Piloting the use of Football Club Community Trust's to create social Hubs for older adults

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Piloting the use of football club community Trust's to create social Hubs for older adults

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ABSTRACT

Objectives: The research summarises the findings from a three-year pilot delivered through the EFL Trust and eleven Club Community Organisations. The aim was to create local social Hubs for older adults, to bring together local people to increase social connections, which may lead to additional physical activity, rather than a targeted physical activity intervention.
Study design: The study was a three-year evaluation of the pilot, to track changes in attitudes and behaviours of participants, and gather feedback on the delivery mechanism and the service providers.
Methods: The study included participant tracking surveys alongside interviews and focus groups with participants and service providers over the three-year pilot.
Results: The greatest impact was on participants' mental wellbeing as opposed to their physical activity levels or attitude/motivation for physical activity. Covid-19 restrictions were felt particularly hard by the most vulnerable in society and the tracking of participants quantified the negative impact of lockdown on life satisfaction and happiness, which the presence of the Hubs helped to redress.
Conclusions: The Hubs model can offer a relatively low cost community based solution which adds to the menu of options in local health systems. The Hubs can help to tackle loneliness, enhance social interactions using the power of the football club to generate demand. The learning showed how to recruit, retain, and sustain networks of older adults using Hubs. The pilot showed the value CCOs can have in local service delivery for older adults, providing semi-structured Hubs which act as a conduit to wider engagement.

1. Introduction

It is well documented that England has an ageing population, with estimates projecting 3.1 m people will be over the age of 85 by 2045, and one in four will be over the age of 65 [1]. This has significant implications for public policy, with a greater number of older adults placing a greater demand on health and social care. The range of care required can be physical, such as the management of long-term health conditions or issues related to falls/accidents, supporting those with illness such as dementia, through to issues related to wider social care such as the preservation of social networks to reduce the effects of loneliness/isolation and maintain mental wellbeing. As life expectancy rises alongside the age of the population, protecting and developing sustainable social networks for older adults can be an essential element of public policy, which can help to reduce the demand for local health and social care services. Previous research has outlined how national physical activity strategies with health outcomes are an established part of public policy in the UK and included in global policies for activity levels by the World Health Organization [2]. UK policy recommendations have taken a universal approach where one size fits all, and physical activity is promoted as the panacea to alleviate all health-related issues for older people [3]. This, however, does not represent the diverse range of circumstances older adults face related to different levels of physical wellbeing, disability, and frequency of meaningful social interactions.

In 2017, Sport England, the arms-length body of government which has responsibility for the growth and development of participation in grassroots sport and physical activity in England, outlined a vision to pilot 20 organisations to reduce inactivity levels in older adults supported with £10 m of funding [4]. The English Football League Trust (EFLT) were successful in securing a £499,999 grant for three years to support the development of 12 'Extra Time Hubs' across England via CCOs. EFLT added £100,000 additional funding, and the pilot was granted a further £250,000 in 2020 to mitigate the effects of the COVID-19 pandemic. The Hub approach was designed as a pilot to try

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and create opportunities for Club Community Organisations (CCOs) to understand more about different types of provision that could help to address the higher proportions of older people classified as inactive. Inactivity is defined by The Chief Medical Officer [5] as achieving less than 30 min of moderate intensity physical activity in a week, quantified in England by Active Lives [6] as 27% of 55–74 year olds and 49% of over 75s in 2017 when the pilot was developed.

Against the backdrop of an ageing (and inactive) population, developing cost-effective initiatives that attract and retain older adults is seen as an important part of the local infrastructure to keep people active and socially connected, leading to improved indicators of health and happiness. The Hubs were not designed to be traditional physical activity interventions, but a focal point to harbour social connections first, which may then lead to additional physical activity. The pilot was created and designed using a Theory of Change, i.e. an attempt to articulate how the provision of inputs, and direction of activities could lead to the creation of positive impacts and outcomes for members and local communities. CCOs have not been traditional suppliers of provision for older adults, and this approach was unique in bringing a different supplier to the space.

2. Literature

The data quantifying the volume and cost of age-related issues is an indicator of the pressures faced by policy makers in government to reduce the impact on health and community services as a consequence of poor health, social isolation, physical inactivity, and the risk of falls. Additionally, it has been identified that loneliness and social isolation are both important predictors of poor health and mortality [7]. Age UK [8] estimated in 2016 that there are 1.2 million adults aged 65+ reporting that they feel chronically lonely in the UK, described as having no meaningful relationships, and there are half a million older adults who report that they do not speak to anyone for at least five or six days in a week. Chronic loneliness has been identified as having such a significant negative impact that for some people it is as risky to health as obesity or smoking [9], and it has been associated with adverse quality of life outcomes for both physical and mental wellbeing [10].

The primary aims of the Hubs were to raise activity levels, increase social connections and reduce loneliness for the participants. The Hubs also aligned closely with the five priority areas in the UK Government's 2015 Sporting Future strategy (physical wellbeing, mental wellbeing, individual development, community development and economic development). Previous estimations quantify that physical inactivity comes at a cost of £7.4 billion annually to the UK [11]. There are significant policy implications for the UK from physical inactivity coupled with an ageing population and the potential for social isolation. These issues can have a negative impact on individuals' quality of life and puts additional pressure on the NHS [12]. For example, half of people aged over 80, and one-third of those aged over 65 suffer a fall at least once per year, causing an estimated cost of £2.3bn per year [12]. The Hubs were not designed as a 'falls prevention' initiative, but the benefits of higher activity levels include both physical and mental wellbeing and can help prevent and manage over 20 chronic conditions and diseases [13]. Research has shown that evidence of successful social isolation interventions was weak, and success arose from interventions that were adaptable, had a community approach, and had productive engagement [14]. Other studies [2] have shown that community sport/physical activity for older adults is complex due to significant differences in social contexts and constraints, illness, disease which makes the policy landscape challenging.

Previous research suggested a redefinition of meaning is required for what physical activity for health and wellbeing involves for older adults, and that policy should include recognition of the value system older adults put on certain activities [2]. This refers to the level of physical intensity, the variety and the type of activities offered that offer positive experiences for participants on an individual and a community level.

2.1. Extra Time Hubs

The ETHs were a concept designed by EFLT to create a national community of older people (retired and semi-retired) by utilising the attraction and 'pull' of local football clubs to facilitate social connections and combat loneliness and inactivity. The pilot aimed to test an approach which reflected a move away from the more traditional delivery of an intervention, towards the facilitation of a network. The aim was to use a co-production strategy to offer members activities that could benefit their physical and mental health. Hubs were created and established at 12 CCOs across the country: Bolton Wanderers, Burton Albion, Charlton Athletic, Crawley Town, Coventry City, Derby County, Lincoln City, Northampton Town, Plymouth Argyle, Shrewsbury Town, Sunderland and Wigan Athletic, although one did not complete the pilot phase.

The rationale for organisations to receive investment through the Active Ageing fund was to be innovative in the design of concept. Partly inspired by University of the Third Age, ETH was designed as a weekly gathering of members which acts as a focal point to create a broader social community. The aim was to create conditions that facilitated members to identify and choose the activities and events offered in the session and create 'spokes' of activities where smaller groups of like-minded people created informal offshoots in addition to the weekly session. The overriding principle at the outset was that CCOs would not deliver, like other interventions are designed to do, but would instead adopt a role to facilitate and enable. The pilot was delivered over a four-year period, with a 12-month consultation exercise before launching, to establish the guiding principles, defined as: treat people with respect, harness their skills and experience, member-led, responsive to individual needs, preferences, and motivations, encourage new activities and interests, keep costs to a minimum. From a sustainability perspective, staff delivered gatherings in the short-term and aimed to transition delivery so that it was member-led, with members facilitating other participants, rather than staff being the focal point as the delivery mechanism.

3. Methods

The method incorporated both qualitative and quantitative tools, including surveys, secondary analysis, focus groups and interviews. Quarterly surveying of members (at 3 monthly points) over three years aimed to understand their engagement in physical activity, assess their physical and mental wellbeing, confidence, social interactions, and feelings of loneliness. Participants were asked to quantify their physical activity levels using the Sport England Short Form Active Lives survey tool, which quantifies the type of activity, days, duration, and intensity, and six additional subjective wellbeing measures based on a four-point agreement scale. All Activators and CCO staff were interviewed at the end of each year from an operational and strategic perspective, and a participant focus group was completed at nine Hubs. The survey was split into three core areas (1) demographics (age, gender, ethnicity, disability, number of people in the household), (2) physical activity levels using the Sport England Short Active Lives Survey questions and (3) subjective wellbeing questions (confidence, happiness, motivation, life satisfaction, loneliness) using validated Office for National Statistics (ONS) questions. Hub gatherings moved entirely online in March 2020 when Covid-19 developed, and tracking surveys also moved online (or were completed by CCO staff over the phone with participants). Face-to-face meetings restarted in all CCOs by spring 2021.

3.1. Sample

Overall, 778 individuals completed a baseline survey and at least one follow-up tracking survey, with 5377 completions generated in total. Additionally, 52 interviews were conducted, and nine focus groups took place involving 35 members. Surveys were analysed cross-sectionally to

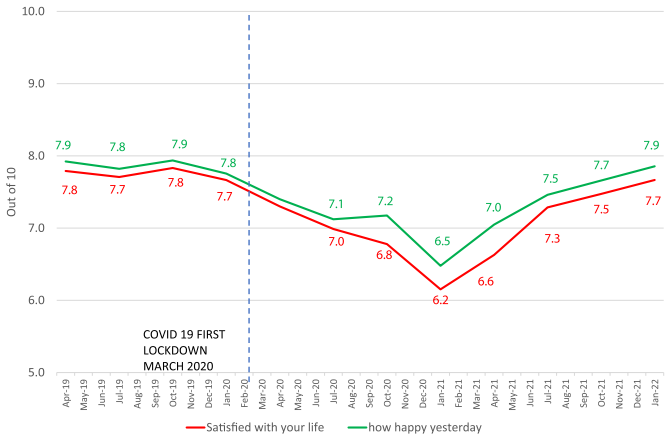

Fig. 1. Tracking of satisfaction and happiness (out of 10) April 2019 to January 2021.

track subjective wellbeing, and longitudinally using repeated measures analysis. Interviews and focus groups were recorded and analysed using thematic analysis. The profile of the members was different to what EFLT originally expected for a programme designed for 55+, with an average age of 71 when joining, and more female members (53% v 47%). Almost two-fifths classed themselves as having a limiting long-lasting disability (38%), 37% lived alone and 38% were categorised as 'inactive' (<30 min per week) when they joined a Hub.

4. Results

The headline results demonstrated that the creation of the Hubs had a greater impact on participants' mental wellbeing as opposed to their physical activity levels or attitude/motivation for physical activity. The restrictions on life following the outbreak of the Covid-19 pandemic were felt particularly hard by the most vulnerable in society and the tracking of participants quantified the impact of lockdown on life satisfaction and happiness (Fig. 1).

The data tracking element outlined that the pandemic had a significant impact on members' wellbeing and social connections, however the indicators returned close to pre-pandemic levels in the latter part of 2021 into 2022. The qualitative member feedback outlined the importance of their Hub for being the catalyst to begin venturing back into community sessions face-to-face and meeting up with people in person.

The tracking outlines that there were statistically significant increases, using Z scores, in the proportion of the sample with the strongest agreement in all six questions and the physical activity question at the base to 12-month stage, i.e. one year after joining a Hub, and base to 9-month stage. There were also significant observations in 4 of the 7 areas at base to 3-months, and base to 9-months. Participants returning data at base and 12 months were less likely to be "active" at baseline than the sample, meaning those with lower levels of activity when they joined were more likely to remain on the programme for longer, which is an important finding for future delivery.

The thematic analysis of the qualitative element of the feedback from CCO staff and members could be themed into four prominent areas; improved social connections, reducing loneliness, ability to meet friends and creating a regular diary appointment which is something to look forward to. Although the Sport England funding had an underlying physical activity element, as part of the physical wellbeing strategic area, the demographic of the members and their tastes and preferences for the Hub activities meant that mental wellbeing and social/community development were the strategic areas where the primary benefits were achieved. For those that wanted to, there was the option to do that *"… this is much better than anything I have been to before because I feel comfortable coming here and taking part in activities that I want to take part in. We have a sitting down section if people want to sit down and chat, and the room to do activities, if we want, we can join in*".

Building relationships and social networks was the main reason Hubs developed and retained members, and CCO staff spent a lot of time harnessing those relationships, making people feel comfortable and included, with examples showing the importance of relationships *"… the social aspect is very important; you feel wanted, they ask after you … people care … you feel part of a big wheel"* and *"… since my husband passed away, I felt that I did not have much company and not many friends that I could call upon and that is a very lonely place. The sessions here have given me the chance to be myself again"*.

5. Discussion

The tracking of members measured changes against the pilots' pre-set outcomes and provided evidence against the key indicators of physical activity, subjective wellbeing, and latterly, loneliness. It also captured the impact of Covid on these indicators. As the pilot was funded via Sport England's Active Ageing investment, there was a clear rationale to use their Short Form Active Lives (SFAL) survey questions as a valid tool for measuring physical activity and creating classifications which could be compared with national data. However, the recruitment of participants attracted a demographic that was older than expected and as outlined in the literature, the measures of physical wellbeing for older adults are much broader than participation in walking, cycling and sport. To demonstrate the efficacy of the pilot to other funding partners post-pilot, having access to additional data would have been advantageous. For example, having specific data on participants' interaction with the health service (e.g. frequency of GP visits) and data around instances of issues linked to frailty (e.g. able to stand-up from a seated position unaided, number of falls etc.) may have reflected a broader range of potential impact. Notwithstanding this, there was evidence in the final year of the pilot that more members were "at least fairly active" (i.e. either classified as "active" or "fairly active") than at any point in the pilot.

The understanding of the benefits from a social connection and tackling loneliness perspective show the value of a local, member-led Hub which uses the power of the football club badge. Football clubs have a unique ability to promote and facilitate activities for their local community in a way other organisations do not. Although enjoyment or interest in football was not cited as a driving factor for many participants to join, the attraction of attending the stadium for gatherings was, for many, a key part of their initial engagement with a Hub.

Future investment in the community Hub concept should consider collecting data which would demonstrate impact (e.g. cost reductions from reduced service use) to other funding partners, not necessarily the physical activity remit underpinning the Active Ageing pilot. The concept is based around the creation of local networks and social environments first, which may then lead to physical activity opportunities is a subtle change compared to traditional programmes for older adults, where the delivery of physical activity sessions for a pre-defined period as an intervention is offered. The social element first is a suitable approach for many older adults, with the broader facilitation of activities that are suitable for the demographic, which may range from activities to aid falls prevention through to more rigorous activities for those that want to participate. This links to the earlier point [2] about the need for greater understanding around the different values older adults gain from the activities they do, and the demand for both individual and community activities.

There were significant unintended outcomes arising from the pandemic which affected the provision of sessions and priorities, including the staff facilitating gatherings being placed on the Furlough scheme in the early parts of the national lockdown or redeployed, which disrupted some CCOs.

The evidence within this research outlines that the Extra Time Hubs model can offer a relatively low cost community based solution to add to

Table 1
Change in activity and subjective wellbeing: Baseline to 3, 6, 9 and 12 months post registration.

	Base	3 Mth	Z	Base	6 Mth	Z	Base	9 Mth	Z	Base	12 Mth	Z
	N = 778			N = 619			N = 540			N = 300		
"Active" (150+ mins)	41.4%	46.3%	1.95	40.4%	51.7%	***3.99***	38.9%	48.0%	***3.02***	35.0%	49.0%	***3.47***
	Strongly agree			Strongly agree			Strongly agree			Strongly agree		
Motivated to be active	32.5%	31.3%	0.51	30.1%	40.9%	***3.97***	30.1%	34.0%	1.37	21.1%	41.3%	***5.34***
Content with relationships	35.8%	50.1%	***5.70***	34.0%	51.1%	***6.08***	33.4%	53.2%	***6.57***	29.2%	50.3%	***5.28***
Have people to ask for help	33.0%	48.0%	***6.03***	30.1%	50.1%	***7.18***	30.8%	50.8%	***6.69***	27.7%	52.7%	***6.24***
Satisfying relationships	34.1%	44.0%	***4.00***	30.5%	45.3%	***5.37***	31.4%	46.5%	***5.09***	27.3%	47.5%	***5.11***
Can achieve personal goals	25.9%	28.1%	0.98	23.7%	29.2%	***2.19***	24.8%	27.5%	1.01	20.7%	32.3%	***3.22***
Never feel lonely	11.8%	17.0%	***2.92***	12.7%	17.7%	***2.45***	12.4%	16.9%	2.09	9.5%	23.1%	***4.51***

* Figures in bold italic denotes significant at 95%.

the menu of options (and delivery agencies) in which the health system can utilise to tackle loneliness and enhance social interactions. The CCO structure is not a traditional provider of community interventions for older adults, and for many CCOs, this was the first time they had delivered a programme aimed at older adults. Their journey of learning over three years showed how to recruit, retain, and sustain networks of older adults into a Hub, and showed the value CCOs can have in providing semi-structured provision for older adults. The evidence around the impact Hub sites for older adults, built through the network of football club community organisations, can have in improving the social connections and wellbeing of members was positive. As Table 1 showed, those members who were less active at baseline were more likely to remain on the programme for longer which is an important observation. This model could be developed by national funding agencies, provided by local organisations, to roll the concept out more widely.

Ethical approval

Ethical approval for this study was provided by Sheffield Hallam University Research Ethics Board.

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Competing interests

None declared.

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