend regularly; actively engage; express satisfaction/enjoyment; act on commitments they make to the group					
	Total					

Appendix 9 Main trial results

TABLE 34 Differences in quality-of-life measures at 6 months (per-protocol analysis)

	Intervention		Control		Unadjusted[a]		Adjusted[b]	
Outcome	*n*	Mean (SE)	*n*	Mean (SE)	Mean difference (95% CI)	*p*-value	Mean difference (95% CI)	*p*-value
SF-36								
Mental health	9	73.9 (5.8)	30	70.7 (3.9)	3.2 (–5.2 to 11.6)	0.452	8.0 (3.3 to 12.7)	< 0.001
Physical functioning	9	51.5 (11.4)	30	56.0 (5.5)	–4.5 (–18.0 to 9.1)	0.519	1.3 (–23.0 to 25.7)	0.914
Role – physical	9	57.6 (8.3)	30	55.4 (5.0)	2.2 (–7.7 to 12.2)	0.662	11.3 (–2.3 to 24.9)	0.104
Bodily pain	9	59.7 (10.7)	30	53.9 (5.4)	5.8 (–14.9 to 26.5)	0.583	12.1 (–2.5 to 26.7)	0.105
General health	9	59.8 (9.4)	30	56.1 (4.2)	3.6 (–11.6 to 18.9)	0.639	0.6 (–8.4 to 9.7)	0.888
Vitality	9	55.6 (6.9)	30	49.6 (4.7)	6.0 (–9.2 to 21.1)	0.440	1.7 (–6.0 to 9.5)	0.661
Social functioning	9	72.2 (9.7)	30	70.0 (5.7)	2.2 (–13.8 to 18.3)	0.786	8.2 (–8.6 to 25.0)	0.336
Role – emotional	9	78.7 (9.2)	30	81.7 (4.4)	–3.0 (–22.9 to 16.9)	0.770	–8.9 (–59.8 to 42.0)	0.731
Physical component summary	9	38.9 (4.8)	30	38.3 (2.1)	0.7 (–7.5 to 8.8)	0.873	1.9 (–2.7 to 6.4)	0.416
Mental component summary	9	51.0 (3.9)	30	49.7 (2.1)	1.3 (–5.4 to 8.0)	0.704	6.7 (4.3 to 9.2)	< 0.001

Outcome	Intervention		Control		Unadjusted[a]		Adjusted[b]	
	n	Mean (SE)	*n*	Mean (SE)	Mean difference (95% CI)	*p*-value	Mean difference (95% CI)	*p*-value
PHQ-9								
Overall score	9	4.4 (1.5)	30	3.6 (0.8)	0.9 (–1.8 to 3.6)	0.526	–1.4 (–2.6 to –0.2)	0.021
EQ-5D								
Tariff	9	0.64 (0.14)	29	0.71 (0.05)	–0.08 (–0.24 to 0.09)	0.372	–0.01 (–0.15 to 0.12)	0.880
Thermometer	9	69.4 (8.8)	30	70.5 (4.0)	–1.0 (–13.2 to 11.1)	0.869	–9.0 (–18.3 to 0.2)	0.054
de Jong Gierveld								
Emotional loneliness score	9	3.1 (0.7)	30	2.2 (0.3)	0.9 (–0.0 to 1.9)	0.056	0.6 (–0.1 to 1.3)	0.093
Social loneliness score	9	1.6 (0.7)	30	1.2 (0.3)	0.4 (–0.4 to 1.2)	0.354	–0.2 (–0.5 to 0.1)	0.235
Overall loneliness score	9	4.7 (1.2)	30	3.3 (0.5)	1.3 (–0.4 to 3.0)	0.122	–0.3 (–0.8 to 0.2)	0.255
GSE								
Total score	9	32.3 (2.2)	30	32.1 (0.7)	0.2 (–3.7 to 4.2)	0.905	1.1 (–0.9 to 3.0)	0.275
ONS well-being								
Total score	9	7.2 (0.6)	30	7.6 (0.3)	–0.3 (–1.3 to 0.7)	0.499	0.1 (–0.4 to 0.6)	0.637

SE, standard error.
a Unadjusted: fixed covariate is randomised group only.
b Adjusted: fixed covariates are randomised group, baseline score, age and sex.
Models are general linear mixed models with befriending group included as a random effect.

Appendix 10 Qualitative research results

TABLE 35 Baseline demographics by participation in qualitative interviews (all participants allocated to the intervention within the pilot study, $n = 35$)

Variable	Scoring	Interviewed ($n = 19$)	Not interviewed ($n = 16$)	Total ($n = 35$)
Sex, *n* (%)	Female	13 (68)	10 (63)	23 (66)
	Male	6 (32)	6 (38)	12 (34)
Age (years)	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	83.3 (6.3)	79.9 (4.8)	81.8 (5.8)
	Median (IQR)	81 (78–88)	78 (76–83)	80 (78–85)
	Min. to max.	75 to 95	75 to 91	75 to 95
Ethnicity, *n* (%)	English/Welsh/Scottish/ Northern Irish/British	19 (100)	15 (94)	34 (97)
	Any other white background	0 (0)	1 (6)	1 (3)
Live with anyone?, *n* (%)[a]	Yes	4 (21)	6 (38)	10 (29)
	No	15 (79)	10 (63)	25 (71)
Live with spouse/partner, *n* (%)	Ticked	2 (11)	6 (38)	8 (23)
Live with children, *n* (%)	Ticked	0 (0)	1 (6)	1 (3)
Live with others, *n* (%)	Ticked	1 (5)	0 (0)	1 (3)
Education, *n* (%)				
One to four O levels/GCSEs/CSEs	Ticked	0 (0)	2 (13)	2 (6)
Five or more O levels/ GCSEs/CSEs	Ticked	1 (5)	2 (13)	3 (9)
Degree	Ticked	2 (11)	3 (19)	5 (14)
Higher degree	Ticked	1 (5)	0 (0)	1 (3)
Professional	Ticked	5 (26)	2 (13)	7 (20)
Other	Ticked	2 (11)	0 (0)	2 (6)
Occupation	Looking after home/family	1 (5)	0 (0)	1 (3)
	Retired	18 (95)	16 (100)	34 (97)

CSE, Certificate of Secondary Education; GCSE, General Certificate of Secondary Education; max., maximum; min., minimum; O level, Ordinary level.

a One interviewed participant said 'yes' to 'live with anyone?' but did not select any options; one participant who was not interviewed selected two options for 'live with anyone?'.

TABLE 36 Baseline SF-36 scores by participation in qualitative interviews (all participants allocated to intervention within the pilot study, $n = 35$)

Variable	Scoring	Interviewed ($n = 19$)	Not interviewed ($n = 16$)	Total ($n = 35$)
Mental health	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	79.2 (15.1)	76.3 (20.4)	77.9 (17.5)
	Median (IQR)	80 (70–90)	80 (67.5–90)	80 (70–90)
	Min. to max.	40 to 100	15 to 100	15 to 100
Physical function	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	64.3 (29.8)	67.2 (25.2)	65.6 (27.4)
	Median (IQR)	75 (35–90)	67.5 (58–88)	70 (55–90)
	Min. to max.	0 to 100	10 to 100	0 to 100
Role – physical	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	68.4 (26.1)	74.6 (24.5)	71.3 (25.2)
	Median (IQR)	56.3 (50.0–100)	78.1 (59.4–100)	75 (50.0–100)
	Min. to max.	25 to 100	25 to 100	25 to 100
Bodily pain	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	62.2 (32.9)	66.9 (24.4)	64.4 (29)
	Median (IQR)	72 (31–100)	67 (41–92)	72 (41–100)
	Min. to max.	0 to 100	32 to 100	0 to 100
General health	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	71.7 (20.9)	66.2 (22.4)	69.2 (21.4)
	Median (IQR)	77 (57–87)	72 (54–79)	72 (57–82)
	Min. to max.	30 to 100	25 to 97	25 to 100
Vitality	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	65.8 (22.8)	58.2 (16.7)	62.3 (20.3)
	Median (IQR)	68.8 (43.8–81.3)	59.4 (50.0–71.9)	68.8 (50.0–75.0)
	Min. to max.	6.3 to 100	25 to 81.3	6.3 to 100
Social function	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	82.2 (26.5)	88.3 (17.4)	85 (22.6)
	Median (IQR)	100 (75.0–100)	93.8 (87.5–100)	100 (75.0–100)
	Min. to max.	25 to 100	37.5 to 100	25 to 100
Role – emotional	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	83.8 (23.3)	94.3 (10.9)	88.6 (19.2)
	Median (IQR)	100 (66.7–100)	100 (91.7–100)	100 (83.3–100)
	Min. to max.	25 to 100	66.7 to 100	25 to 100

TABLE 36 Baseline SF-36 scores by participation in qualitative interviews (all participants allocated to intervention within the pilot study, $n = 35$) (*continued*)

Variable	Scoring	Interviewed ($n = 19$)	Not interviewed ($n = 16$)	Total ($n = 35$)
Physical component	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	43.5 (11.4)	44.1 (9.6)	43.8 (10.5)
	Median (IQR)	45.4 (33.4–55.0)	43.8 (35.7–52.1)	44.2 (34.0–53.7)
	Min. to max.	22.7 to 57.2	29.6 to 61.2	22.7 to 61.2
Mental component	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	53.9 (8.8)	54.3 (9.7)	54.1 (9.1)
	Median (IQR)	56.1 (49.2–59.3)	56.7 (51.0–60.1)	56.2 (50.9–59.3)
	Min. to max.	25.3 to 63.6	24.3 to 68.1	24.3 to 68.1

Max., maximum; min., minimum.
The SF-36 dimensions are scored on a scale from 0 (poor) to 100 (good).

TABLE 37 Other baseline participant-reported outcome scores by participation in qualitative interviews (all participants allocated to intervention within the pilot study, $n = 35$)

Variable	Scoring	Interviewed ($n = 19$)	Not interviewed ($n = 16$)	Total ($n = 35$)
EQ-5D[a]	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	0.71 (0.36)	0.75 (0.2)	0.73 (0.29)
	Median (IQR)	0.85 (0.62–1)	0.8 (0.67–0.83)	0.8 (0.62–1)
	Min. to max.	–0.37 to 1	0.2 to 1	–0.37 to 1
EQ-5D VAS[b]	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	77.3 (17.8)	72.4 (19.8)	75.1 (18.6)
	Median (IQR)	80 (67–90)	80 (50–90)	80 (61–90)
	Min. to max.	26 to 96	40 to 100	26 to 100
de Jong Gierveld emotional loneliness score[c]	*n* (%)	18 (94.7)	16 (100)	34 (97.1)
	Mean (SD)	2.3 (2)	1.4 (1.4)	1.9 (1.8)
	Median (IQR)	3 (0–4)	1 (0–3)	1 (0–3)
	Min. to max.	0 to 6	0 to 4	0 to 6
de Jong Gierveld social loneliness score[d]	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	1.5 (1.7)	1.3 (1.8)	1.4 (1.7)
	Median (IQR)	1 (0–3)	0 (0–2.5)	1 (0–3)
	Min. to max.	0 to 5	0 to 5	0 to 5
de Jong Gierveld overall loneliness score[e]	*n* (%)	18 (94.7)	16 (100)	34 (97.1)
	Mean (SD)	3.9 (3.3)	2.6 (2.8)	3.3 (3.1)
	Median (IQR)	3 (1–6)	1 (1–5)	2 (1–6)
	Min. to max.	0 to 11	0 to 9	0 to 11
PHQ-9[f]	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	2.7 (3.6)	3.2 (3.8)	2.9 (3.6)
	Median (IQR)	1 (0–4)	2.5 (2–4)	2 (0–4)
	Min. to max.	0 to 13	0 to 16	0 to 16
ONS well-being[g]	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	7.3 (3)	8.4 (1.3)	7.8 (2.4)
	Median (IQR)	8 (7–9)	8 (8–10)	8 (7–9)
	Min. to max.	0 to 10	6 to 10	0 to 10
GSE[h]	*n* (%)	19 (100)	16 (100)	35 (100)
	Mean (SD)	33.1 (5)	34.3 (4)	33.7 (4.5)
	Median (IQR)	34 (29–38)	35.5 (30–37)	35 (29–38)
	Min. to max.	24 to 40	27 to 39	24 to 40

Max., maximum; min., minimum; VAS, visual analogue scale.
a The EQ-5D utility score is measured on a scale from –0.56 to 1.00 (good health).
b The EQ-5D VAS is measured on a scale from 0 (worst imaginable health state) to 100 (best imaginable health state).
c The de Jong Gierveld emotional loneliness scale is scored from 0 to 6, with higher scores indicating more loneliness.
d The de Jong Gierveld social loneliness scale is scored from 0 to 5, with higher scores indicating more loneliness.
e The de Jong Gierveld overall loneliness scale is scored from 0 to 11, with higher scores indicating more loneliness.
f The PHQ-9 is measured on a scale from 0 to 27, with higher scores indicating more severe depressive symptoms.
g The ONS well-being measure is scored on a 0 to 10 scale with a higher score indicating better well-being.
h The GSE is scored on a scale from 10 to 40, with higher scores indicating more perceived self-efficacy.
Models are general linear mixed models with befriending group included as a random effect.

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