Ambition for Ageing

Interim Report – Data Analysis

Jessica Thorley
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Report to:	AfA partners
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Summary of Purpose:	For information

A programme led by:
Greater Manchester Centre for Voluntary Organisation

St Thomas Centre
Ardwick Green North
Manchester M12 6FZ
www.ambitionforageing.org.uk

0161 277 1000
ambitionforageing@gmcvo.org.uk
@afageing

GMCA GREATER MANCHESTER COMBINED AUTHORITY
NATIONAL LOTTERY FUNDED
GMCVO

Contents

Glossary / List of new terms

AfA	Ambition for Ageing
GM	Greater Manchester
GMCVO	Greater Manchester Centre for Voluntary Organisation
LA	Local Authority
LDLs	Local Delivery Leads
N/n=	Sample size
ONS	Office for National Statistics

Executive Summary

Introduction and background

Ambition for Ageing (AfA) is a £10.2 million Greater Manchester level programme aimed at creating more age-friendly places and empowering people to live fulfilling lives as they age. It is funded by the Big Lottery Fund's Ageing Better programme, which aims to reduce social isolation of older people. Led by GMCVO, the 5 year programme is delivered by a cross-sector partnership, with Local Delivery Leads (LDLs) leading on the work in 25 neighbourhoods (wards) across 8 local authorities in Greater Manchester. AfA's belief is that a series of small changes within communities will bring about large scale success in a practical and sustainable sense that will ultimately help to reduce social isolation.

The AfA evaluation takes an approach that looks at the programme as a whole, rather than focusing on the individual projects funded through LDL panels. AfA has a number of core outcomes against which it aims to show progress, consisting of a programme evaluation, strategic evaluation, and process evaluation. The focus of this report is in analysing data collected for the purposes of measuring the 'programme evaluation' component of the evaluation, shown in figure 1.1. This report compiles analysis of data collected between Jan 2016 and Dec 2017 through standardised forms distributed across projects and submitted quarterly to GMCVO.

Figure 1.1: Ambition for Programme Evaluation Outcomes

Outcome	Indicators
Programme Evaluation	
Wards in which the programme is delivered are more age-friendly	The majority of older people in GM engaged by the programme will identify their neighbourhood as age-friendly.
	The infrastructure conducive to an age-friendly neighbourhood has increased.
	The majority of older people in GM engaged by the programme will show an improvement in self-perception of how socially connected they are.
Older people in the designated wards have increased and improved social connections	In areas supported by the project, more older people will undertake activities of interest.
	In areas supported by the project, the capacity of local assets will increase, providing a greater range of choices for older people.
	The GM Economic Strategy in 2020 will make direct reference to the role of older people in economic prosperity.

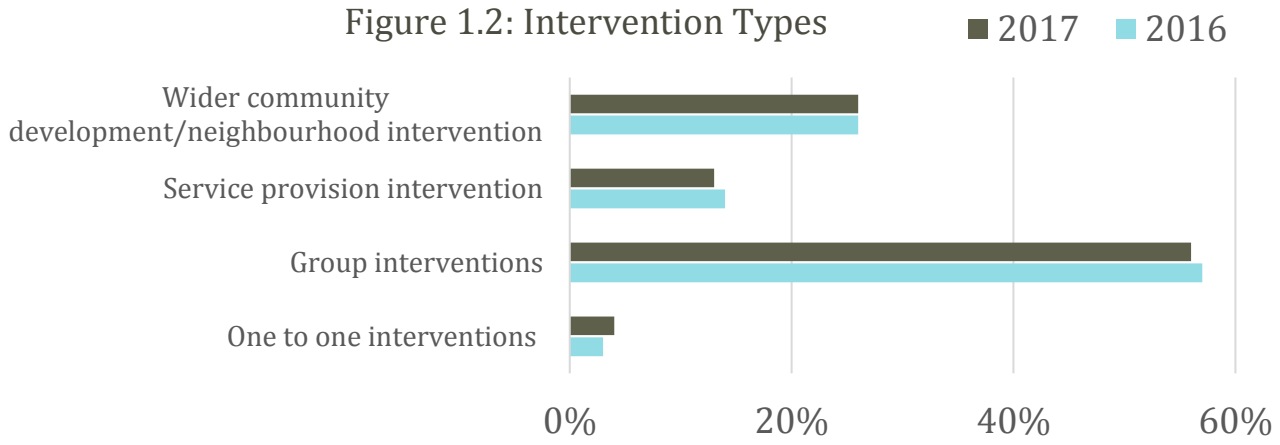
The majority of the report consists of a comparison across years, analysing changes in investment activity, demographic characteristics of those engaged, and variations in baseline measures of age-friendliness and social isolation in 2016 and 2017. Chapter 8 of the report then reports on preliminary analysis of follow-up questionnaire responses. These questionnaires are completed 6 months after programme entry (or at programme exit, if this occurred earlier), to capture any changes in perceptions and behaviours of respondents since their involvement in AfA.

Programme Activity and Engagement

By the end of December 2017, there had been 610 projects funded by AfA across the 8 districts. The majority of these commenced in 2017 (63%). The average spend per investment was £1258, with some variation in average by area (minimum £996, maximum £1742). There were a diverse range of investment themes, covering areas such as skills and employment, digital inclusion, physical activity and intergenerational activities. The most common theme was social action, which was identified as primary theme in 30% of all projects.

Project interventions are grouped into 4 main categories: one to one interventions; group interventions; service provision interventions; and wider community development/neighbourhood interventions. Whilst the number of each intervention type increased in 2017, the proportion of each intervention type remained very similar across the two years analysed. Group interventions remained the most common type of intervention, with over half of projects utilising this method. Although this method of intervention has been found to be effective at reducing social isolation, wider community development/neighbourhood interventions are considered to be more sustainable in the long-term. AfA will need to explore ways in which to support projects and activities that fall under these other intervention types to become sustainable post-AfA.

Figure 1.2: Intervention Types



By the end of December 2017, there were **almost 10,000 older people involved in the design and planning of AfA projects**. The numbers participating in the projects and events were even greater. With many older people undertaking activities of interest, and local assets being facilitated to provide a range of choices and activity types for older people, this provides indication of the programme working well towards its intended outcome that 'older people in the designated wards have increased and improved social connections'.

2017 saw a large increase in the numbers of older people engaging in the AfA evaluation: 151% increase in participants; 18% increase in volunteers; 504% increase in event attendees. Additionally, there were some changes in the characteristics of people who took part in the evaluation.

Changes in Engagement – Who's Involved?

After recommendations in the 2016 report for AfA to try to increase engagement with a more diverse range of individuals, 2017 saw some key changes in the characteristics of those taking part in the evaluation.

There was an increase in the relative number of men involved, from a quarter in 2016 to just under a third in 2017. This proportion reflects the national average for all Big Lottery Ageing Well programmes (Jan 2018)[1].

The range of distinct ethnicities engaged with increased from 12 to 29 in 2017, compared to the previous year.

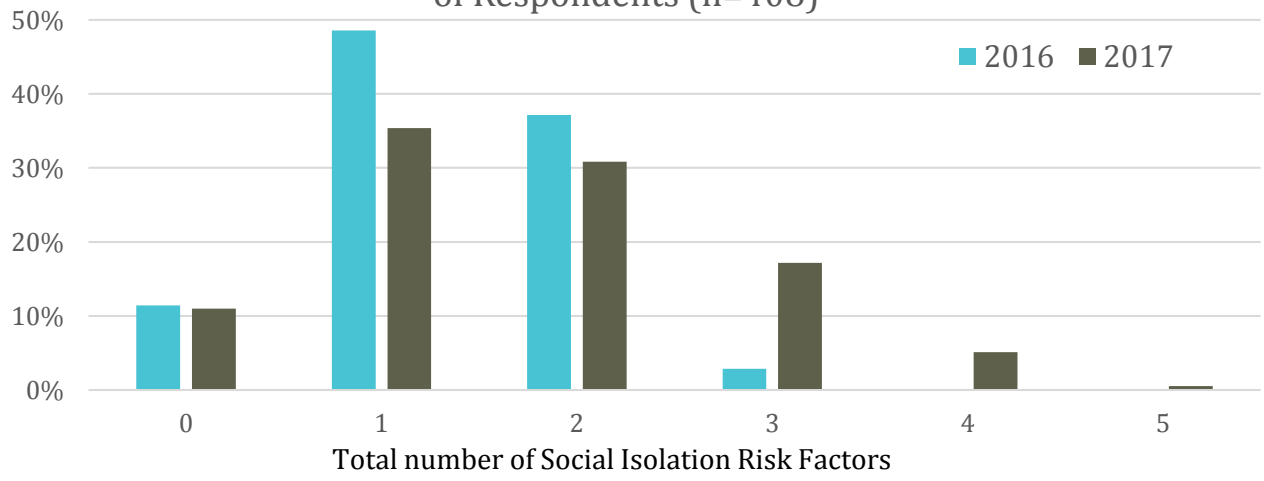
The proportion of the respondents identifying as gay, bisexual or lesbian also increased, from 3% in 2016 to 7% in 2017.

This increased representation from minority groups is positive as many of these characteristics have been found to be associated with an increased risk of social isolation.

Risk of Social Isolation

Analysis of characteristics associated with increased risk of social isolation found that the average number of social isolation risk factors experienced by respondents in 2017 was 30% higher than those experienced by respondents in 2016. Figure 1.3 shows that the percentage of respondents with 3+ risk factors at baseline was higher in 2017 than in 2016.

Figure 1.3: Distribution of Number of Social Isolation Risk Factors of Respondents (n=408)



This suggests that AfA engaged more respondents at risk of social isolation in 2017 than it did in the previous year (based on these measures). However, it is important to remember that those taking part in the evaluation are not necessarily representative of all individuals engaged with the AfA programme. Additionally, accumulation of risk factors is not a definitive way of measuring risk of social isolation; the weighting of these factors may be unequal, and some participants may have a low number of these particular risk factors but still be at high risk of social isolation. As such, this is a conservative and limited measure of risk of social isolation; the risk of social isolation for those involved in the programme may be higher.

Age-friendly Neighbourhoods

Overall, a large majority of participants (80%) stated that their neighbourhood was 'very' or 'somewhat' age-friendly, and this stayed relatively consistent across years. However, there were variations within the cohort. Most notably, respondents experiencing higher numbers of social isolation risk factors were more likely to state that their neighbourhoods were 'not at all' or 'not really' age-friendly than those experiencing fewer risk factors.

[1] Fulfilling Lives: Ageing Better National Evaluation, Analysis of Common Measurement Framework (CMF)data, Ecorys January 2018

18%

of those with **2 or fewer social isolation risk factors** felt their neighbourhood was '**not at all' or 'not really' age friendly**

29%

of those with **3+ social isolation risk factors** felt their neighbourhood was **'not at all' or 'not really' age-friendly**

Most notably, respondents who identified as providing support or as having a long standing health condition or disability were more likely to say that their neighbourhood was 'not really' or 'not at all' age-friendly than those who did not. Respondents with these characteristics were also less likely to believe that they could influence decisions in their local areas. This suggests that those who are more vulnerable and at risk of social isolation may see their neighbourhoods as less age-friendly, and may feel disempowered and unable to make a difference.

There was also some geographical variation in the extent to which participants thought their neighbourhoods were age-friendly, with the proportion of respondents stating that that their neighbourhood was 'not at all' or 'not really' age-friendly ranging from 17% to 30%, depending on the district. This highlights the appropriateness and the benefits of AfA taking a 'place-based' approach, rather than applying a 'one size fits all' model. By recognising area-level differences, AfA's approach allows for effective local solutions to emerge, which are tailored to the assets and challenges of the area the programme is being delivered in.

Civic Participation – Older People as Agents of Change

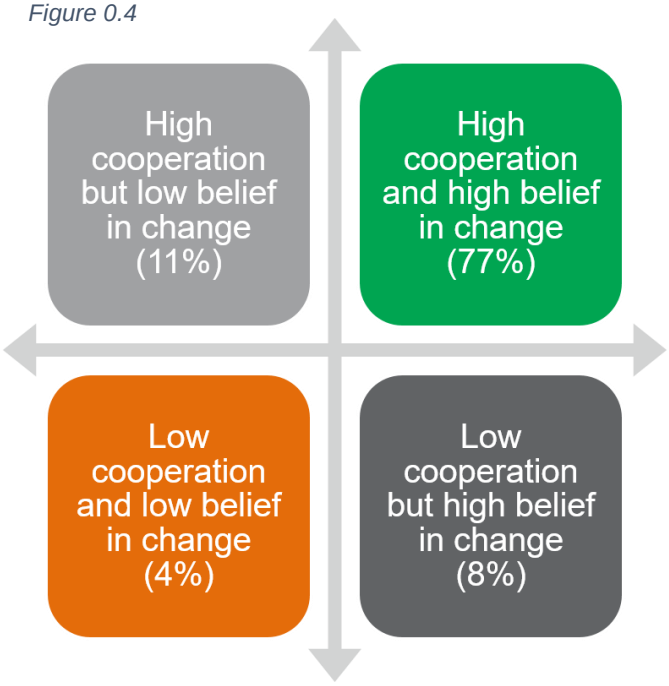
The AfA programme is built on the belief that older people are not simply passive consumers of services but are active agents, who can work together to drive their neighbourhoods to become more age-friendly. AfA puts older people at the heart of designing the places they live, facilitating the development of existing assets within communities with the view that a series of small changes can bring about large-scale success.

The value of this approach is highlighted by the finding that **respondents who feel that their voices are being heard and can influence decisions in their local area generally feel that their neighbourhoods are more age-friendly than those who do not**. Analysis found indication of a positive correlation between how age-friendly an individual thinks their neighbourhood is, and the extent to which that individual believes that they can influence decisions in their local area.

In comparison, analysis uncovered no such relationship between perception of age-friendliness and a second measure of civic participation: the extent to which an individual believes that people can change things in their local area if they work together. In fact, **the large majority of respondents tended to agree or definitely agreed that people can change things if they work together, regardless of whether they thought their neighbourhood was currently age-friendly**. This wide-spread belief is a huge asset for AfA, as older people's engagement with not only the activities of the programme, but also the core values and approach of the programme, is fundamental to the success of AfA. This finding provides support for a key principle of the AfA programme; the idea that older people can come together and, with investment facilitating this action, make sustainable and positive changes in their local areas.

Whilst individuals may feel that change can be made by working together, this does not necessarily mean that they would be willing to work together with others to achieve this change themselves. To explore this, extent of respondent agreement with the statements 'I would be willing to work with others' and 'People can change things in my neighbourhood if they work together' were analysed, revealing a positive relationship between the two statements. This suggests that, generally, if a respondent answered positively to one question, they were also likely to answer positively to the other. Further analysis uncovered four key categories of respondents (shown in figure 1.4)

Figure 0.4



The large majority of respondents had both high cooperation and high belief in change, i.e. they tended to agree or definitely agreed with both statements. This is encouraging for AfA, as this type of person is likely to respond well to an asset-based approach and increase the potential for sustainability of action after the programme ends. These people have the drive to make a change, and will likely benefit from initial support and facilitation that AfA can provide to help them achieve this.

However, 23% of respondents did not fall into this category. 11% stated that they would be willing to work with others but didn't feel that people could change things in their neighbourhood by working together. This group may need the programme to empower and support them to see the difference they can make. For activity to be sustained after programme end, it will be crucial for AfA to demonstrate evidence of change, both locally and strategically across GM, to this group to show that their input is worthwhile.

8% of respondents agreed that people can change things if they work together, but would not be willing to work with others to achieve this themselves. Additionally, a further 4% disagreed with both statements: they would not be willing to work with others and didn't believe that people could create change in their neighbourhood by working together. There may be a variety of reasons for these attitudes, such as disinterest, disempowerment, or feeling that they are unable to contribute. Notably, respondents in these two groups were more likely to have a long-standing health condition or disability than those in the majority group, however the sample sizes analysed were very small.

AfA acknowledges that an asset-based approach can run the risk of contributing to inequalities by inadvertently excluding those who are most marginalised. The high level of engagement with respondents who are willing to work with others and believe that people can change things if they work together reflects the type of individual that is often attracted to, and at the heart of, asset-based approaches. However, with almost a quarter of respondents having a different attitude to working together, this provides some indication that AfA's approach is not only engaging the 'usual suspects'. The programme would benefit from increased understanding of participants with these differing views, and AfA should continue building and identifying inclusive practices, to ensure that projects are not excluding those who are more marginalised and potentially disempowered.

Social Isolation

AfA recognises that social isolation is a multi-dimensional concept, and, as such, the evaluation attempts to measure this through a series of proxies made up of subjective and objective measures.

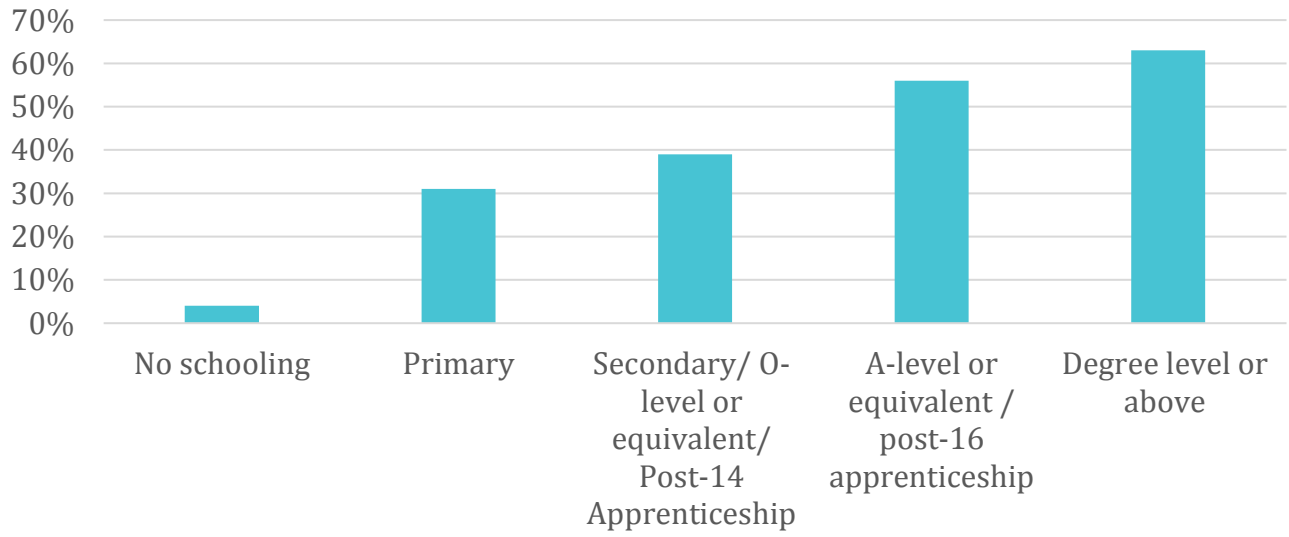
On average, levels of neighbourhood attachment were positive, with the majority of respondents agreeing or strongly agreeing with statements such as 'I regularly stop and talk to people in my neighbourhood', and 'I feel like I belong in this neighbourhood'. However, respondents were slightly less likely to respond positively to the more action-oriented statements relating to relationships, such as 'I borrow things and exchange favours with my neighbours' and 'If I needed advice about something I could go to someone in my neighbourhood'. These action-oriented statements could indicate the presence of stronger social ties that may help to prevent or reduce social isolation, and it is these that AfA should seek to improve.

Analysis found there to be huge variation in the use of technology in this cohort. Whilst a wide range of different social media platforms were used, a third of respondents still used no technology at all. Accessible communication is a key element of reducing social isolation and creating age-friendly communities. This highlights that a 'one size fits all' approach will likely be ineffective for engaging with such a diverse population, and care must be taken to identify the most appropriate means of communication and promotion for the intended audience for projects.

Volunteering is associated with lower social isolation, so understanding whether respondents already volunteer provides some insight into how engaged respondents are in their local areas without AfA. Overall, 41% of respondents were involved in volunteering already.

However, there was disparity in the characteristics of who volunteered. In particular, as formal education level increased, so did the likelihood of a respondent stating that they volunteered (see figure 1.5). Additionally, those with higher levels of formal education were also more likely to state a desire to volunteer if they were not currently volunteering, than those with lower levels of formal education.

Figure 1.5: Percentage Currently Volunteering (n=662)



Although this analysis does not control for other factors, these trends may indicate a potential under-utilisation of older people with lower levels of formal education in volunteering roles. Additionally, these trends may reflect identity; whether an individual recognises their activities as volunteering or whether they wish to identify with the label 'volunteer'. LDLs should to take this into consideration when defining and recruiting to their volunteer roles.

6 Months On – Changes since Involvement with the Programme

The respondent 'journey' is captured through follow up questionnaires at 6 and 12 months, which allow us to see whether perceptions and stated behaviours have changed since participating in the programme. Respondent numbers are relatively small at this stage in the programme (n≈100), but can give a preliminary indication of change. This can give us some potential indication of the impact of the programme, however it is not known what proportion of change can be attributed to the programme, as other factors are also likely to have an impact on responses. As such, this analysis should be used as starting point for further exploration and discussion, rather than as an end result.

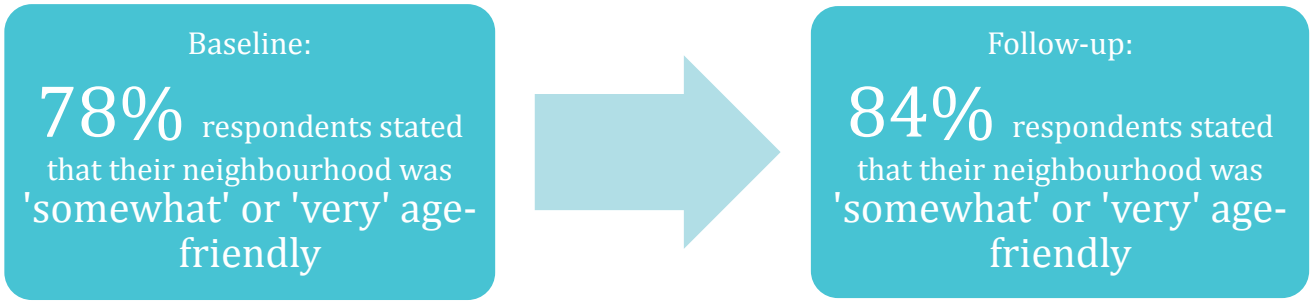
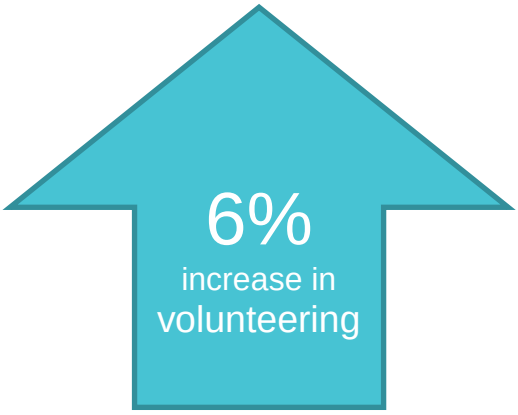


Figure 0.6

Overall, there was an increase in the proportion of respondents perceiving their neighbourhood to be 'somewhat' or 'very' age-friendly, increasing by 6 percentage points since baseline. This provides some indication of AfA meeting Outcome 1, that 'Wards in which the programme is delivered are more age-friendly'.



There was also an overall increase in the percentage of respondents volunteering.

The second programme outcome for AfA is: 'Older people in the designated wards have increased and improved social connections'. Overall, analysis found that changes in social isolation since involvement in AfA varied greatly. Whilst there has been an increase in volunteering, substantial variance in the change in neighbourhood attachment mean that there is no clear trend of improvement in self-perception of social isolation.

Figure 0.7

Overall, there is considerable variation in the data for all variables of interest which cannot be thoroughly explored with the existing sample numbers. These variations may be explored further when more data becomes available, and could benefit from further qualitative analysis to explore the nuances within the variation. It is hoped that future analysis will also be able to include responses from 12-month follow up questionnaires, to identify potential changes in effects over time.

Finally, these findings are not intended to be representative of all those taking part in the evaluation, or the programme as a whole. Most notably, respondents who may be considered more at risk of social isolation were over-represented in the follow-up data; people with longstanding health conditions or disabilities; people with caring responsibilities; and people who are widowed.

Conclusions and Recommendations

- Huge increases in activities and engagement with older people is evidence of the programme working well towards its intended outcome that, in areas supported by the programme, more older people will undertake activities of interest and the capacity of local assets will increase. However, with only a quarter of projects being community development/neighbourhood interventions (considered to be more sustainable than other intervention types) AfA will need to ensure strategies are in place for sustainability of these projects after the programme ends. Additionally, AfA will need to think carefully about the nature of projects launched in the programme's final year, and how sustainable these are.

- Changes in the characteristics of respondents indicates that AfA has acted upon recommendations to engage a more diverse range of respondents in the evaluation, and has been successful in engaging with more people at risk of social isolation.

- The presence of geographical variations provides support for AfA's place-based approach, rather than a 'one size fits all' model.

- Although perceptions of age-friendliness are generally high, variation within the cohort suggests that there are some groups who are less likely to perceive their neighbourhoods as age-friendly, such as those with caring responsibilities or long-term health conditions or disabilities. The programme would benefit from further research into the experiences of these individuals, to explore whether this cohort have specific issues related to age-friendliness which may not currently be being tackled by the programme.

- Analysis of attitudes towards working together and age-friendliness found that the majority of respondents are willing to work together and believe people can change things if they work together, regardless of how age-friendly their neighbourhood currently is. This is encouraging for the programme, as older people's engagement is fundamental to the success of Ambition for Ageing, and provides support for AfA's asset-based approach. However, around a quarter of respondents have different attitudes and beliefs about working together. An asset-based approach can risk excluding those who are most marginalised and disempowered. AfA have recognised the risks of asset-based approaches contributing to inequalities, and LDLs will need to ensure they are implementing strategies to try to prevent this. AfA would benefit from further research into those partaking in the progamme who have different attitudes about working together and driving change, to explore why they chose to get involved, and how the programme can best engage and accommodate people with different motivations.

- Preliminary analysis of follow up questionnaires provides indication of increases in age-friendliness and volunteering. However, there is considerable variation in this data and relatively low sample numbers. It is recommended that LDLs renew efforts and strategies to collect follow up data, including 12 month follow ups. An increase in data would allow exploration of not simply whether the programme has been successful, but who it has been successful for, and whether changes have had a longer-lasting impact.

Section 1: Introduction

Utilising quantitative data collected through quarterly monitoring, this report provides analysis of activity and engagement in Ambition for Ageing across the first two years of the programme. The majority of the analysis (chapters 3 to 6) consists of a comparison across years, analysing changes in activity and engagement from 2016 to 2017. These chapters cover changes in investment activity, demographic characteristics of those engaged, and variations in baseline measures of age-friendliness and social isolation. Following this, Chapter 7 provides initial analysis of changes in participants' perceptions and behaviours since their involvement with the project, conducting preliminary analysis of data collected though 6-month follow-up surveys. Final recommendations and concluding remarks can be found in Chapter 8.

Background

Ambition for Ageing (AfA) is a £10.2 million programme in Greater Manchester (GM) aimed at creating more age-friendly places and empowering people to live fulfilling lives as they age.

It is funded by the Big Lottery Fund's Ageing Better programme, which aims to reduce older people's social isolation.

Led by GMCVO, the 5 year programme is delivered by a cross-sector partnership with Local Delivery Leads (LDLs) leading on the work in 25 neighbourhoods (wards) across 8 local authorities in Greater Manchester:[2]

- Bolton: Crompton, Halliwell and Tonge with the Haulgh. The LDL in Bolton is a partnership between Bolton CVS, Age UK Bolton and Bolton at Home.
- Bury: Moorside, Radcliffe North and St Mary's. The LDL in Bury is Groundwork in Bury, Bolton and Oldham.
- Manchester: Burnage, Hulme & Moss Side, Moston and Miles Platting. The LDL in Manchester is Manchester School of Architecture at Manchester Metropolitan University (MMU), in partnership with Southway Housing Trust.
- Oldham: Alexandra, Crompton and Failsworth West. The LDL in Oldham is a partnership between Age UK Oldham and Action Together (formerly VAO).
- Rochdale: Central Rochdale, Firgrove & Smallbridge and West Middleton. The LDL in Rochdale is a partnership led by Kashmir Youth Project (KYP) with CVS Rochdale, Bangladesh Association & Community Project, Demesne Community Centre and Meadowfields Community Centre.
- Salford: Broughton, Langworthy and Weaste & Seedley. The LDL in Salford is Age UK Salford in partnership with Salford CVS and Inspiring Communities Together.
- Tameside: Ashton Waterloo, Denton South and Hyde Newton. The LDL in Tameside is a partnership between Age UK Tameside and Action Together (formerly CVAT).
- Wigan: Atherton, Leigh West and Pemberton. The LDL in Wigan is Age UK Wigan Borough.

These LDLs are responsible for funding a series of small investments in the neighbourhoods listed. These investments are directed and led by older people, and each can have an upper value of £2,000.

For more information on the AfA programme, including contact details for LDLs in your area, please either visit the AfA website: http://www.ambitionforageing.org.uk/ or get in touch with the AfA team at GMCVO at ambition@gmcvo.org.uk or 0161 277 1000.

[2] The local authorities of Stockport and Trafford do not meet the Big Lottery Fund's requirements for funding

AfA uses the term ‘older people’ to refer to people aged 50 and above, recognising that, due to inequalities, individuals experience age-related challenges at very different points in their lives. AfA’s belief is that a series of small changes within communities can bring large scale success in a practical and sustainable way that will ultimately help to reduce social isolation. AfA takes an asset-based approach to build on existing resources in local areas, supporting communities to be more connected and for there to be more opportunities and activities for older people in the places they live.

The following chapter outlines data collection methodologies and provides context to the data presented throughout the report.

Section 2: Methodology

Evaluation Approach and Outcomes

GMCA is the evaluator for the Ambition for Ageing programme in GM.

The evaluation takes an approach that looks at the programme as a whole, rather than focusing on the individual projects funded through LDL panels. This is because the principles of proportionality[3] mean that it would require disproportionate resources to conduct in-depth evaluation on each individual funded project.

AfA has a number of core outcomes against which it aims to show progress, shown in figure 2.1 below. The evaluation is split into three components: programme evaluation, strategic evaluation, and process evaluation.

This focus of this report is on data collection for the 'programme evaluation' component of the evaluation.

Figure 2.1: Ambition for Ageing Outcomes

Outcome	Indicators
Programme Evaluation	
Wards in which the programme is delivered are more age-friendly	The majority of older people in GM engaged by the programme will identify their neighbourhood as age friendly.
	The infrastructure conducive to an age-friendly neighbourhood has increased.
	The majority of older people in GM engaged by the programme will show an improvement in self-perception of how socially connected they are.
Older people in the designated wards have increased and improved social connections	In areas supported by the project, more older people will undertake activities of interest.
	In areas supported by the project, the capacity of local assets will increase, providing a greater range of choices for older people.
Strategic Evaluation	
AfA has influenced delivery of programmes affecting older people in a positive way.	Projects have sustained activity beyond the life of the project.
	Projects have received investment to grow in scale following inception.
	Programmes external to AfA have been influenced by AfA
AfA has influenced strategy in GM relating to older people, social isolation and age-friendly neighbourhoods.	A strong older people's network will be sustained beyond the length of the project.
	The GM Economic Strategy in 2020 will make direct reference to the role of older people in economic prosperity.

[3] In evaluation, proportionality refers to the principle that the amount of evaluation activity should be relevant and not exceed what is justified in relation to the size of the programme being delivered. In this case, as projects are very small, only a very small amount of evaluation activity should take place for each individual project. However, the overall programme is large, so this allows for a large amount of overall activity.

Data Collection

LDLs are required to collect key data from people engaging with Ambition for Ageing to demonstrate progress towards the outcomes. They submit this data to a central database managed by GMCVO and GMCA every quarter (April, July, October and January).

5 LDLs (Bolton, Manchester, Oldham, Tameside and Wigan) were appointed in November 2015, and started data collection in January 2016. The remaining three LDLs were appointed in April 2016 and started data collection at this point.

This is report is made up of quantitative data, utilising data collected on the following:

a) Project Information (investments and non-funded activity recorded on the database, e.g. events)

b) Volunteer Information: volunteers complete questionnaires with a range of key data at baseline, 6 month follow up and 12 month follow up (to measure change, i.e. progress against outcomes).

c) Participant Information: participants complete questionnaires with a range of key data at baseline, 6 month follow up and 12 month follow up (to measure change, i.e. progress against outcomes).

d) Events/Activity feedback: community level feedback/data on a small number of key questions and demographic data.[4]

Full copies of the questionnaires are available on request.

Due to relatively low numbers of follow ups collected within the timeframe analysed, the majority of this report focuses on a comparison of baseline data of respondents in 2016 compared to 2017. The analysis of follow-up data is intended to give an indication of change following involvement in the progamme, but is unable to give a representative estimation of the true impact of the programme.

AfA follows a 'test and learn' approach, which is embodied in all aspects of the programme, including the evaluation process. Due to improvements in data cleansing and modifications in data operationalisation, numbers in this report may vary from those in the original 2016 Baseline report. As such, all 2016 analysis has been re-run using the same techniques as in the 2017 analysis, to ensure a consistent and meaningful comparison.

The data presented in this report is designed to give an indication of activities and engagement in the project. The design of the evaluation means that data collected is not necessarily representative of everyone who has taken part in the AfA programme. Additionally, other types of data are also collected by the LDLs, such as case studies and community audits, which provide a richer, more in-depth understanding of projects within the programme. Although these fall out of the scope of this report, it is the intention that this data will inform future evaluation work of the programme.

Sample sizes

Data sample sizes vary by area, and the data presented throughout the report is not equally representative of all AfA areas. The data within this report is accurate at March 2018.

By the end of 2017, there were a total of 2738 demographics forms completed, made up of 1,141 (41%) participant forms, 294 (11%) volunteer forms, and 1,303 (48%) event forms.

This data was then filtered to remove duplicates and to exclude participants under the age of 50 in the baseline questionnaires. The presumption was made that respondents were over the age of 50, unless they explicitly stated otherwise.

[4] The two forms are issued separately at events.

By filtering for age, 12 participants were removed from the 2016 data, and 121 were excluded from the 2017 data analysis, leaving a total demographic form sample of **2,418**. Due to event feedback forms having been collected separately to event attendee demographic information, this data was unable to be filtered by age.

The final numbers used for analysis broken down by area can be found in appendix 1.A. This portrays the maximum total sample size, but sample sizes for each question vary, as individual respondents may not have answered every question. Sample sizes for individual questions are provided throughout the report where applicable.

Please note, sample size should not necessarily be used as an indication of performance, as each LDL is using a different model and approach which are not directly comparable. For example, Manchester's model involves the use of participant questionnaires in all instances, and as such other questionnaire sample sizes are zero.

It is likely that there are some duplicates or slight errors within the data.[5] However, these are estimated to be at low levels and not likely to affect the percentages as indicative of overall trends provided throughout the report.

[5] Arising from both user error and technical problems

Section 3: Projects (Investments)

Projects

In 2017 there were a total of 353 investments (projects with costs associated) across all 8 areas, and an additional 30 projects with no allocated costs. With 156 more projects in 2017 than 2016, there was a 103% increase in the number of investments compared to the previous year.

2017 saw a £358,316 increase in investment, from £207,132 in 2016 to £565,448 by the end of 2017[6]. This represents a 173% increase in amount invested. The table below (figure 3.1) shows the breakdown of this by area and year.

Figure 3.1: Projects by Area 2016 and 2017

	Number of projects 2016	Number of projects 2017	Amount invested 2016	Amount invested 2017
Bolton	48	48	£36,237	£59,367
Bury	10	76	£3,743	£124,511
Manchester	28	42	£44,008	£77,925
Oldham	46	53	£40,118	£59,122
Rochdale	8	34	£5,111	£49,945
Salford	11	35	£2,443	£51,472
Tameside	32	56	£28,210	£63,774
Wigan	44	39	£47,261	£79,331
Total	**227**	**383**	**£207,132**	**£565,448**

The table shows that Bury had the largest increase in projects and amount invested in 2017. Wigan had fewer projects in 2017 than 2016, but the amount invested into these projects was greater than in 2016.

Figure 3.2 (overleaf) shows the overall number of projects and their associated costs for 2016 and 2017 combined:

[6] Investment date is based on the project start date. Where this is unavailable, the date used is the date it was added to the database.

Figure 3.2 Projects and Costs 2016 & 2017				
Area	**Projects (n)**	**Projects %**	**Cost £**	**Cost %**
Bolton	96	15.7%	95,604	12.4%
Bury	86	14.1%	128,254	16.6%
Manchester	70	11.5%	121,933	15.8%
Oldham	99	16.2%	99,241	12.8%
Rochdale	42	6.9%	55,057	7.1%
Salford	46	7.5%	53,915	7.0%
Tameside	88	14.4%	91,984	11.9%
Wigan	83	13.6%	126,592	16.4%
Grand Total	**610**	**100%**	**772,580**	**100%**

By the end of 2017, the overall average spend per investment was £1258.27. The average spend per investment is broken down by area in figure 3.3 below:

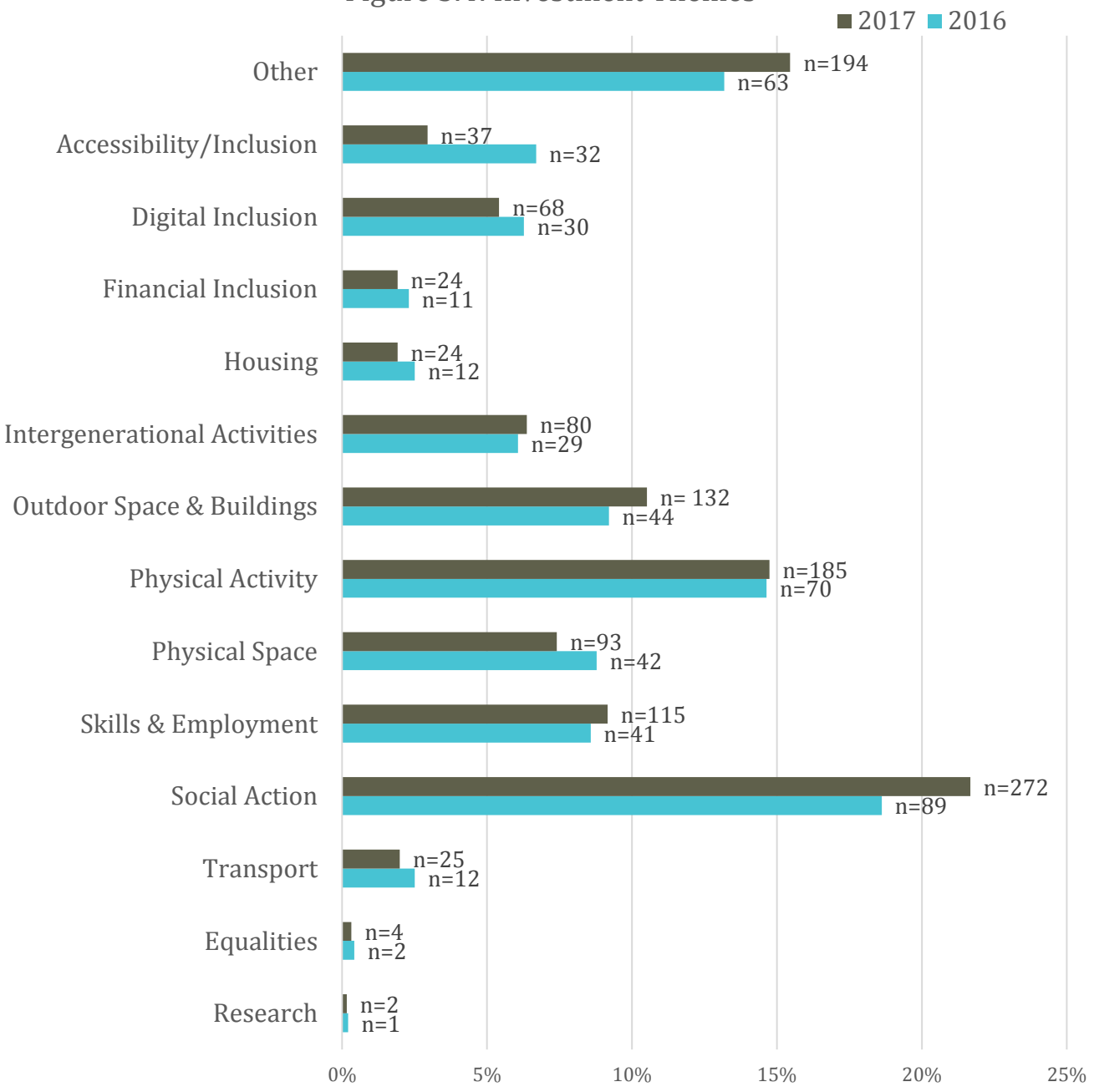
Figure 3.3: Average Investment Spend Per Area

Investment Themes and Intervention Types

Projects fall under the themes represented in figure 3.4, below. Note that more than one theme per project investment can be allocated, so the total number of themes will add up to more than the total number of projects.

As in 2016, social action was still the most common project theme in 2017, and the least common were research and equalities. However, some aspects of equalities are captured under other themes, such as accessibility and inclusion. The graph shows that, although overall numbers have increased, the proportion of each theme has stayed very similar to the previous year.

Figure 3.4: Investment Themes



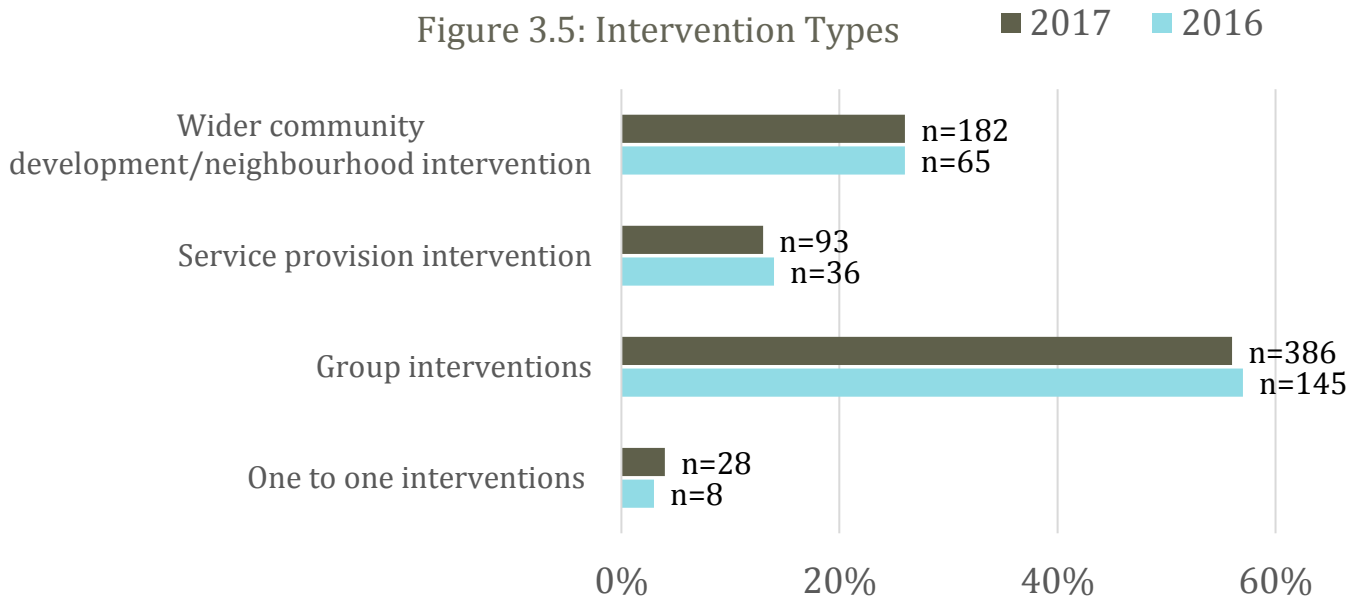
MICRA identify that there are commonly four types of intervention used to tackle social isolation.[7] These are:

- One-to-one interventions: these focus on targeting individuals and working with them on a one-to-one basis, such as home visits.
- Group interventions: interventions or programmes that bring older people together in groups to engage in activities and develop relationships.
- Service provision interventions: interventions that link older people to statutory services or provide a statutory service with the express aim of reducing social isolation.

[7] Full definitions available in Social Isolation Among Older People in Urban Areas, Tine Buffel, Samuéle Rémilliard-Boillard and Chris Phillipson, 2015.

- Wider community development/neighbourhood interventions: efforts that focus on the wider community and adapting this to become more age-friendly/removing barriers to social participation.

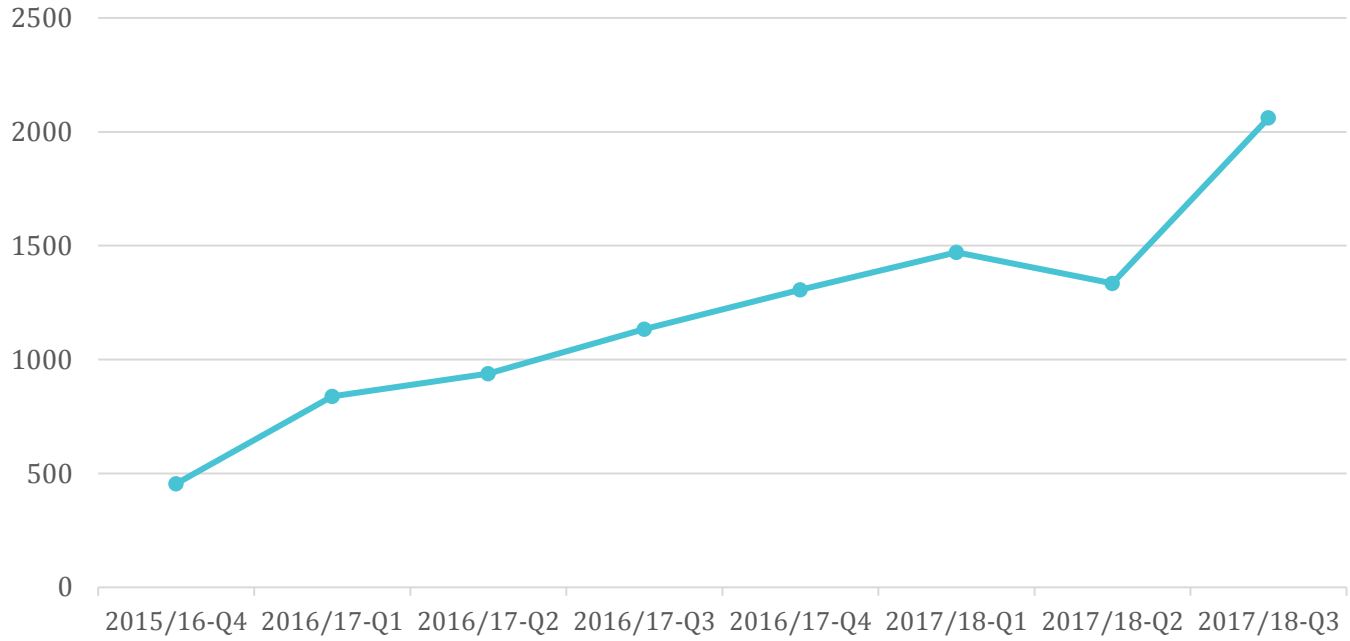
Figure 3.5 below shows that, although the numbers of each intervention type have increased in 2017, the proportion of each intervention type has remained very similar to 2016. Group intervention has remained the most common type of intervention, with over half of projects utilising this intervention method.



The high number of group interventions is promising for what AfA is trying to achieve, as MICRA has found group interventions to be effective at reducing isolation. However, wider community development/neighbourhood interventions are considered to be more sustainable in the long-term, so the programme may want to look at increasing use of this method in order for projects to continue after the AfA programme finishes.

In total, there were **9539 older people** involved in the planning of these projects. The number of older people involved in 2017 was almost double that in 2016, with 3367 involved in 2016 and 6172 involved in the 2017. Figure 3.6 below shows the number of older people involved has generally increased each quarter. This reflects the trend for a general increase in the number of projects per quarter over time.

Figure 3.6: Number of older people involved in project design and delivery by quarter



Section 4: Characteristics

Characteristics of the sample

This section provides an overview of the characteristics of people involved in Ambition for Ageing, comparing those engaged in 2016 with those engaged in 2017 to identify notable differences. It gives a breakdown of those engaging with AfA as Participants, Volunteers and Event Attendees based on demographic data of baseline reports[8].

Where available, GM benchmarks are provided to indicate how representative the sample is of the general population. Note that these comparators usually represent all ages, rather than only amongst people over 50, so a slight difference may be expected. In addition, the GM benchmarks include data for Stockport and Trafford, where AfA does not currently operate. Benchmarks are indicative of wider trends only.

The final numbers used for analysis are broken down by area in 1.B.

Overall, while the number of participants increased by 151% in 2017, numbers of volunteers engaged remained similar, with a small increase of 18%. The largest increase was in event attendees, with an increase of 504%. However, It important to note that those attending events may or may not also be directly involved in the projects, so their level of engagement with AfA is unknown. As sample sizes vary by area, this analysis should not been seen as equally representative of all areas involved. Bury, Manchester, Oldham and Tameside residents are currently over-represented compared to the other four areas.

Age and Gender

In total, the average age of those included in the analysis was 69. The average age of those commencing involvement in the project in 2016 was 71, and the average age of those commencing involvement in the project in 2017 was 68. This suggests a slight shift towards engaging with younger older people. Analysis of the distribution of the age ranges engaged supports this, indicating a slight skew towards engaging with younger participants in 2017 (see appendix 1.C for 2016 and 2017 histograms). However, this sample is not necessarily representative of everyone who took part in the project, and not all respondents reported their age. A total of 324 respondents (13%) were removed from the age analysis due to missing data or a preference not to state their age.

Figure 4.1, below, shows the distribution of age by gender. It shows that women are over-represented in every age category, with a trend for increased over-representation as age increases.

Figure 4.2 shows the gender distribution by year. In 2016, the sample was approximately three quarters (74%) women and 25% men. In 2017 the percentage of women reduced to just over two thirds (68%) women and the percentage of men increased to 32%. This suggests that more men were engaging with the programme than in the previous year (although this is not necessarily representative of all engaging with AfA). Although this is still not representative of the GM population (50% ONS, 2015[9]), it is an improvement on the previous year and suggests

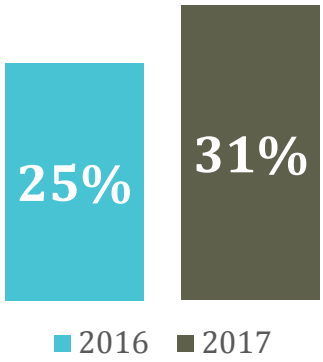
[8] Note that this section only reports on data received. It is not representative of all areas or all individuals, and should not be considered as such. It is representative of those who have answered questionnaires via AfA and those on whom we report in the next sections. As a result, this chapter is intended to frame the rest of the report and should not be considered as distinct from this.

[9] Office for National Statistics, Greater Manchester Labour Market Profile, downloaded from NOMIS: https://www.nomisweb.co.uk/reports/lmp/lep/1925185547/report.aspx

the programme is engaging better with men than they were before. These figures also reflect the national average percentage of women participating in all Ageing Better programmes[10].

Figure 4.1 Age and Gender of al Respondents (2016 & 2017)		
Age (years)	**Man**	**Woman**
50-59 (n=328)	40%	60%
60-69 (n=515)	35%	65%
70-79 (n=502)	28%	72%
80+ (n=248)	24%	76%
Grand Total	**32%**	**68%**

Figure 4.2: Percentage of Men 2016 and 2017



Of those who reported their gender, 0.9% of 2017 respondents stated that their gender was not the same as assigned at birth, compared to 2% in 2016.

Time living in Ward

The length of time that respondents have lived in their wards have stayed similar across years. The average length of time was 30 years for respondents in 2017, and 31 years in 2016. A table comparison of this can be found in appendix 1.D.

Education

As in 2016, a large majority of the respondents in 2017 had secondary education as their highest form of education. There were slightly fewer 2017 respondents with primary education as their highest form of education, and slightly more 2017 respondents with degrees and post graduate qualifications, which may suggest a slight increase in the overall level of education of the respondents. However, due to sample numbers and proportions of missing data each year (26% missing or prefer not to say), this is not necessarily representative of all respondents. What can be seen is that there is a range of education levels engaging. A direct comparison cannot be made with ONS data due to differences in measurement, so we cannot know whether these proportions are usual for this population.

Figure 4.3 Education Level of Respondents		
Education Level	**2016 (n=375)**	**2017 (n=1415)**
No schooling	4.8%	5%
Primary	17.1%	13.9%
Secondary/ O-level or equivalent/ Post-14 Apprenticeship	44.3%	41.3%
A-level or equivalent / post-16 apprenticeship	12.8%	14.2%
Degree level or equivalent	15.5%	18.6%
Postgraduate degree level or equivalent	5.6%	7.1%
Total	**100%**	**100.00%**

[10] Fulfilling Lives: Ageing Better National Evaluation, Analysis of Common Measurement Framework (CMF)data, Ecorys January 2018

Employment Status
There was a slight decrease in proportion of retirees engaged in the second year, from 78% in 2016 to 75% in 2017. There was also a slight increase in the number of participants employed full time, and a decrease in the number employed part time, however these sample size numbers are small (see appendix 1.E for full table). In both years, approximately 10% of the sample stated that they were unemployed. After controlling for age, the age-adjusted unemployment rate was 8.4% in 2016 and 8.1% in 2017. This remains higher than the ONS average unemployment rate for 16-64 year olds in Greater Manchester, which was 6.2% in 2016.

Ethnicity
The ethnicity distribution of the sample remained similar in both years, with the overwhelming majority of participants identifying themselves as White/White British (86% in 2017). Overall, the profile is very similar to ONS averages for Greater Manchester, displayed in the final column of figure 4.4 below.

Figure 4.4 Ethnicity of Respondents			
Ethnicity	**2016 (n = 413)**	**2017 (n = 1748)**	**GM % (2011)**
Asian/Asian British	11.8%	11.4%	10%
Black/Black British	2.9%	2.2%	3%
White/White British	85.3%	85.8%	84%
Mixed	0.0%	0.1%	2%
Other	0.0%	0.5%	1%
Total	100%	100%	100%

Whilst 2017 proportions have remained similar to 2016 overall, the variety of ethnicities within these categories increased, with 12 distinct ethnicities recorded in 2016 and 29 distinct ethnicities recorded in 2017. This suggests the programme is engaging with a more diverse range of ethnicities than in 2016, and may be running more projects that appeal to ethnic minorities than before.

Religion
As in 2016, the majority of respondents in 2017 identified themselves as Christian. However, the percentage identifying as Christian decreased from 77% in 2016 to 70% in 2017. The percentage of respondents identifying as Muslim also reduced, from 12% in 2016 to 8% in 2017.

The proportion identifying as having ‘no religion’ doubled from 6% in 2016 to 13% in 2017. However, this is still considerably lower than the general Greater Manchester population of 21% (ONS, 2011). The percentage of Buddhists, Hindus and Jews also increased slightly, however these represent small sample numbers.

Overall, the profile of respondents has moved closer to that of the general GM population (ONS, 2011).

Figure 4.5 Religion of Respondents			
Religion	**2016 (n = 468)**	**2017 (n = 1745)**	**GM % (2011)**
Buddhist	0.2%	0.6%	0.4%
Christian	77%	70%	62%
Hindu	0.6%	1%	1%
Jewish	0%	2%	1%
Muslim	12%	8%	9%
Sikh	0.2%	0.1%	0.2%
No religion	6%	13%	21%
Other	4%	5%	0.3%
Grand Total	**100%**	**100%**	**100%**

Sexuality

The percentage of respondents identifying as heterosexual decreased, from 97% in 2016 to 93% in 2017. The percentage of respondents identifying as gay, bisexual or lesbian increased from 3% to 7% (see table in appendix 1.F).

Sexual Orientation is not systematically recorded in most official data sources. As a result, accurate estimates of the number of people not identifying as heterosexual in the local and national population vary. The most reliable estimates indicate that those identifying as Lesbian, Gay or Bisexual represent between 5-7% of the general population, and 1% of those aged 50 and over in the UK nationally[11]. However, we do not have a definitive Greater Manchester benchmark with which to compare. Additionally, 22% of the sample did not state their sexuality in 2017, with 60% of these specifically opting to 'prefer not say'.

Marital Status

There was an 7% point increase in the proportion of respondents who stated that they are cohabiting, married, or civil partnered, from 39% in 2016 to 46% in 2017. There was a 15% reduction in the proportion that stated they are a widow/widower, from 33% in 2016 to 28% in 2017. This is still higher than the general Greater Manchester population (7%), but may be expected due to the age demographic of those involved in the programme. The proportion that stated that they were single remained similar across the years, as did the proportion who stated that they were divorced (see appendix 1.G for full table).

However, due to some respondents selecting more than one option[12], care should be taken in interpreting these findings.

Ilness/Disability

The proportion of respondents who stated that they are experiencing a longstanding illness or disability stayed relatively similar; 50% in 2016 and 48% in 2017 (see appendix 1.H). There is no direct Greater Manchester comparison data available, however figures indicate that 19% of people in Greater Manchester have a disability, and 6% of people identify as being in bad or very

[11] https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2015

[12] There was a lot of cross-coding in this question, with participants selecting multiple responses. These respnses were removed before analysis due to an inability to identify the respondent's most recent marital status. As such, the response rate for the question is lower, and is not necessarily representative of all respondents.

bad health (ONS, 2011). This suggests that levels of long-standing poor health and disability are higher in the AfA cohort. This is not unexpected considering the older demographic of the cohort.

Care and Support

As in 2016, approximately 18% of respondents in 2017 answered 'yes' to the question: 'Is there anyone sick, disabled, or needs support whom you look after or provide support to?' (see appendix 1.I).

Systematic benchmarking data on those acting as carers for someone else is not available. However, 2% of benefit claimants (of working age) were claiming a carer's allowance in May 2016 (ONS). The Carer's Trust estimates that about 10% of the population are carers (Carers Trust, 2017). This suggests that those engaging with AfA have higher levels of caring responsibilities than the general population[13].

Analysis of these characteristics helps to construct a picture of who is engaging with AfA and and who is providing data. Additionally, we can begin to explore to what extent AfA has engaged with socially isolated individuals, as many of these characteristics are closely linked to being at risk of social isolation.

Social Isolation Risk Factors

Research indicates that an individual is at a higher risk of experiencing social isolation if they have certain characteristics (Buffel et. al., 2015). These include:

- Being older;
- Being male;
- Being widowed or separated from a partner;
- Living alone;
- Having a minority protected characteristic (e.g. ethnicity, religion, sexual orientation, gender);
- Under- or un-employment in mid-life;
- Having poor health; and
- Caring for others.

These risk factors are not mutually exclusive, and risk is potentially increased as the number of factors any one individual has increases.

An analysis was conducted to determine how 'at risk' respondents were (across all data sets), based on the number of risk factors individuals possess.

Of the characteristics above, the following were classified as risk factors:

- Being male;
- Identifying a minority ethnicity or religion[14];
- Identifying a minority sexual orientation or gender status;
- Being single or widowed;
- Having a long-standing physical or mental illness or disability; and
- Being a carer.

[13] Please note that this data is only collected from participants and volunteers, not of event attendees (unlike the rest of the demographic data).

[14] These were combined in the recognition that one is often strongly correlated with the other, so there is a risk of double counting risk factors by counting separately.

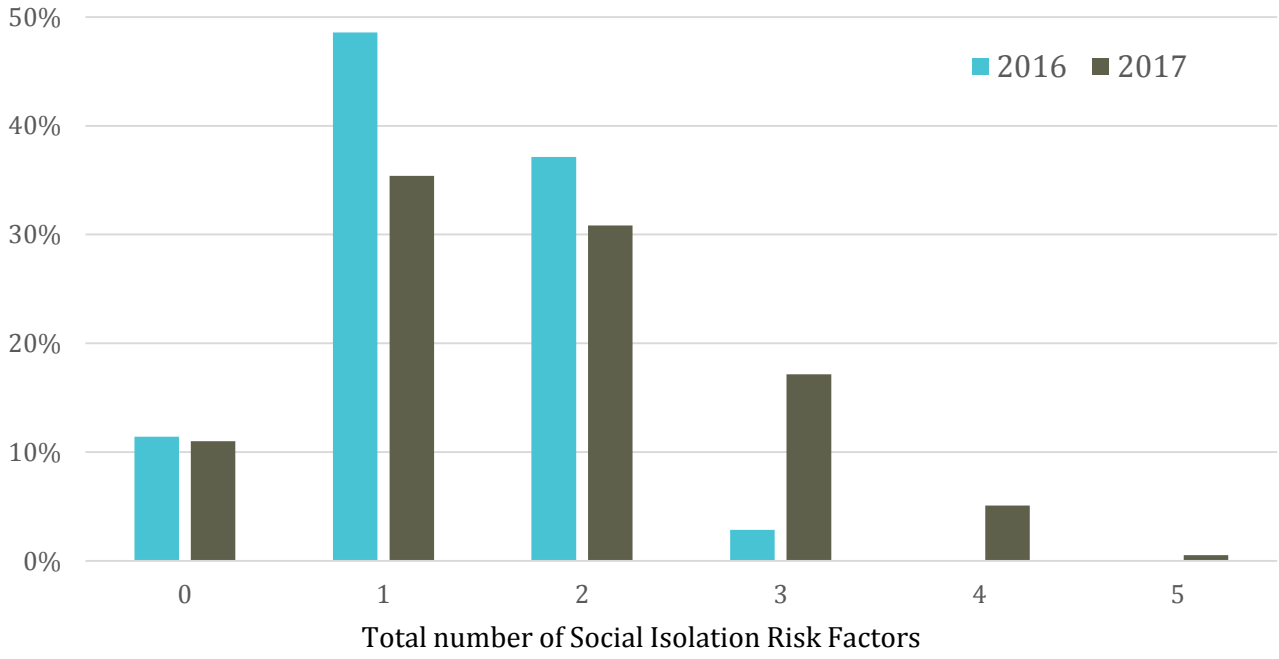
- Living alone[15]

Age was excluded from this, given the demographic profile of respondents.

Risk of Social Isolation: 2016 compared to 2017

The graph below (figure 4.6) shows that the percentage of respondents experiencing 2 or fewer social isolation risk factors at baseline was lower in 2017, compared to 2016. The percentage of respondents with 3+ risk factors at baseline was higher in 2017.

Figure 4.6: Distribution of Number of Social Isolation Risk Factors of Respondents (n=408)



On average, the total number of social isolation risk factors experienced by respondents in 2017 was 30% higher than respondents in 2016 (from 1.3 to 1.7).
The most common number of risk factors remained 1, with 49% of respondents experiencing one risk factor in 2016 and 35% of respondents experiencing one risk factor in 2018. The proportion of respondents experienced no risk factors remains similar (approximately 11%).

Overall, this suggests that the AfA programme engaged more participants at risk of social isolation in 2017 than it did in the previous year (based on these measures).

This analysis only includes respondents who answered all 6[16] of the social isolation risk factor questions, to prevent a skew towards lower risk factor scores due to missing data (responses coded as 0). As such, numbers of participants included in the analysis are lower (n=408) and results may not be representative of the sample as a whole.

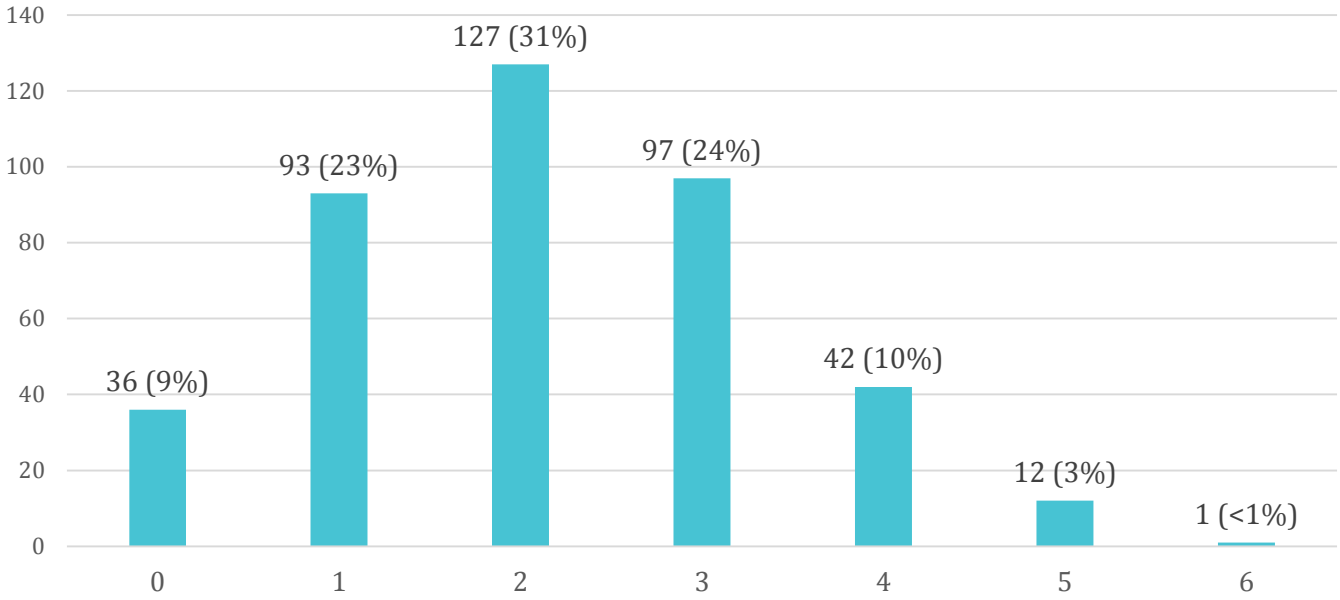
Living Alone

Living alone is another key risk factor of social isolation, which was not included in the baseline analysis for 2016 due to limited data. However, due to a larger number of responses in 2017, this can now be taken into consideration for the sample as a whole, to give a more thorough picture of risk of social isolation in our sample.

[15] Living alone was excluded from the cross-year comparison, due to technical problems meaning data was not collected in the database about living situations for a substantial period in 2016. As such, there is a very small sample size for this question in 2016 (n=50).
[16] Excluding 'living alone' as a measure

The distribution of total risk factors including the 'living alone' indicator is shown for the overall sample in the graph below (figure 4.7).Once this extra indicator is included, the average number of risk factors experienced increases from 1.7 to 2.1, and the average number of risk factors for those who are experiencing at least one risk factor increases from 1.9 to 2.3.

Figure 4.7: Prevalence of Number of Risk Factors in the Overall Sample (2016 and 2017)



The most common number of risk factors experienced is 2 (31%), whereas this was 1 factor when living alone was excluded. This reflects the fact that many of the 2017 respondents stated that they live alone (48%) and, as such, is an important indicator to include when assessing their social isolation risk.

There are some caveats to this data:

- This analysis is a simple way of providing an indication of risk, and does not act as a comprehensive overview of who is at risk of social isolation and who is not. It is indicative only and does not mean that those with a higher number of factors are definitely socially isolated, or that those without any risk factors will not at some point experience social isolation.
- In addition, not all risk factors will carry 'equal weight' – some may place an individual at a higher risk than others, and this will vary from person to person based on their life experiences and situations.
- As above, this data is only inclusive of those who have answered the questions. Risk factors may be higher as not all individuals have answered all questions.

Due to low sample numbers, this data cannot be meaningfully broken down to explore potential geographical variations.

The next two sections will analyse data looking at the first two outcomes: Age Friendly Neighbourhoods and Social Contact. The demographic data provided in this section should be borne in mind when looking at this data.

Section 5: Age-Friendly Neighbourhoods

To what extent do you live in an age-friendly neighbourhood?

The first Ambition for Ageing Outcome is 'wards in which the programme is delivered are more age-friendly'. This is currently measured by asking those engaging with the programme for their views about where they live.

The term 'Age-friendly' can mean different things to different people, but when we use the term within the AfA programme we refer to people of all ages being respected and able to actively contribute to decisions about the places that they live in.

'An age-friendly world enables people of all ages to actively participate in community activities and treats everyone with respect, regardless of their age. It is a place that makes it easy for older people to stay connected to people that are important to them. And it helps people stay healthy and active even at the oldest ages and provides appropriate support to those who can no longer look after themselves.'

World Health Organisation

This section will look at the results from the question 'To what extent do you live in an age-friendly neighbourhood' as well as other questions on perceptions of neighbourhoods and communities. This will provide an understanding of individuals' perceptions age-friendliness and civic participation.

To what extent do you feel that you live in an age-friendly neighbourhood?			
My neighbourhood is not at all age-friendly	My neighbourhood is not really age-friendly	My neighbourhood is somewhat age-friendly	My neighbourhood is very age-friendly

This question is included in Participant, Volunteer and Event Feedback forms. This provides a large sample size of 3,015, for perceptions of age-friendliness across 2016 and 2017[17].

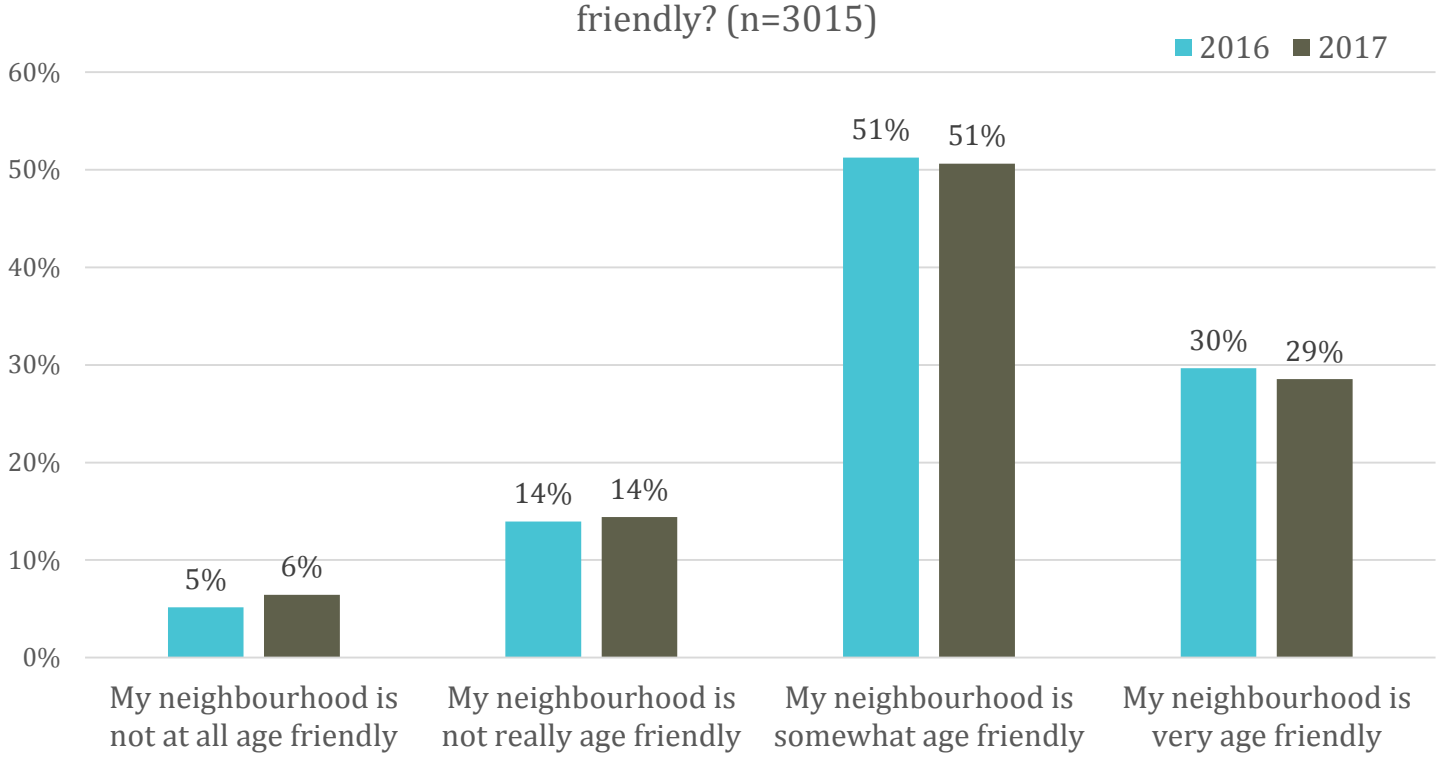
76% of volunteers responded that their neighbourhood is somewhat or very age-friendly, along with 78% of participants and 81% of event feedback (see appendix 2.A for full comparison table). Due to only minor variations due to questionnaire type, the responses are analysed together.

The graph below (figure 5.1) shows that there is little variation in levels of response to this question from 2016 to 2017, when looking at the entire sample.

Overall, 80% of respondents considered their neighbourhood to be 'very' or 'somewhat' age-friendly (see figure 5.1). Whilst this is a high baseline, AfA can still make an impact as the GM Strategy aims for 90% of people over the age of 50 to identify their neighbourhood as 'very' or 'somewhat' age-friendly by 2020.

[17] Please note that although the participant and volunteer forms have been filtered to exclude under 50's prior to analysis, this is not possible with the event feedback forms due to the forms being anonymous.

Figure 5.1: To what exent do you think your neighbourhood is age friendly? (n=3015)



Age-friendliness and Individual Characteristics

All demographic data was analysed alongside this question to determine whether there were any notable variances based on shared characteristics.

Due to demographic information not being linked to event questionnaire feedback, this analysis only looks at the data from volunteer and participant forms, with a maximum sample number of **1196.**

There were no identifiable trends between age-friendliness and gender, education level, employment status, marital status, living status, or length of time living in their ward.

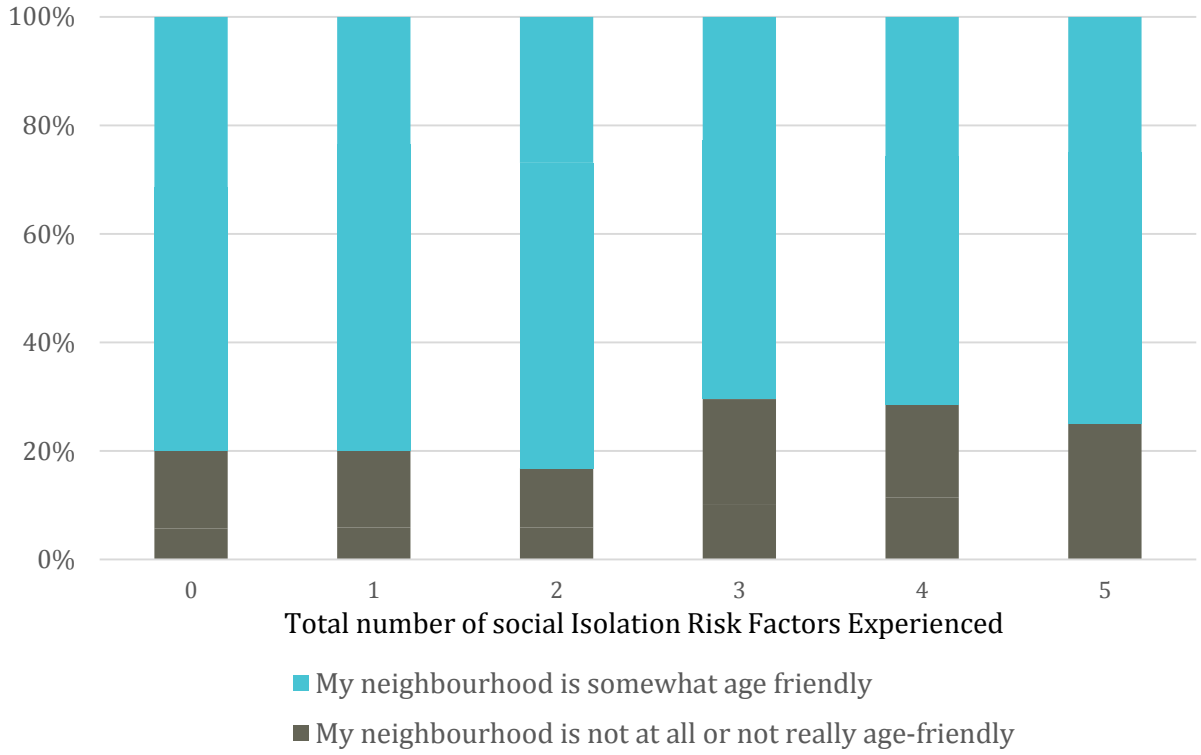
Figure 5.5 shows some variation in perception of age-friendliness due to age. The table shows that, as age increases, the proportion responding that their neighbourhoods are somewhat or very age-friendly also increases. This suggests that those who are younger have a more negative perception of the age-friendliness of their neighbourhoods.

Figure 5.2 Age and Extent of Neighbourhood Age-friendliness		
Age (n=927)	**My neighbourhood is 'not at all' or 'not really' age-friendly**	**My neighbourhood is 'very' or 'somewhat' age friendly**
50-59 (n=197)	31%	69%
60-69 (n=320)	25%	75%
70-79 (n=280)	21%	79%
80+ (n=130)	19%	81%

The graph below (figure 5.3) shows the difference in perceptions of age-friendliness by respondents experiencing different numbers of social isolation risk factors. The graph indicates that the respondents experiencing more social isolation factors were also more likely to have a negative perception of the extent of age-friendliness in their neighbourhood, compared to those experiencing fewer social isolation risk factors. Approximately 30% of those with 3+ social isolation risk factors responded that their neighbourhoods were 'not really' or 'not at all' age-friendly, compared to approximately 20% of participants experiencing 2 or fewer social isolation risk factors responding this way.

However, due to low numbers available to be included in the social isolation risk factor analysis, these results are not necessarily representative of all respondents, only individuals who answered all of the social isolation risk factor and age-friendliness questions.

Figure 5.3: Perception of Age Friendliness by Number of Social Isolation Risk Factors Experienced (n=374)



Exploring some of these risk factors individually, analysis found that respondents with a longstanding health condition or disability were more likely to respond that their neighbourhood was 'not really' or 'not at all' age-friendly, with 24% responding this way compared to 17% of those who stated that they did not have a longstanding health condition or disability.

A similar trend was found for respondents who stated that they were currently providing support or care, with 26% of these respondents stating that their neighbourhood was 'not really' or 'not at all' age-friendly compared to 19% of those who stated that they were not currently providing support or care.

It may be that respondents who are potentially more marginalised or vulnerable, such as those who have caring responsibilities, health conditions and at higher risk of social isolation, may experience their areas as less age-friendly or accessible than those who are less vulnerable.

However, these patterns have emerged when characteristics have been analysed in isolation, and potential confounding factors were have not been accounted for. Variations may be affected by any number of factors, and we cannot be sure that any variations are due to any one particular characteristic.

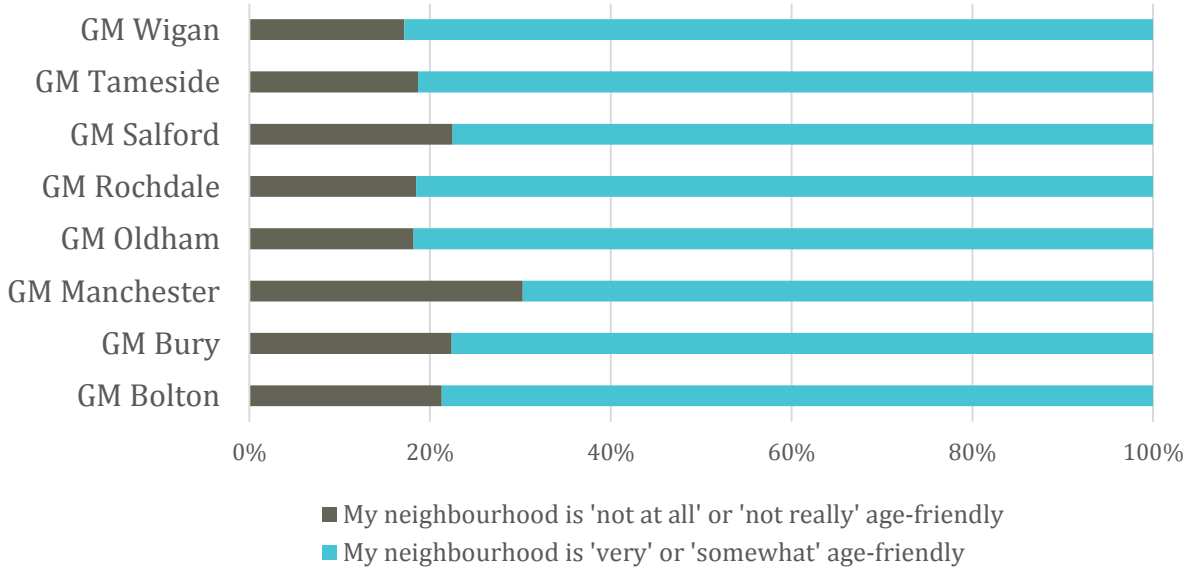
It should be noted that all individuals will have different perceptions of what an age-friendly neighbourhood actually is, so their answers are not necessarily directly comparable. A follow up report will be forthcoming which analyses qualitative data collecting through the evaluation questionnaires, to explore how respondents understand the concept of age-friendliness, and what an age-friendly community means to them.

Age-Friendliness and LA Area

When exploring responses on an area level, some geographical variations emerge. The graph below (figure 5.3) shows these variations, with positive responses in shades of blue and negative responses in shades of grey. A full table comparison of these variations can be found in appendix 2.B.

It is important to note that these are baseline comparisons, measuring perceptions of neighbourhood age-friendliness at commencement of engagement in the AfA programme. As such, they should not be mistaken for a measure of LDL performance in these areas.

Figure 5.4: Extent of Baseline Age-friendliness by Area



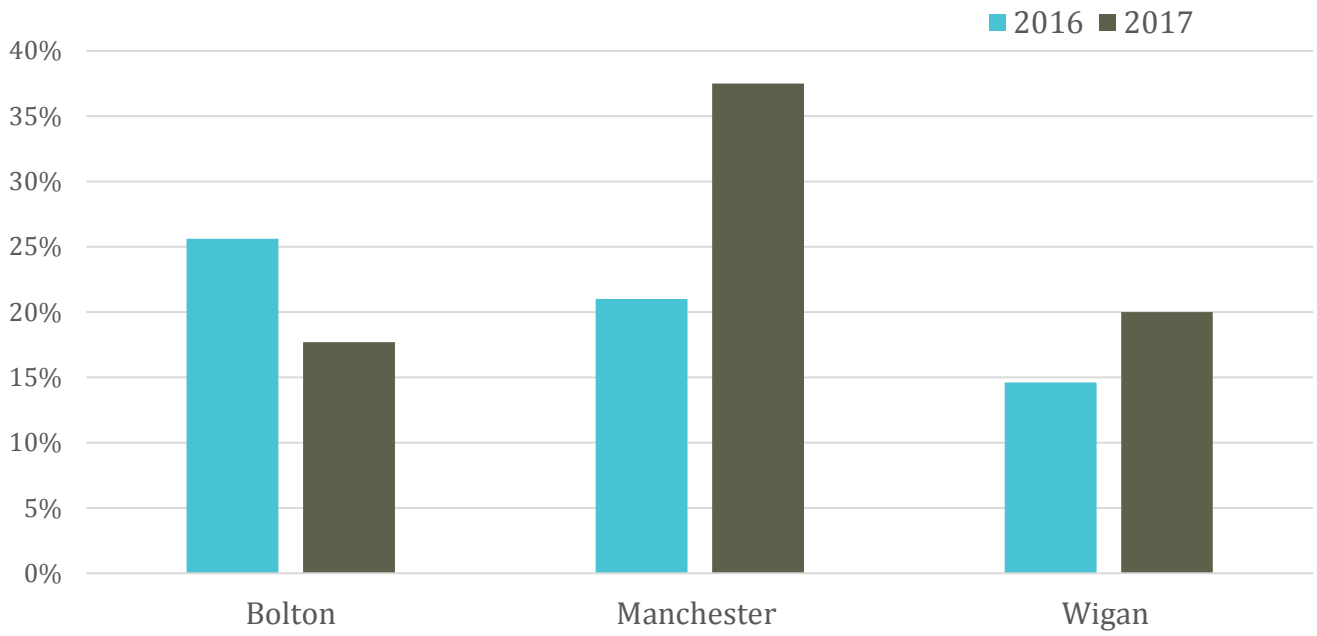
The graph shows that a larger proportion of respondents stated that their neighbourhoods are ‘not at all’ or ‘not really’ age-friendly in Manchester, Salford and Bury than in other areas. Conversely, Rochdale, Oldham and Wigan have a larger proportion of respondents stating that their neighbourhoods are ‘somewhat’ or ‘very’ age-friendly. Oldham also has the highest percentage of respondents stating that their neighbourhood is ‘very’ age-friendly, with 39% responding this way.

These geographical variations in baseline responses likely reflect both area and individual differences of the populations engaged in the programme, and demonstrate the importance of place-based responses in developing more age-friendly communities.

Although the overall levels of age-friendliness have remained approximately the same across 2016 and 2017, there are some variations on a more local level. A full table of these changes can be found in appendix 2.C.

Of particular note are changes in responses for Manchester, Wigan and Bolton. The graph below (figure 5.4) shows the percentage change in those giving a negative response to the extent of their neighbourhood age-friendliness.

Figure 5.5: Percentage of Respondents stating that their neighbourhood is 'not really' or 'not at all' age-friendly at baseline



The graph shows an increase in the proportion of negative responses at baseline for both Manchester and Wigan. Conversely, Bolton had a decrease in the proportion of negative responses at baseline.

These changes could represent changes in the type of individuals targeted and engaged in the second year, or changes in the areas in which projects are delivered. It would be interesting to explore these changes on a more local level, in light of local programme practices and approaches.

Civic Participation

Civic participation is about how involved we feel in the places in which we live. It's also about how much we feel we can influence what goes on in where we live, and is a good indicator of a sense of belonging and happiness in our local neighbourhoods. Civic participation is linked to social isolation because if we feel we can get involved in the places that we live, then we are less likely to end up isolated in them.

A matrix of two questions is asked on Event Feedback Forms and Participant Questionnaires. This question is matched with the Citizenship Survey, which ran from 2001 – 2010/11. Whilst the data cannot be matched against data from current years, it is a validated tool with which to measure people's feelings of a) influence over their local area and b) ability to change things in their area.

The question is as follows:

Do you agree or disagree that…				
	Definitely disagree	Tend to disagree	Tend to agree	Definitely agree
I can influence decisions affecting my local area				
People can change things in my local area if they work together				

Analysis of responses found that those engaged in 2017 were slightly less likely to feel like they could influence decisions in their local area compared to those engaged in 2016, with 51% agreeing in 2017 compared to 55% in 2016. This may be due to increased targeting in the second year of individuals at greater risk of social isolation. In comparison, there was little variation in responses to the second statement, 'People can change thing in my local area if they work together', across years, with approximately 84% of respondents agreeing with the statement (see appendices 2.D and 2.E for tables of comparison).

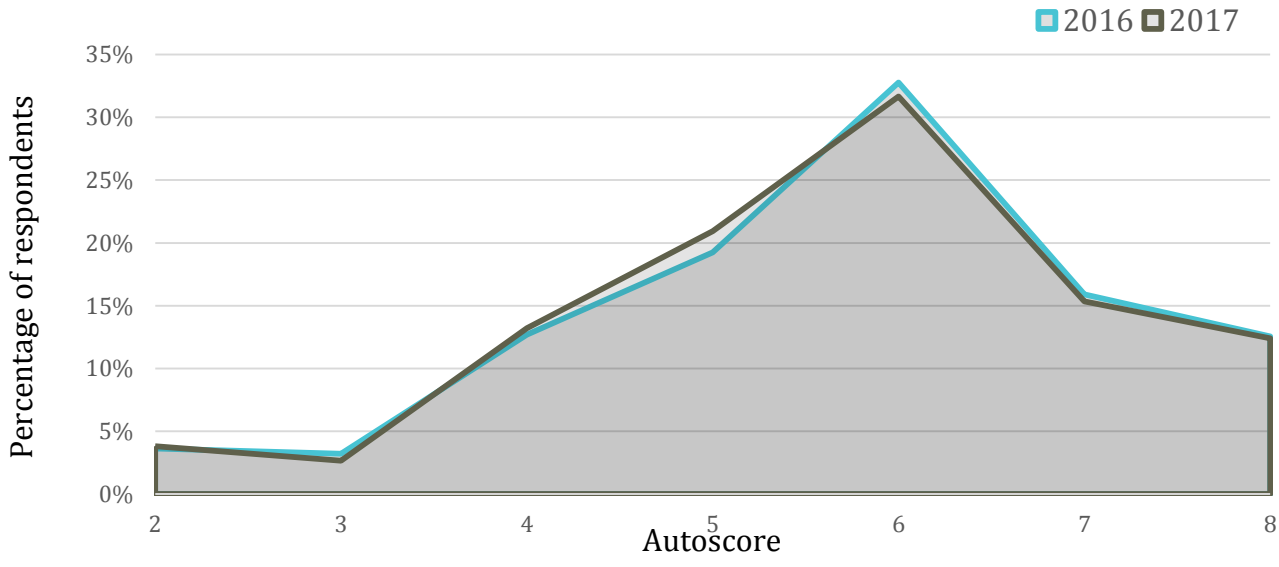
Autoscores

An autoscore is attached to this question when individuals respond to both statements (i.e. do not state 'prefer not to say' for one or both statements). The minimum score, where individuals answer 'Definitely Disagree' to both statements, is 2. The maximum score, where individuals answer 'Definitely Agree' to both statements, is 8. A low score (close to 2) indicates that people are not confident about the potential for changing or influencing practice in their local area. A high score (close to 8) indicates the reverse.

The **average autoscore was 5.7** in both 2016 and 2017. There was little variation between the average autoscores by questionnaire type (e.g. participants compared to event attendees).

The graph below (figure 5.8) shows that the distribution of responses in 2017 was very similar to those in 2016. This indicates that participants are generally positive at baseline about their civic participation, despite engagement with participants at increased risk of social isolation.

Figure 5.8: Civic ParticipationAutoscores (N=2451)



For Participant Questionnaire respondents, it is possible to analyse autoscores alongside demographic information. Excluding missing data, this provided a maximum sample size of **573**.

Due to low numbers in minority categories, ethnicity, sexual orientation and religion were unable to be meaningfully analysed.

The average autoscore for respondents included in this analysis was 5.5.

There were no notable variations between the average scores when looking at age, gender, social isolation factor score, education level, caring/support responsibilities, or an individual's living situation.

There were some slight variations in average autoscore by employment status, with the average autoscore of retired respondents 7% lower than employed respondents, and the average autoscore of unemployed respondents 3% lower than employed respondents (5.4 and 5.6 respectively, compared to an average of 5.8 for employed respondents).

Average autoscores of respondents who stated that they had a longstanding health condition or disability were 5% lower than those who did not (5.3 compared to 5.6). (See appendix 2.G for full table comparison).

Although the autoscore can provide a broader measure of civic participation, it may mask variations between the responses. Analysing the two questions individually allows for potential variations in responses to these questions due to respondent characteristics, and increases the sample size from 573 to 896 ('People can change things in my local area by working together') and 881 ('I can influence decisions affecting my local area').

Due to small numbers in minority characteristics, ethnicity, sexual orientation and religion could not be meaningfully analysed for this data.

'I can influence decisions affecting my local area': variations by respondent characteristics

There was notable variation between men and women, with 46.8% of women tending to disagree or definitely disagreeing with the statement, compared to 54% of men. In other words, 15% more men than women tended to disagree or definitely disagreed that they can influence decisions affecting their local area.

47% of respondents who stated that they provided support or care tended to disagree or definitely disagreed that they can influence decisions affecting their local area, compared to 41% of those who don't.

51% of respondents who stated that have a longstanding health condition or disability tended to disagree or definitely disagreed that they can influence decisions affecting their local area, compared to 41% of those who don't. (A full table breakdown of these can be found in appendix 2.H).

Figure 5.9, below, shows response variations by living situation. 60% of respondents who were living with other family members tended to agree or definitely agreed with the statement, compared to 50% of those who live with a partner and 48% of those who live alone.

Figure 5.9 Living Situation and the extent to which 'I can influence decisions affecting my local area'		
Living situation (n=560)	**Definitely to tend to agree**	**Definitely or Tend to disagree**
Living Alone	47.6%	52.4%
Living with other family member	60.8%	39.2%
Living with Partner	49.6%	49.4%

There were no notable variations in responses to this question due to age or number of social isolation risk factors. Although there was some variation in response due to education level and employment status, no trend was identifiable.

'People can change things in my local area by working together': variations by respondent characteristics

Although there was variation in responses to the first statement in relation to gender, health, living situation and caring responsibilities, there was no identifiable variation due to these characteristics for the second statement. There was also no identifiable variation or trend due to marital status, education, age, number of social isolation risk factors or how long a respondent had lived in their ward.

The table below (figure 5.10) shows variations in response to this statement by employment status. Respondent who stated that they were unemployed were most likely to tend to agree or definitely agree with the statement (91%), whilst respondents employed part time were the least likely to tend to agree or definitely agree (78%) . However, numbers of respondents employed part-time were relatively low.

Figure 5.10 Employment Status and Extent to which 'People can change things in my local area if they work together'		
Employment Status	**Definitely or tend to agree**	**Definitely or tend to disagree**
Employed full-time (n=43)	86%	14%
Employed part-time (n=37)	78.4%	21.6%
Retired (n=477)	81.1%	18.9%
Self-employed (n=14)	85.7%	14.3%
Unemployed (n=90)	91.1%	8.9%

Overall, responses to this statement were generally positive, with little variation due to demographic characteristics.

Age-friendliness and Civic Participation

When exploring responses to these statements alongside responses to age-friendliness, analysis revealed a weak positive correlation (0.3) between perception of neighbourhood age-friendliness and the extent to which someone believes that they can influence decisions in their local area (see appendix 2.I). In other words, there is some indication of a relationship between responses to the two questions: if respondents are more positive about age-friendliness, they tend to be more positive about their ability to influence decisions too, and vice versa. This highlights the value of AfA's focus as a programme 'with' older people rather than simply 'for' older people, as it suggests that participants who feel that their voices are

being heard and can influence decisions in their local area generally feel that their neighbourhoods are more age-friendly than those who do not.

In comparison, there is no identifiable correlation between perception of neighbourhood age-friendliness and the extent to which respondents think that people can change things in their local area. The majority of respondents tend to agree that people can change things if they work together, regardless of whether or not they think their neighbourhood is currently age friendly (see appendix 2.J). This is encouraging for the programme, as older people's engagement is fundamental to the success of Ambition for Ageing. This finding provides support for a key principle of the AfA programme; the idea that older people can come together and, with investment facilitating this action, make sustainable and positive changes in their local areas.

Section 6: Social Contact

The second outcome for Ambition for Ageing is 'Older people in the designated wards have increased and improved social connections' in the recognition that this has an inverse relationship to social isolation. In other words, the absence of social isolation is the presence of good quality and frequent social connections.

As outlined by Buffel et. al., 2015, there is no one singular agreed way of measuring the absence or presence of social isolation. Measurement *"should take into account both its objective (social disconnectedness) and subjective (perceived social isolation) dimensions."*

As a result, the outcome is measured through a series of proxies. The first section below analyses subjective measures, assessing subjective feelings of social connectedness, including neighbourhood attachment and involvement. The second sections analyses more objective measures, with data about frequency and type of social contact.

Subjective Measures

Participant and Volunteer questionnaires include a matrices question that assesses relationships and social contact in their neighbourhoods. This is as follows:

Please look at the statements below and indicate how strongly you agree or disagree with each (please tick in the corresponding box).					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I feel like I belong to this neighbourhood					
The friendships and associations I have with other people in my neighbourhood mean a lot to me					
If I needed advice about something I could go to someone in my neighbourhood					
I borrow things and exchange favours with my neighbours					
I would be willing to work together with others on something to improve my neighbourhood					
I regularly stop and talk with people in my neighbourhood					

This matrix is designed to provide a comprehensive picture of:

- Neighbourhood belonging (linked closely to community attachment);
- Quality and quantity of relationships within neighbourhoods; and
- Active expression of these relationships (e.g. putting the relationships into action through exchanging favours and providing advice).

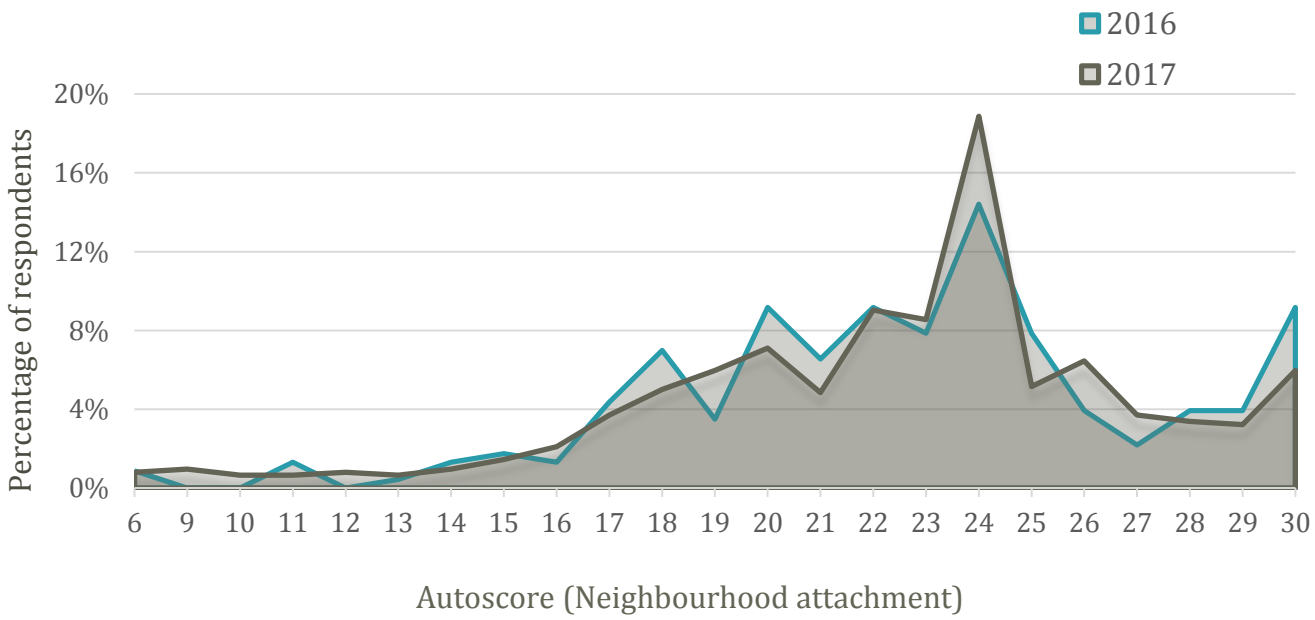
Complete answers (where an individual has answered each statement) are then given an autoscore. The minimum score, where an individual has answered 'Strongly Disagree' to all statements, is 6. The maximum score, where an individual has answered 'Strongly Agree' to all

statements, is 30. A low score (close to 6) indicates dissatisfaction with a neighbourhood and poor relationships within it. A high score (close to 30) indicates the opposite.

The overall **average autoscore was 22.4**, indicating a generally positive response to the question.

This reflects a marginal decrease in average score, from 22.6 in 2016 (n=229) to 22.4 in 2017(n=620). Figure 6.1 shows the distribution of scores each year. The graph shows that the most common score in both years was 24. For areas where data can be reported, the average scores were similar, indicating little variation by place[18].

Figure 6.1: Neighbourhood Attachment Autoscore Distribution (n=849)

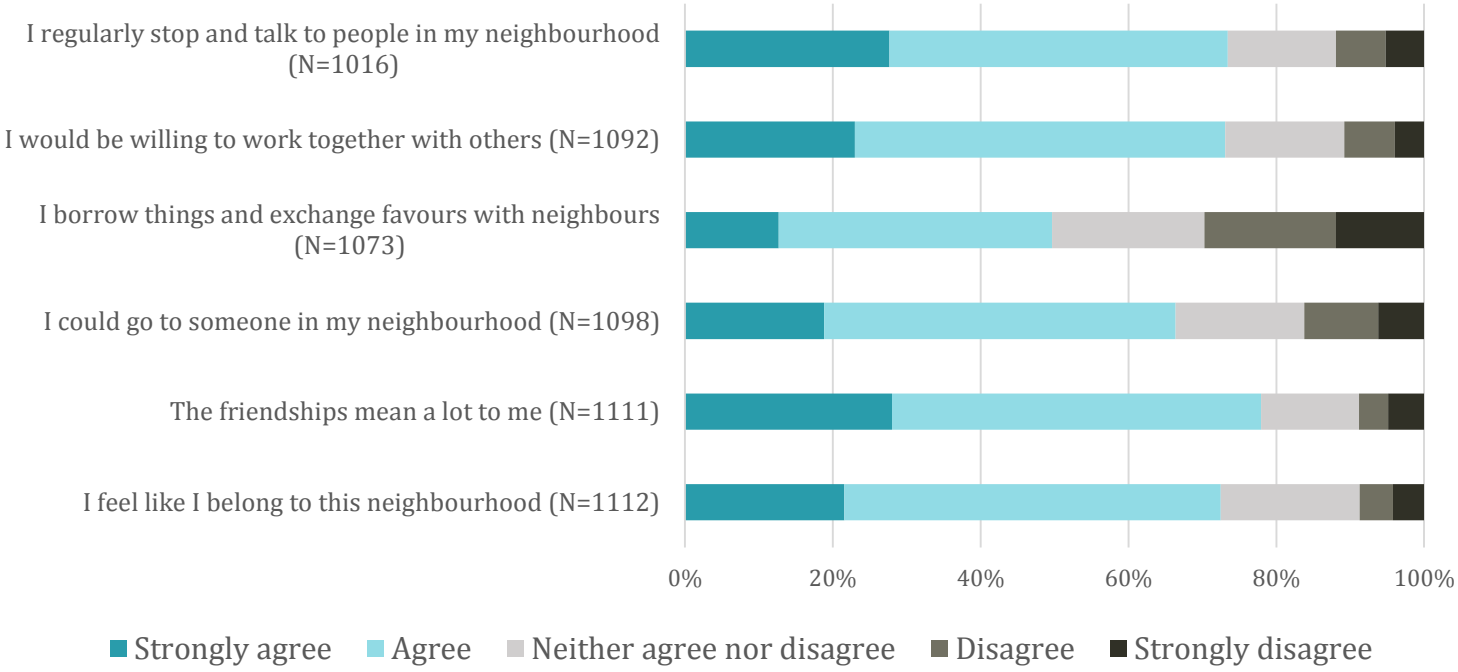


Analysis of the 6 questions reveals a generally moderate positive correlation between most of the questions (see appendix 2.K for correlation matrix). In other words, if an individual has responded positively to one question, they are also more likely to have responded positively to the others, and vice versa. This provides support for looking at these measures together to form an overall picture of neighbourhood attachment.

Exploring variations between statement responses, figure 6.2 (overleaf) shows the responses to each of neighbourhood attachment statements separately. This includes answers where the full matrices was not answered (i.e. an individual only responded to 5 or fewer statements). As such, this data also includes Manchester and provides a higher overall sample size[19]. There was little variation in response proportions by year.

[18] Full matrix data is not available for Manchester as the last statement was excluded, so the data is incomplete and this means that an autoscore cannot be calculated for this data.
[19] Except for the last statement: 'I regularly stop and talk with people in my neighbourhood'

Figure 6.2: Neighbourhood Attachment Questions (Overall sample, 2016 and 2017)



AfA responses are least positive to the statements 'I borrow things and exchange favours with my neighbours' and 'If I needed advice about something I could go to someone in my neighbourhood'. This is consistent for both 2016 and 2017.

This is interesting as these statements appear to be the most action-oriented of statements relating to relationships. For example, whilst friendships and associations may mean a lot to someone, actively gaining advice or exchanging favours with those friends is a step further, and may represent stronger social ties. These are the actions that prevent or reduce social isolation, and the element that AfA should seek to improve.

Working Together: Cooperation and Belief in Change

The questionnaires included two questions on the topic of working together: 'I would be willing to work together with others' and 'People can change things in my neighbourhood if they work together'. Responses were analysed to explore the relationship between these questions. Responses were filtered to only include positive and negative responses, so that responses could be matched across questions, leaving a final sample number of 633 for analysis[20].

Analysis found a weak positive correlation[21] between responses to the two questions. This suggests that, generally, if a respondent answered positively to one question, they were also likely to answer positively to the other. However, there were some variations. Responses were analysed to uncover four categories of respondents:

High cooperation and high belief in change (77%) The majority of people fell into this category, responding positively to both questions. This is promising for the programme, as these individuals are likely to respond well to an asset-based approach with older people at the centre,

[20] Those who stated that they 'neither agree nor disagree' with the statement 'I would be willing to work together with others' were excluded due to their being no equivalent response to the other question.
[21] Spearman rank correlation: 2.7, Pearson correlation: 2.4

where AfA can provide support and facilitation. Engagement with this type of individual is likely to increase the potential for sustainability of action after AfA finishes.

High cooperation but low belief in change (11%) For this significant minority**,** they agreed or strongly agreed that they would be willing to work together with others, but tended to or definitely disagreed that people could change things in their local area if they worked together. This was not specific to one area, as respondents from all LAs fell into this category. This group has the enthusiasm to work together, but may need the AfA programme to empower and support them to see the difference they can make. Providing and communicating evidence of change locally is likely to be important to these individuals if activity is to be sustained after the programme ends. There were no clear differences in demographic make-up of this group compared to the majority group, but many of the minority characteristics had too small numbers to analyse.

High belief in change but low cooperation (8%) This smaller group of respondents tended to agree or definitely agreed that people could change things if they worked together, but disagreed or strongly disagreed that they would be willing to work with others in their local community. This group believe change can be achieved through working together, but wouldn't be willing to work with others to achieve this in their neighbourhood. However, we cannot conclude from this why they would not be willing to work with others, for example they may be uninterested, or may feel they have nothing to give. Interestingly, this group were more likely to have a longstanding health condition or disability than the majority group (74% compared to 50%), and were more likely to live alone (73% compared to 41% of the majority group). However, these are low numbers, so care should be taken in interpreting these findings. Further research would assist in understanding this group better.

Low belief in change and low cooperation (4%) This was the smallest category, with very few respondents falling into this group (n=25). Due to the methodological approach of AfA, it may be expected that the programme may not attract many participants that fall into this category. Low numbers mean characteristics of this group are difficult to analyse, but preliminary analysis does suggest that respondents in this group are more likely to have a longstanding health condition or disability than the majority group (75% compared to 50%) and more likely to be providing care or support than the majority group (27% compared to 18%).

The high level of engagement with respondents who are willing to work with others and believe that people can change things if they work together reflects the type of individual that is often attracted to and at the heart of asset-based approaches. However, AfA has recognised that asset-based approaches can risk contributing to existing inequalities[22], excluding those who are the most socially isolated. The projects need to take care to ensure that they are inclusive and supportive of those who are more marginalised and potentially disempowered.

Due to low numbers, variations in response to this at a local level could not be analysed.

Objective Measures

A series of objective measures of social contact are also included in the questionnaires. This data is collected through a combination of volunteer and participant forms, and includes:

1. Contact with others via digital technology, including video-messaging services (such as Skype or FaceTime) and social media (both);
2. Contact with others face-to-face and over the phone (participants); and
3. Frequency of volunteering/community engagement (volunteers).

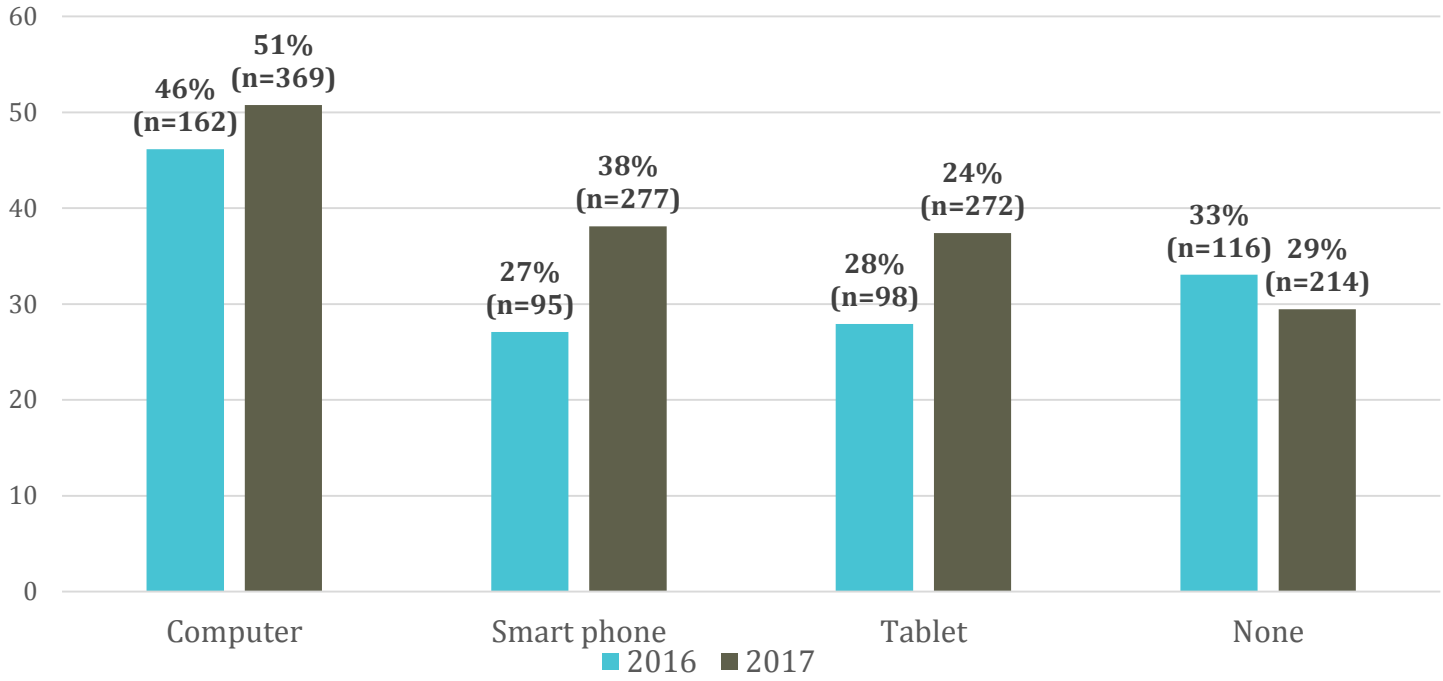
[22] Briefing Asset Based Approaches and Inequalities, Ambition for Ageing March 2018 https://www.ambitionforageing.org.uk/resources

The first data set, on the use of digital technology to communicate, is drawn from both participants and volunteer forms.

Use of Digital Technology

Figure 6.3 below shows that baseline technology use in respondents increased slightly in the 2nd year, with 33% of respondents not using any technology in 2016 compared to 29% in 2017. Computers remained the most commonly used form of technology.

Figure 6.3: Do you use a computer, smartphone or tablet? (N=1078)

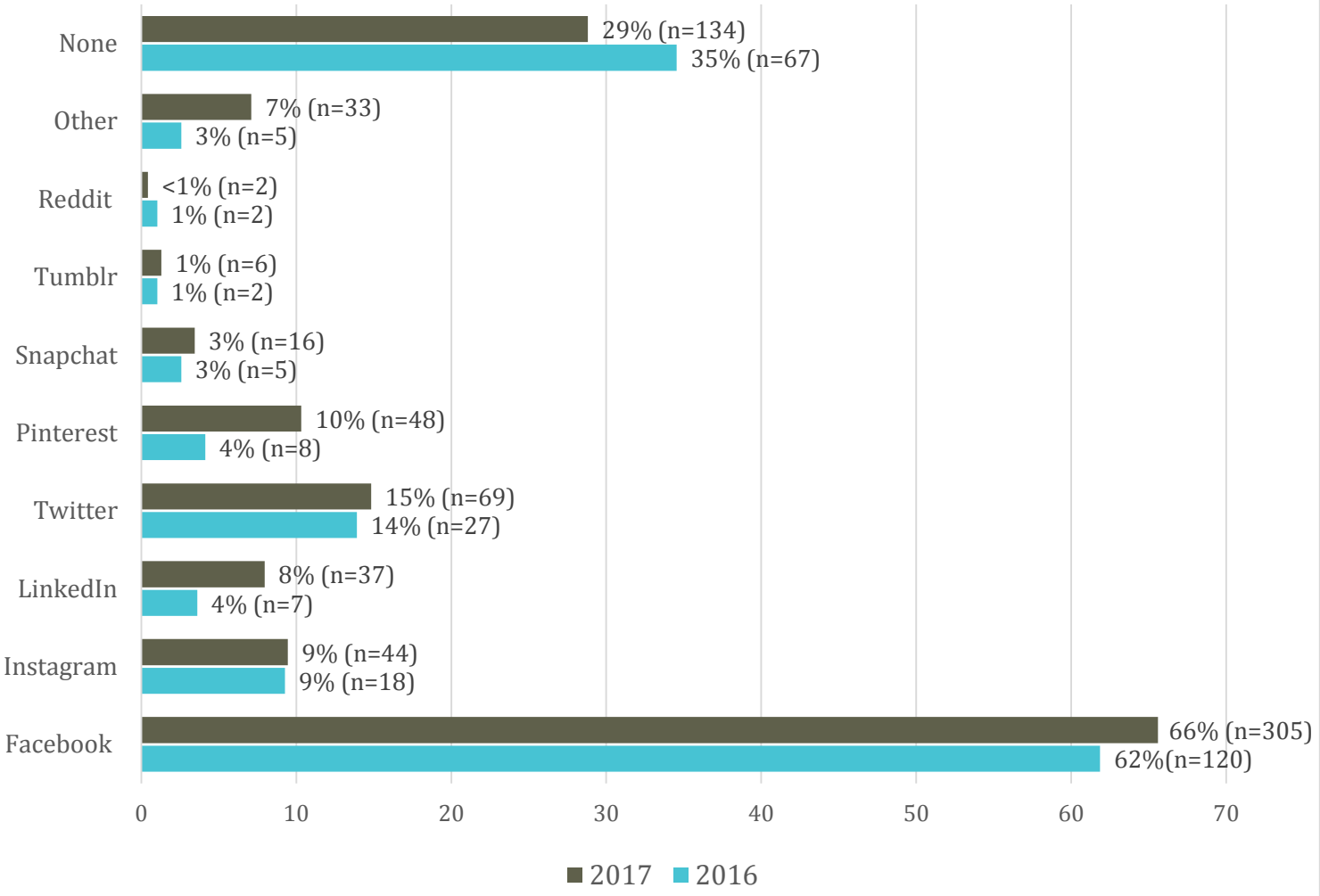


Note that people who do use a computer, smartphone or tablet may use more than one. As a result, the totals above add up to more than the total sample size.

Those who responded that they do use a computer, smartphone or tablet were then asked about their social media usage. Figure 6.4 (overleaf) shows that a wide range of social media platforms were reportedly used, although many of these had few users from this cohort. Facebook was the most common social networking site in both 2016 and 2017, with 65% of respondents using this platform overall. However, around a third of those who use technology responded that they do not use any form of social media.

Email usage increased slightly in 2017, with 79% of respondents stating that they use email in 2017 compared to 75% in 2016. This likely reflects the slight overall increase in technology use.

Figure 6.4: Do you belong to any social networking websites? (N=659)



Overall, this analysis shows that there is a great deal of variation in digital technology use within this cohort. This highlights the need for local and tailored approaches to promotion and communication, identifying the most appropriate means of communication and being aware when using those channels of who may be at risk of being excluded.

Face to face and telephone communication: friends, family, neighbours and colleagues

Compared to respondents in 2016, respondents in 2017 were slightly less likely to have contact face to face or by telephone three or more times a week. Conversely, 2017 respondents were slightly more likely to have contact by text message three or more times a week, with 55% responding this way in 2017 compared to 52% in 2016. Additionally, the proportion of respondents stating that they had contact 'every few months' or less decreased in 2017 compared to 2016, for all forms of communication (see appendix 3.A for tables).

Figure 6.5 (overleaf) shows the frequency of contact respondents had with friends, colleagues, family or neighbours through face to face or telephone communication for all respondents (2016 and 2017). This data excludes Manchester.

Figure 6.5 Frequency of contact with friends, colleagues, family or neighbours						
	Less than once a year	**Once or twice a year**	**Every few months**	**Once or twice a month**	**Once or twice a week**	**Three or more times a week**
Meet up (n=841)	6%	<1%	3%	8%	35%	47%
Speak on the phone (n=811)	5%	<1%	3%	10%	28%	55%
Send or receive text messages (n=748)	19%	1%	3%	5%	17%	54%

Overall, text messaging was still the least commonly used form of communication, with 20% of respondents stating that they use this medium once a year or less. Contact 'three or more times a week' remained the most common frequency of social contact in both years for all forms of communication, suggesting fairly regular interactions with other individuals via these mediums.

However, there again remain a minority who may not be in regular contact with other people. It is also important to note that interaction online does not necessarily provide the same level of quality interaction that face-to-face meetings do.

Volunteering

Volunteering in older age is associated with lower social isolation, so understanding whether our volunteers and participants also volunteer elsewhere provides an insight as to how engaged in their local areas our volunteers are without AfA.

Analysis around volunteering was conducted on a maximum sample size of **875**.

Respondents in 2017 were slightly less likely to volunteer than those in the previous year, with 41% of respondents volunteering in 2017 compared to 44% in 2016. This may reflect the engagement with individuals at higher risk of social isolation.

Of the 59% of 2017 respondents who stated that they did not volunteer, 24% of these stated that they want to volunteer. This is less than the 32% of respondents that wanted to volunteer in 2016.

Volunteering and characteristics of respondents

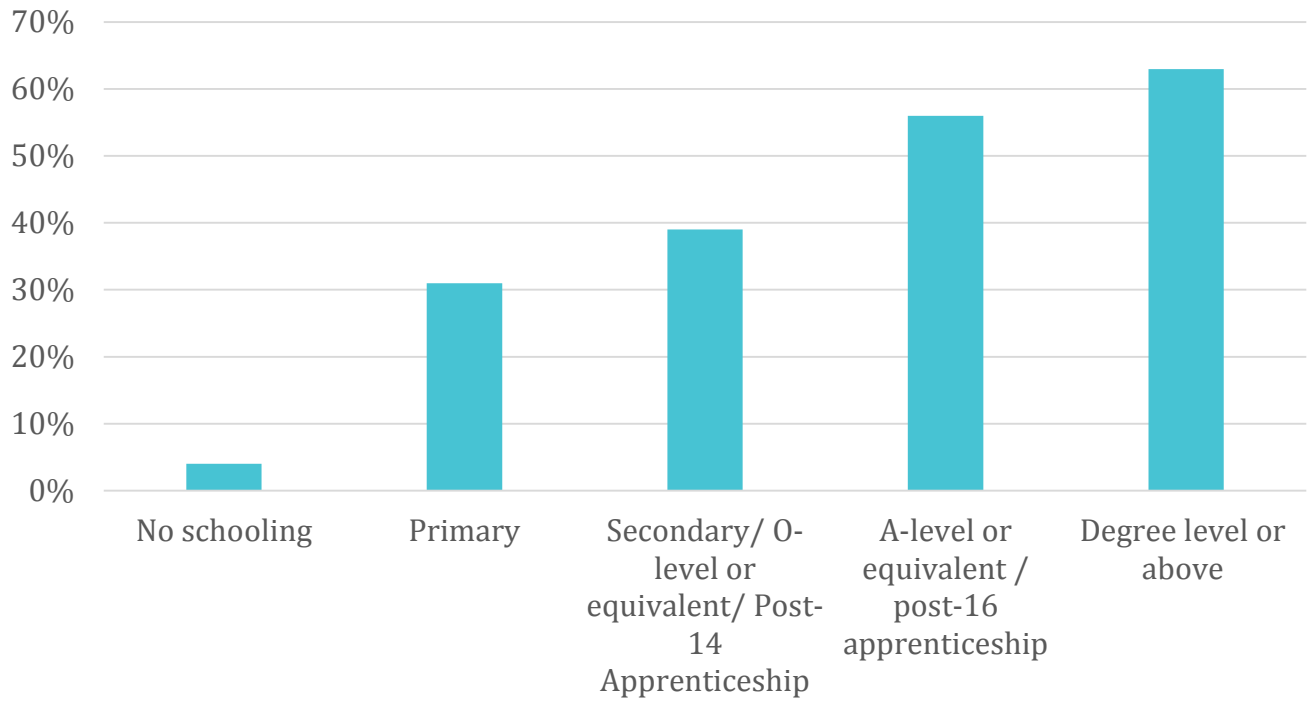
Analysis of the data from 2016 and 2017 revealed that men were slightly more likely to state that they volunteer than women, with 44% of men stating that they volunteer compared to 40% of women. Additionally, of those who stated that they do not currently volunteer, men were more likely to state that they would like to volunteer.

Figure 6.6 Gender and Volunteering		
	Currently volunteering (frequency)	Are not currently volunteering, but want to (frequency)
Men	44% (121)	27% (38)
Women	40% (218)	19% (52)

However, whilst men are still underrepresented in the evaluation data, it is unknown how representative this is of all the men taking part in AfA.

Figure 6.7 below shows that, as education level increases, so does the likelihood that a respondent states that they are volunteering.

Figure 6.7: Percentage Currently Volunteering (n=662)



Additionally, those with higher levels of formal education are also generally more likely to want to volunteer if they are not currently volunteering, than those with lower levels of formal education. Of the participants who stated that they were not volunteering, 40% of those educated to a-level or above stated that they want to volunteer, compared to just 15% of those educated to secondary school level or lower.

Although confounding variables have not been controlled for in this analysis, these trends may indicate a potential under-utilisation of older individuals with lower levels of formal education in the volunteering sector in GM. Additionally, these trends may reflect identity, and whether an individual recognises their activities as volunteering or chooses to identify with the label of 'volunteer'. LDLs should to take this into consideration when defining and recruiting to their volunteer roles.

Overall, these measures provide some indication of the level of social isolation of those engaged by AfA. The next section will explore potential changes in these responses since participating in the programme.

Section 7: 6-month follow up

Analysing follow up responses allows us to see whether perceptions and stated behaviours of respondents have changed since participating in the programme. This can give us some indication of the impact of the programme.

After filtering for duplicates and respondents under the age of 50, there were 226 follow up forms completed in 2016 and 2017, made up of a combination of 6-month follow ups and 12-month follow ups. Due to the low number of 12-month follow ups, this analysis will focus on the change between those with a baseline and a 6-month follow up, which represents 14% of the overall sample. These follow ups were usually completed at 6 months, or at programme exit, whichever occurred first.

Due to low numbers and potential sample bias, this analysis does not claim to be representative of the change in all participants. Additionally, we cannot know what proportion of change can be attributed to the programme, as other factors are also likely to have an impact on responses. As such, this analysis should be used as starting point for further exploration and discussion, rather than an end point.

Characteristics of the follow-up sample

Demographic characteristics of those who completed 6-month follow ups were analysed to determine how closely this sub-sample matched the whole sample of baseline respondents.

Characteristics are very similarly proportionate in five key areas: levels of education, ethnicity, length of time living in ward, gender, and average age.

However, retirees are disproportionately represented in the follow-up data, with 82% of respondents being retired compared to 75% of all baseline respondents. Additionally, there are no unemployed respondents in the follow-up data.

Christians are also slightly over-represented, with 79% of the follow-up respondents stating that they are Christian compared to 72% of all baseline respondents. Heterosexuals are also slightly overrepresented (97% compared to 93% in the overall sample).

The most substantial differences in representation are in respondent marital status, illness/disability, and caring responsibilities.

Only 17% of the follow-up respondents are married or in a civil partnership, compared to 41% of all baseline respondents. Additionally, 44% are widowed, compared to 29% of all baseline respondents.

88% of the follow-up respondents stated that they have a long-standing illness or disability, compared to just 48% of all baseline respondents. The proportion of follow up respondents stating that they provided support or care was over double that of all baseline respondents (42% compared to just 18%).

Looking at where this data comes from, Wigan is disproportionally represented in the follow-up data, with 41% of the follow-up data coming from that LA.

This indicates that there are certain groups that are over and under-represented in the following analysis, and as such it should not be taken as representative of everyone engaging in the AfA evaluation.

Age-Friendliness

109 respondents answered the question about the extent of neighbourhood age-friendliness in both their baseline and 6-month follow up questionnaire.

The potential responses were coded as follows:

Response	My neighbourhood is not all age-friendly	My neighbourhood is not really age-friendly	My neighbourhood is somewhat age-friendly	My neighbourhood is very age-friendly
Score	1	2	3	4

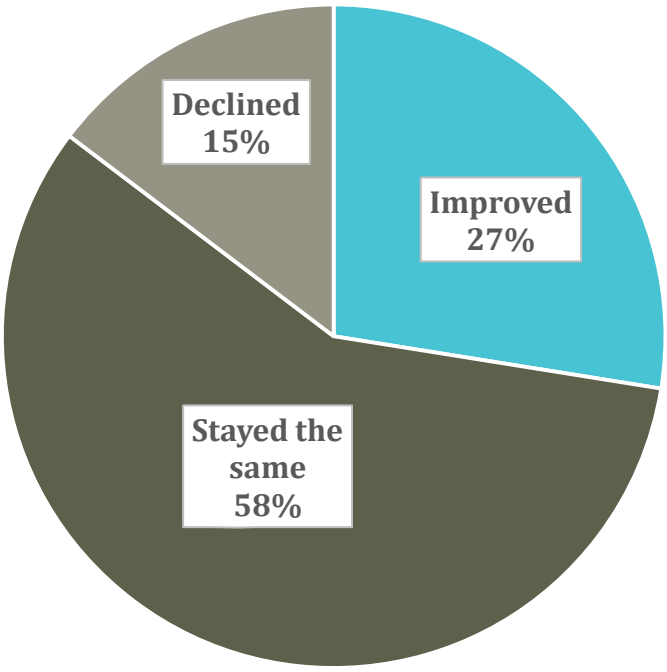
The percentage of respondents answering that their neighbourhood was somewhat or very age-friendly **increased from 78% to 84%.** The median and most common response remained 3 ('My neighbourhood is somewhat age-friendly').

The pie chart below (figure 7.1) shows changes in responses for this question.

The graph shows that the majority of respondents (58%) gave the same response at follow up as they did at baseline. 27% stated that their neighbourhood was more age-friendly at follow-up, and 15% stated that their neighbourhood was less age-friendly at follow-up.

The most common response for those who stayed the same was 3 (My neighbourhood is somewhat age-friendly) and 28% of this group stated that their neighbourhood was very age-friendly at baseline, leaving them no room for improvement.

Figure 7.1 Changes in response to Extent of Age friendliness from baseline to 6-month follow-up



Respondents whose scores improved over time tended to have given a more negative response at baseline, with 40% of them stating that their neighbourhood was 'not really' age-friendly when first asked[23]. This group then moved up an average of 1 category at follow up.

Conversely, respondents who stated that their neighbourhood was less friendly at follow up tended to have begun with a more positive response at baseline; all of them stated that their neighbourhood was somewhat or very age-friendly when first asked. This group then moved down an average of 1 category at follow up. These trends may reflect a 'reversion to the mean' effect, whereby responses move closer to the average over time.

Overall, this provides some evidence towards AfA meeting Outcome 1: 'Wards in which the programme is delivered are more age-friendly'. However, this small sample of follow-up

[23] None of this sample stated that their neighbourhood was not at all age-friendly at baseline.

responses is not necessarily representative of all those taking part in the AfA programme. Additionally, there is substantial variation within individual responses which would be interesting to explore further if further data becomes available.

Civic Participation

There were 84 respondents with a civic participation autoscore at both baseline and 6-month follow up.

The autoscores were calculated by combining responses from the following two statements:

'I can influence decisions in my local area'
'People can change things if they work together'

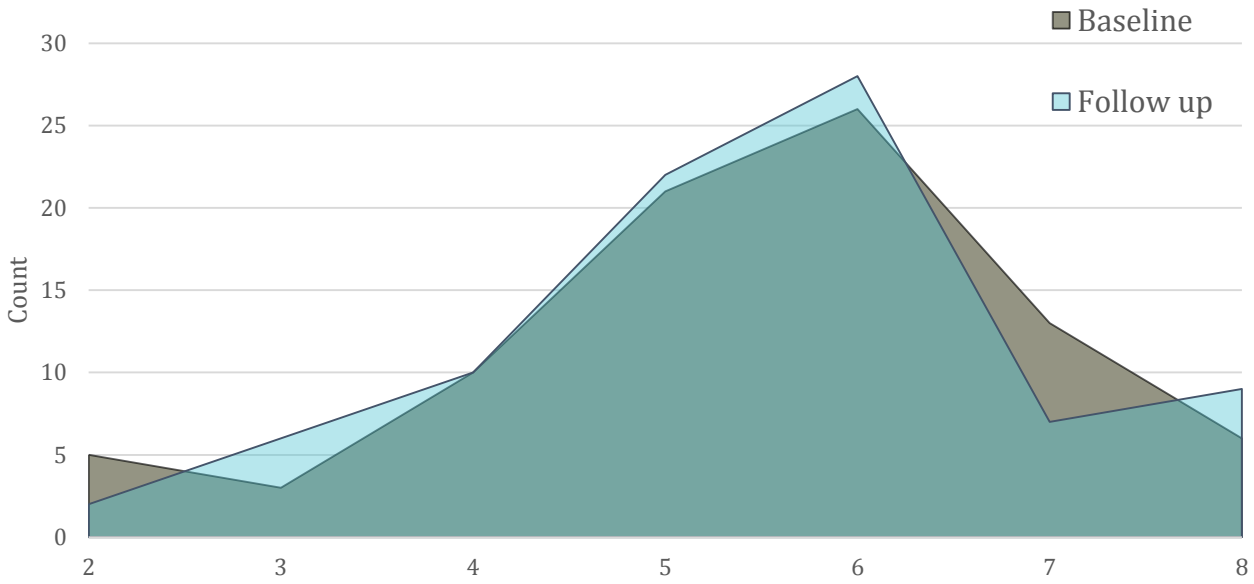
The potential responses for each were coded as follows:

Response	Definitely disagree	Tend to disagree	Tend to agree	Definitely disagree
Score	1	2	3	4

Autoscores ranged from 2 ('Definitely disagree' with both statements) to 8 ('Definitely agree' with both statements).

There was **no change** in average score from baseline to 6-month follow up. The median and most common score remained 6.
The graph below (figure 7.2) shows the distribution of scores for baseline scores compared to follow ups.

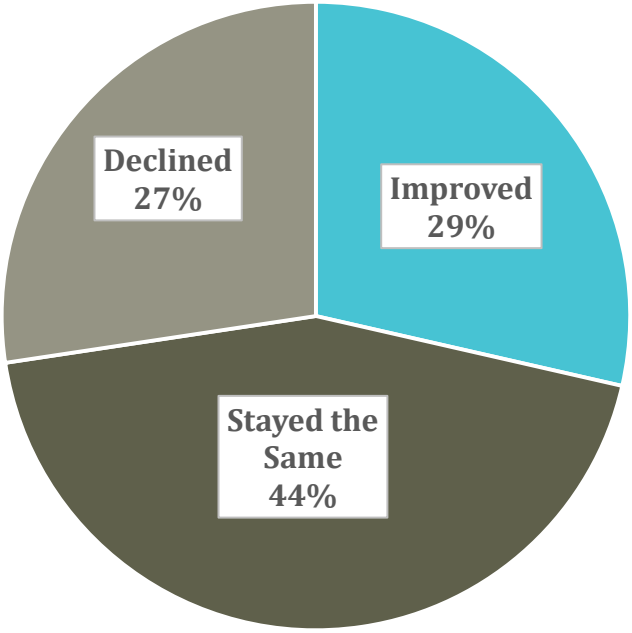
Figure 7.2: Change in Civic Participation autoscores in baseline compared to follow up



The pie chart below (figure 7.3) shows directional change for respondents.

The graph shows that the majority of respondents' scores stayed the same at baseline and 6-month follow-up (44%). 29% had higher civic participation scores at follow-up, and 27% had lower scores at follow-up.

Figure 7.3 Change in Response for Civic Participation autoscore from baseline to 6-month follow up



The average score for respondents who stayed the same was 5.5, indicating a slightly positive score, and matching the average score of the whole sample.

The respondents whose scores improved at follow-up tended to have started off with a lower than average baseline score (4.6), whereas the respondents who's scores declined tended to start off with a higher than average baseline score (6.3).

There was an average change of almost 2 points for both the improvers and the decliners, in opposite directions.

The two statements comprising the civic participation autoscore were also analysed separately to explore variations in responses.

There was **no change** in average score from baseline to 6-month follow up for either of the questions when analysed individually, and the median and most common score remained 3 (Tend to agree). As above, those that improved tended to have a lower than average score at baseline, and those who improved tended to have a higher than average score at baseline.

Social Isolation

As discussed earlier in this report, social isolation is measured through a variety of proxies. Due to low response numbers and high variance in response, objective measures were unable to be analysed for this report. Instead, this section focuses on social isolation as indicated by neighbourhood attachment autoscore and volunteering.

Neighbourhood Attachment

There were 105 respondents with a neighbourhood attachment autoscore at both baseline and 6-month follow up[24].

The autoscore was calculated from responses to the following 6 statements:

'I feel like I belong to this neighbourhood'
'The friendships and associations I have with other people in my neighbourhood mean a lot to me'
'If I needed advice about something I could go to someone in my neighbourhood'
'I borrow things and exchange favours with my neighbours'

[24] Manchester was excluded from this analysis due to them collecting data for only 5 of the 6 statements

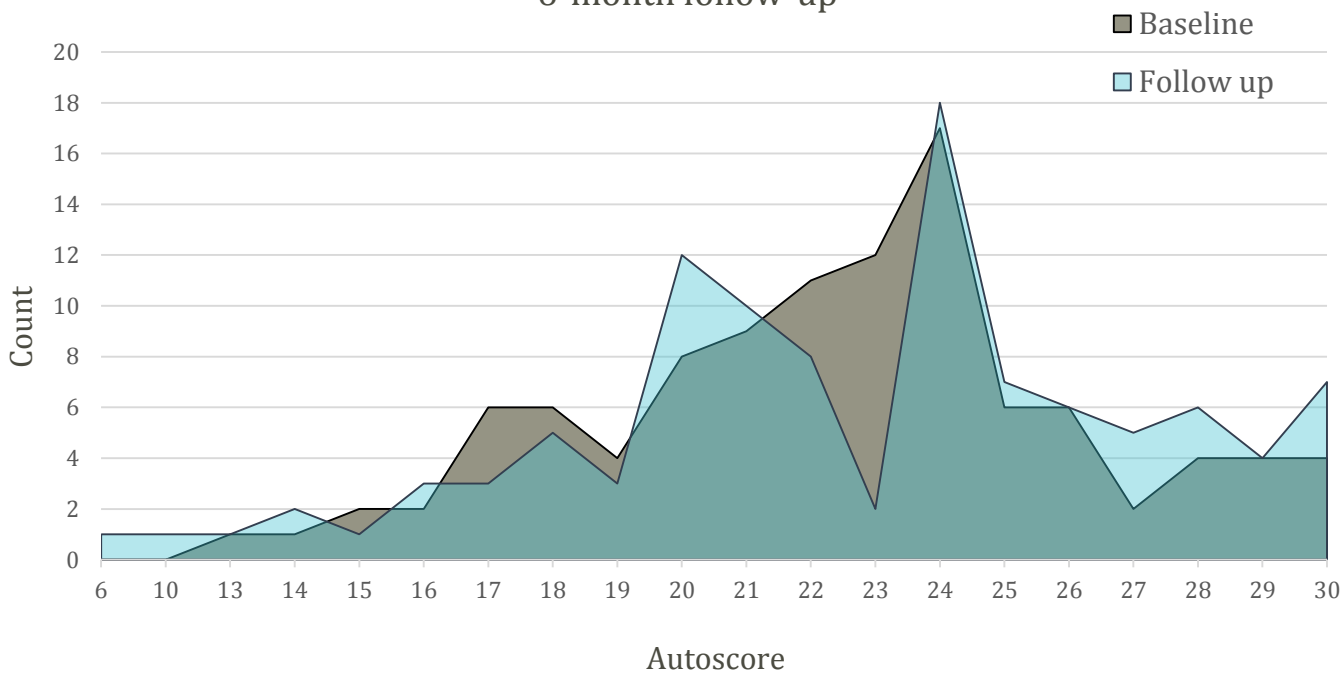
‘I would be willing to work together with others on something to improve my neighbourhood’
‘I regularly stop and talk with people in my neighbourhood’

The potential responses for each were coded as follows:

Response	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Score	1	2	3	4	5

There was a **marginal increase in score**, from 22.5 at baseline to 22.7 at follow-up (1% increase). The median score increased from 23 to 24. The graph below (figure 7.4) shows the distribution of scores for baseline scores compared to follow-ups. The distribution of responses is more varied at follow-up, with a smaller peak at 20, followed by a drop and then a larger peak at 24.

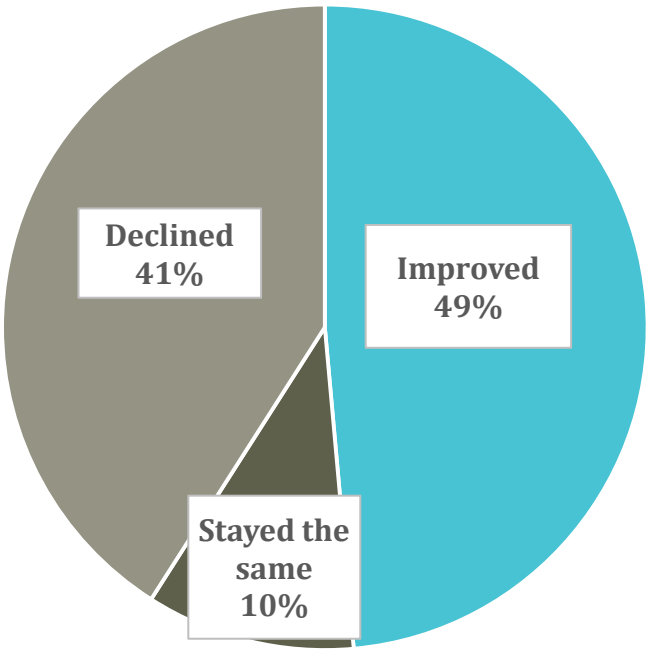
Figure 7.4: Neighbourhood Attachment Autoscore comparison: Baseline and 6-month follow-up



The pie chart below (figure 7.5) shows directional change for respondents.

The graph shows that the majority of respondents’ scores improved at follow-up compared to their baseline score (49%). 41% had lower neighbourhood attachment scores at follow-up, and 10% stayed the same.

Figure 7.5 Change in Neighbourhood Attachment Autoscore from Baseline to 6-month Follow Up



The average score for respondents who's scores stayed the same was 22.6, indicating a slightly positive score.

The respondents whose scores improved at follow-up had a lower average score at baseline than those whose scores declined (20.9 compared to 24.2, respectively).

There was an average change of approximately 4 points for both the improvers and the decliners, in opposite directions.

Although overall neighbourhood attachment levels have stayed the same, this analysis shows there is substantial variation in individual responses which would be interesting to explore further when more data is available.

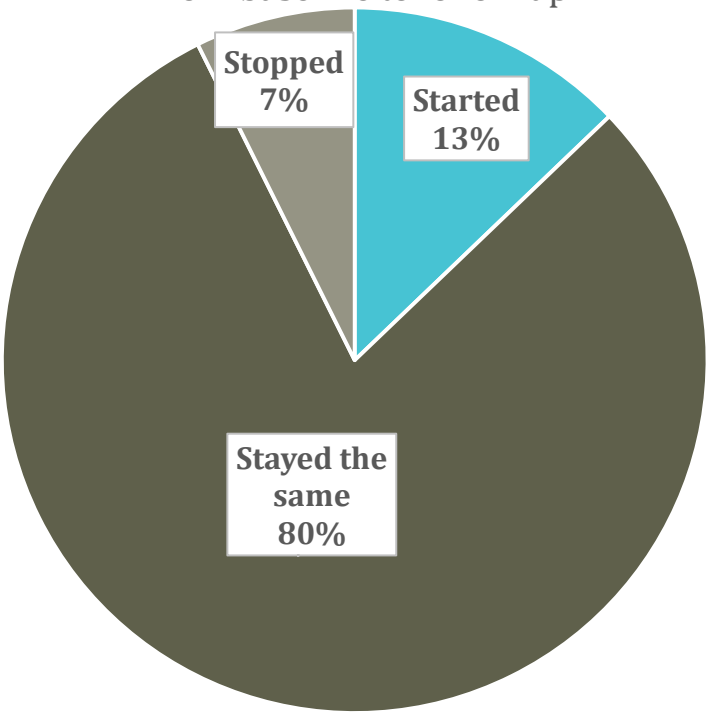
Volunteering

There were 110 respondents who stated whether or not they volunteer at both baseline and 6-month follow-up.

The percentage of respondents who stated that they volunteered **increased 6%**, from 46% at baseline to 52% at follow up.

Figure 7.6 (overleaf) shows change in volunteering activity from baseline to follow-up.

Figure 7.6 Change in volunteering activity from baseline to follow up



The large majority of respondents (80%) stated that there had been no change in their volunteering activity. Of these, 49% were already volunteering and 51% were not.

13% stated that they had started volunteering, and 7% stated that they had stopped volunteering.

Of those who were not volunteering, 11% stated that they wanted to volunteer.

The second programme outcome of AfA is: 'Older people in the designated wards have increased and improved social connections'. Overall, analysis shows that changes in social isolation since involvement in AfA are greatly varied. There has been a slight increase in volunteering, but substantial variance in neighbourhood attachment scores mean that there is no clear trend for improvement in self-perception of social isolation.

However, as stated previously, the data included in this analysis is limited and not representative of the whole sample taking part in the evaluation, or the wider programme participants. As numbers of follow up responses increases, other trends may emerge. Additionally, this analysis only examines changes at 6-months. It may be take longer than this for impacts to emerge. Future analysis intends to make use of data collected through 12-month follow up questionnaires once the sample size increases, to examine changes over a longer period of time.

Further qualitative research would also be beneficial, to better understand the nuances of the variation and provide a deeper understanding of experiences of social isolation within the cohort.

Section 8: Conclusions and Recommendations

Overall, there was much more progamme activity in 2017 than 2016, with an increase of 103% in the number of projects and an increase of 174% in monetary investment. There was an increase in investments in all LA areas, and an increase in the number of older people involved in the planning and design of projects, as well as participating, volunteering, and attending events. This increased activity and engagement with older people is evidence of the programme working well towards its intended outcome that, in areas supported by the programme, more older people will undertake activities of interest and the capacity of local assets will increase.

The majority of projects (56%) have utilised group intervention methods, which are recognised by MICRA as effective ways to increase social participation. However, the proportion of community development/neighbourhood interventions, which have been shown to be more sustainable, have remained lower (26% in both 2016 and 2017). Projects may want to look at developing further interventions of this nature to increase the likelihood of sustainability post-AfA, particularly as the programme enters its final year. Additionally, AfA will need to ensure strategies are in place for increasing the likelihood of sustainability for the projects that are not community development/neighbourhood interventions.

The programme has generally engaged with a large number of varied and diverse older people, and the second year of the programme appears to have been even more successful in engaging with individuals at higher risk of social isolation. This is reflected in the fact that the proportions of men engaged have increased, the proportions of heterosexuals have decreased, and the average number of social isolation risk factors experienced by respondents has increased. As such, baseline responses to some of the outcome-related questions were lower for some of these individuals, indicating potentially higher levels of social isolation. However, certain demographic groups were still over-represented in the evaluation, particularly white women. With the imminent launch of a range of AfA scaled programmes designed specifically to target marginalized groups, it will be interesting to explore who engages with these projects, and how their baseline responses compare to those currently engaging with AfA projects.

Initial analysis of follow-up questionnaires identified an increase from 78% to 84% in the proportion of respondents identifying their area as ‘somewhat’ or ‘very’ age-friendly, providing some indication that the programme outcome to increase age-friendliness in areas where the programme is delivered is being met. Whilst respondent perceptions of age-friendliness are generally high, variation within the cohort suggests that there are some groups who are less likely to perceive their neighbourhoods as age-friendly, such as those with caring responsibilities or long-term health conditions or disabilities. The programme would benefit from further research into the experiences of these individuals, to explore whether this cohort have specific issues related to age-friendliness which may not currently be being tackled by the programme.

Whilst analysis of follow-ups indicated an increase in perception of neighbourhoods as age-friendly, changes in social isolation were more varied. One key limitation of this analysis is that numbers of follow ups are relatively low and certain groups, such as widowed, retired, and respondents with long-standing health difficulties or disabilities, are over-represented. Increasing both the number of follow-ups, and a more diverse range of individuals engaging with the follow ups, is recommended. This would enable a better of understanding of changes since involvement with the project, as well as understanding how these changes may differ for different types of individual i.e exploring not simply whether the programme has been successful, but who it has been successful for. As the programme enters its third year, there will be an increased opportunity to gather data from 12-month follow-up questionnaires, and it

is recommended that LDLs renew efforts and strategies to collect this data. This will allow for analysis of changes post-involvement in AfA in relation to key outcomes, to see whether differences have had a lasting impact.

Analysis uncovered substantial geographical variations in the baseline data, which provides support for AfA's use of place-based approaches for developing age-friendly communities and tackling social isolation. With an increase in follow-up data, it is hoped that changes in outcomes will also be able to be explored through a place-based lens in future evaluation work.

A positive correlation between perception of neighbourhood age-friendliness and an individual's ability to influence decisions in their local area highlights the value of AfA's focus as a programme 'with' older people rather than simply 'for' older people, recognising the importance of empowering older people and ensuring their voices are heard. The asset-based approach is currently engaging many respondents who are willing to work with others and who believe that people can create change by working together (with 77% respondents stating this). With older people's engagement being fundamental to AfA's success, this is encouraging for both the programme and its potential for sustainable action. However, this approach also runs the risk of excluding those who are most marginalised and disempowered. AfA have recognised the risks of asset-based approaches contributing to inequalities, and LDLs will need to ensure they are implementing strategies to try to prevent this. AfA could benefit from further research into the significant minority partaking in the progamme who have different attitudes about working together and driving change, to explore why they chose to get involved, whether their attitudes have remained the same since involvement in the programme, and how AfA can best engage and accommodate people with different motivations and opinions about their civic participation.

Appendices

Appendix 1: Total Sample and Respondent Details at Baseline

A. Total Sample Sizes

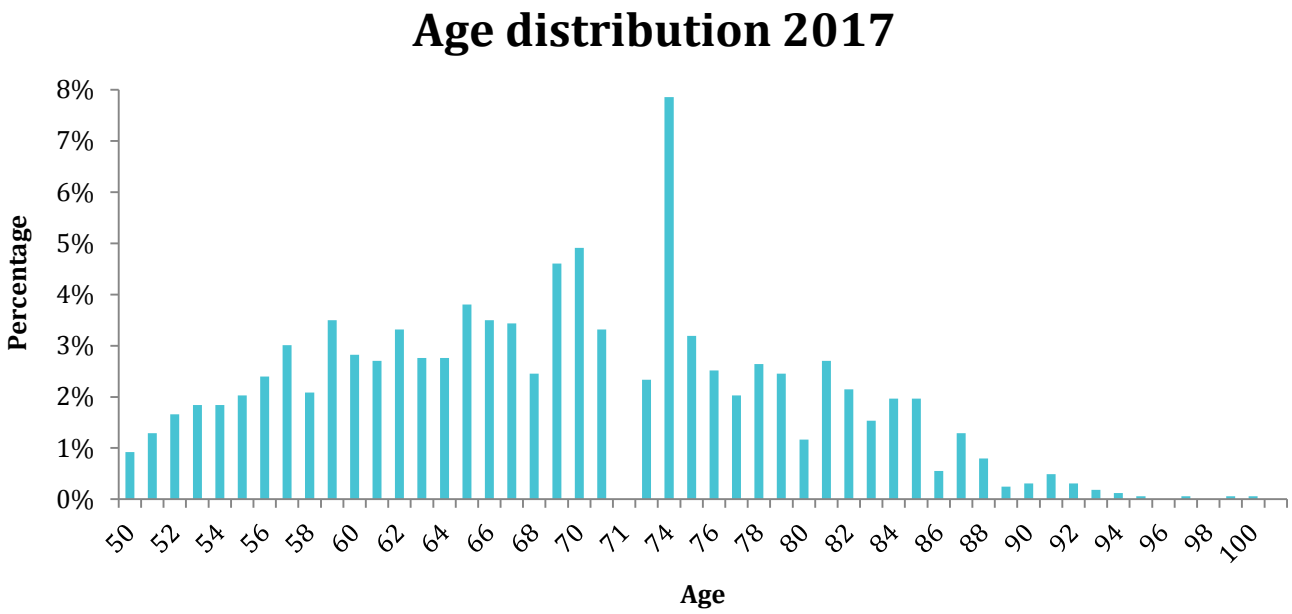
Total Sample Sizes						
Area	**Baseline Participant forms**	**6 month follow up Participant forms**	**Baseline Volunteer forms**	**6 month follow up Volunteer forms**	**Event forms (feedback)**	**Event attendee forms (demographics)**
Bolton	96	26	20	3	301	43
Bury	135	0	27	0	334	289
Manchester	207	0	0	0	0	114
Oldham	99	21	27	6	602	301
Rochdale	98	1	37	9	167	5
Salford	65	1	17	3	128	63
Tameside	129	15	17	0	596	349
Wigan	162	57	8	1	141	47
Total	**991**	**121**	**205**	**22**	**2,269**	**1,211**

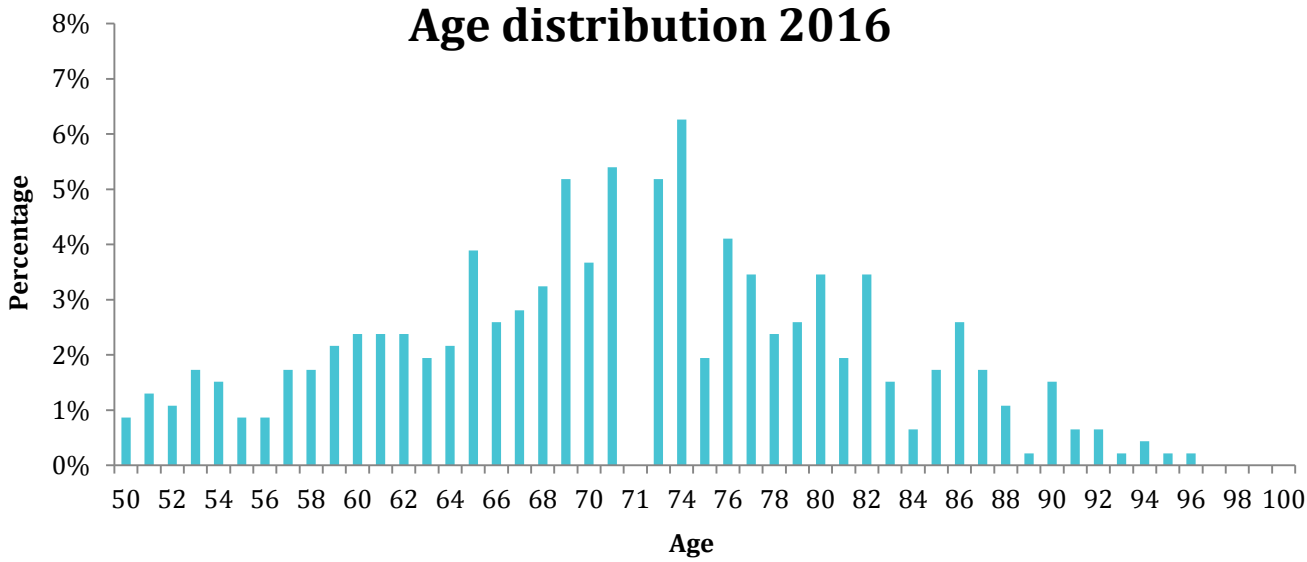
B. Questionnaire Type by Area (the percentages in brackets show the proportion of that questionnaire type coming from that area).

Questionnaire Type by Area						
	Participant (n=991)		**Volunteer (n=205)**		**Event (n=1211)**	
Area	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Bolton	13 (4%)	83 (12%)	12 (13%)	8 (7%)	10 (6%)	33 (3%)
Bury	5 (18%)	130 (18%)	4 (4%)	23 (21%)	16 (9%)	273 (26%)
Manchester[25]	97 (34%)	110 (15%)	0	0	0	114 (11%)
Oldham	50 (18%)	49 (7%)	23 (24%)	4 (4%)	79 (50%)	222 (21%)
Rochdale	18 (6%)	80 (11%)	11 (12%)	26 (23%)	1 (<1%)	4 (<1%)
Salford	16 (6%)	49 (7%)	37 (39%)	32 (29%)	20 (12%)	43 (4%)
Tameside	20 (7%)	109 (15%)	4 (4%)	13 (12%)	31 (18%)	318 (31%)
Wigan	63 (22%)	99 (14%)	3 (3%)	5 (4%)	15 (9%)	32 (3%)
Total (per year)	**282**	**709**	**94**	**111**	**172**	**1039**

[25] There are no volunteer forms for Manchester because they only collect data of this type using the participant form.

C. Histograms of age distributions for each year





D. How long have you lived in your ward? Proportions per year

Length of Time	2016 (n = 451)	2017 (n = 1443)
<5 years	11.09%	9.08%
5-10 years	12.42%	13.51%
11-30 years	28.60%	33.61%
31-50 years	29.27%	26.20%
>50 years	18.63%	17.60%
Total	**100%**	**100%**

E. Employment – proportions per year

Employment Status	2016 (n = 486)	2017 (n = 1583)
Employed full-time	4.32%	7.96%
Employed part-time	7.20%	4.93%
Retired	78.19%	74.48%
Self-employed	0.82%	2.72%
Unemployed	9.47%	9.92%
Grand Total	**100.00%**	**100.00%**

F. Sexuality – proportions per year

Sexuality	2016 (n = 378)	2017 (n = 1444)
Bisexual	1.32%	2.77%
Gay	1.59%	2.77%
Heterosexual	96.83%	93.21%
Lesbian	0.26%	1.25%
Grand Total	**100.00%**	**100.00%**

G. Marital Status – proportions per year

Marital Status	2016 (n = 483)	2017 (n = 1687)
Co-habiting	1.66%	3.85%
Divorced	13.25%	12.39%
Married or civil partnered	37.27%	41.79%
Single	14.49%	13.81%
Widow or Widower	33.33%	28.16%
Grand Total	**100.00%**	**100.00%**

H. Longstanding illness or disability – proportions per year

Longstanding illness/disability?	2016 (n = 461)	2017 (n = 1529)
No	49.89%	52.26%
Yes	50.11%	47.74%
Grand Total	**100.00%**	**100.00%**

I. Providing support – proportions per year

Is there anyone you support?	2016 (n = 302)	2017 (n = 675)
No	82.45%	82.37%
Yes	17.55%	17.63%
Grand Total	**100.00%**	**100.00%**

Appendix 2: Age-friendliness and Civic Participation Crosstabs

A. Extent of neighbourhood age-friendliness by questionnaire type

Age-friendly neighbourhood	Participant	Volunteer	Events
My neighbourhood is not at all age-friendly	7.33%	6.15%	5.39%
My neighbourhood is not really age-friendly	14.78%	17.32%	13.71%
My neighbourhood is somewhat age-friendly	50.64%	55.87%	50.11%
My neighbourhood is very age-friendly	27.24%	20.67%	30.79%
Grand Total	**100.00%**	**100.00%**	**100.00%**

B. Neighbourhood age-friendliness by area

	My neighbourhood is not at all age-friendly	My neighbourhood is not really age-friendly	My neighbourhood is somewhat age-friendly	My neighbourhood is very age-friendly
GM Bolton	8.96%	12.32%	59.66%	19.05%
GM Bury	7.54%	14.86%	48.56%	29.05%
GM Manchester	8.65%	21.62%	50.27%	19.46%
GM Oldham	3.47%	14.71%	42.81%	39.01%
GM Rochdale	5.00%	13.46%	60.38%	21.15%
GM Salford	6.67%	15.83%	55.00%	22.50%
GM Tameside	6.07%	12.60%	47.12%	34.21%
GM Wigan	4.01%	13.14%	56.93%	25.91%
Grand Total	**6.04%**	**14.26%**	**50.81%**	**28.89%**

C. Table showing extent of age-friendliness by area for 2017, and the increase/decrease from the previous year.

To what extent do you live in an age-friendly neighbourhood?	My neighbourhood is not at all age-friendly	My neighbourhood is not really age-friendly	My neighbourhood is somewhat age-friendly	My neighbourhood is very age-friendly
GM Bolton	8.6% (-0.7%)	9.1% (-7.2%)	61.4% (+3.9%)	20.8% (+3.9%)
GM Bury	7.9% (+4.7%)	15.2% (+5.5%)	47.4% (-17.1%)	29.5% (+6.9%)
GM Manchester	13.5% (+11%)	24% (+5.5%)	46.2% (-9.4%)	16.3% (-7.2%)
GM Oldham	2.7% (-1.5%)	15% (+0.6%)	41.6% (-2.3%)	40.6% (+3.1%)
GM Rochdale	5.4% (+2%)	14.4% (+4.1%)	61.4% (+5.4%)	18.8% (-9.5%)
GM Salford	5.9% (-3.2%)	15.7% (-0.7%)	56.8% (+7.7%)	21.6% (-3.9%)
GM Tameside	5.8% (-1.3%)	13.2% (+3%)	47.3% (+0.8%)	33.7% (-2.5%)
GM Wigan	6.2% (+4.1%)	13.8% (+1.3%)	56.2% (-5.4%)	23.8% (-4%)
Grand Total	**6.45%**	**14.41%**	**50.61%**	**28.53%**

D. Responses to 'I can influence decisions affecting my local area' by year

I can influence decisions affecting my local area	2016 (N=819)	2017 (N=1859)	Total Sample (N=2678)
Definitely agree	14.65%	13.29%	13.70%
Tend to agree	46.40%	42.01%	43.35%
Tend to disagree	25.27%	30.29%	28.75%
Definitely disagree	13.68%	14.42%	14.19%

E. Responses to 'People can change things in my local area if they work together' by year

People can change things in my local area	2016 (N=872)	2017 (N=1915)	Total Sample (N=2787)
Definitely agree	34.17%	34.31%	34.27%
Tend to agree	50.23%	49.40%	49.66%
Tend to disagree	8.60%	10.34%	9.80%
Definitely disagree	7.00%	5.95%	6.28%

F. Responses to Civic Participation questions by area

I can influence decisions affecting my local area	Definitely agree	Tend to agree	Tend to disagree	Definitely disagree
GM Bolton (N=341)	16.42%	48.68%	23.46%	11.44%
GM Bury (N=420)	14.76%	37.62%	32.86%	14.76%
GM Manchester (N=158)	8.86%	41.14%	32.28%	17.72%
GM Oldham (N=590)	15.59%	47.63%	24.92%	11.86%
GM Rochdale (N=232)	12.07%	44.40%	30.60%	12.93%
GM Salford (N=143)	11.19%	46.85%	26.57%	15.38%
GM Tameside (N=549)	12.02%	40.80%	30.60%	16.58%
GM Wigan (N=245)	13.47%	39.59%	31.43%	15.51%
Total Sample (N=2678)	**13.70%**	**43.35%**	**28.75%**	**14.19%**

People can change things in my local area	Definitely agree	Tend to agree	Tend to disagree	Definitely disagree
GM Bolton (N=355)	40.56%	47.04%	6.48%	5.92%
GM Bury (N=429)	33.33%	47.09%	13.05%	6.53%
GM Manchester (N=163)	31.90%	54.60%	8.59%	4.91%
GM Oldham (N=602)	36.05%	48.17%	8.97%	6.81%
GM Rochdale (N=233)	25.75%	62.66%	9.01%	2.58%
GM Salford (N=147)	38.10%	48.30%	8.84%	4.76%
GM Tameside (N=583)	31.39%	49.40%	11.32%	7.89%
GM Wigan (N=275)	36.36%	47.64%	9.45%	6.55%
Whole Sample (N=2787)	**34.27%**	**49.66%**	**9.80%**	**6.28%**

G. Average Civic Participation score by characteristics

Employment Status	Average Civic Participation Autoscore
Employed full-time	5.766666667
Employed part-time	5.75862069
Retired	5.412060302
Self-employed	5.666666667
Unemployed	5.614285714
Overall average	**5.482374768**

Do you currently have a longstanding health condition or disability?	Average Civic Participation Autoscore
No	5.644787645
Yes	5.311111111
Overall average	**5.474480151**

H. Responses to 'I can influence decisions affecting my local area' by characteristics

I can influence decisions affecting my local area					
Supporting anyone? (N=629)	**Definitely agree**	**Tend to agree**	**Tend to disagree**	**Definitely disagree**	**Grand Total**
No	9.25%	42.39%	31.98%	16.38%	100.00%
Yes	14.55%	42.73%	31.82%	10.91%	100.00%
Grand Total	**10.17%**	**42.45%**	**31.96%**	**15.42%**	**100.00%**

I can influence decisions affecting my local area				
Do you have a longstanding health condition or disability? (n=609)	**Definitel y agree**	**Tend to agree**	**Tend to disagree**	**Definitely disagree**
No	12.46%	41.75%	34.34%	11.45%
Yes	7.69%	41.35%	31.09%	19.87%
Grand Total	**10.02%**	**41.54%**	**32.68%**	**15.76%**

I. Cross tab of age-friendliness and responses to 'I can influence decisions affecting my local area'. Spearman Rank correlation coefficient of 0.3. Highest proportion highlighted in green.

I can influence decisions affecting my local area					
Age-friendliness	**Definitely agree**	**Tend to agree**	**Tend to disagree**	**Definitely disagree**	**Grand Total**
My neighbourhood is not at all age-friendly	10.20%	20.41%	32.65%	36.73%	100.00%
My neighbourhood is not really age-friendly	4.63%	25.93%	36.11%	33.33%	100.00%
My neighbourhood is somewhat age-friendly	9.04%	44.93%	32.60%	13.42%	100.00%
My neighbourhood is very age-friendly	17.86%	50.00%	25.60%	6.55%	100.00%
Grand Total	**10.58%**	**41.45%**	**31.45%**	**16.52%**	**100.00%**

J. Cross tab of age-friendliness and responses to 'People can change things in my local area if they work together'. Highest response proportions highlighted in green.

People can change things in my local area if they work together				
Age-friendliness	**Definitely agree**	**Tend to agree**	**Tend to disagree**	**Definitely disagree**
My neighbourhood is not at all age-friendly	34.04%	38.30%	12.77%	14.89%
My neighbourhood is not really age-friendly	25.93%	56.48%	10.19%	7.41%
My neighbourhood is somewhat age-friendly	23.22%	60.16%	11.87%	4.75%
My neighbourhood is very age-friendly	32.80%	54.30%	9.14%	3.76%

K. Correlation Matrix – neighbourhood attachment proxies

	I feel like I belong to this neighbo ur-hood	*The friendship s mean a lot to me*	*I could go to someone in my neighbor-hood*	*I borrow things and exchange favours with my neighbours*	*I would be willing to work together with others*	*I regularly stop and talk with people in my neighbour hood*
I feel like I belong to this neighbourhood	1					
The friendships mean a lot to me	0.6	1				
I could go to someone in my neighbourhood	0.6	0.6	1			
I borrow things and exchange favours with my neighbours	0.4	0.4	0.5	1		
I would be willing to work together with others	0.4	0.4	0.4	0.4	1	
I regularly stop and talk with people in my neighbourhood	0.5	0.5	0.5	0.4	0.4	1

Appendix 3: Objective Measures of social contact

A. Objective measures of social contact 2016 and 2017 comparison

How often do you meet up?			
	2016 (n=238)	2017 (n=603)	Grand Total
Less than once a year or never	8.40%	4.98%	5.95%
Once or twice a year	0.84%	1.00%	0.95%
Every few months	3.78%	2.99%	3.21%
Once or twice a month	8.40%	7.79%	7.97%
Once or twice a week	28.99%	37.31%	34.96%
Three or more times a week	49.58%	45.94%	46.97%
Grand Total	**100.00%**	**100.00%**	**100.00%**

How often do you speak on the phone?			
	2016 (n=227)	2017 (n=584)	Grand Total
Less than once a year or never	6.17%	4.97%	5.30%
Once or twice a year	0.44%	0.86%	0.74%
Every few months	3.08%	2.40%	2.59%
Once or twice a month	7.93%	10.27%	9.62%
Once or twice a week	24.23%	28.42%	27.25%
Three or more times a week	58.15%	53.08%	54.50%
Grand Total	**100.00%**	**100.00%**	**100.00%**

How often do you text?			
	2016 (n=204)	2017 (n=544)	Grand Total
Less than once a year or never	23.53%	17.65%	19.25%
Once or twice a year	0.98%	1.10%	1.07%
Every few months	4.41%	2.21%	2.81%
Once or twice a month	4.41%	5.88%	5.48%
Once or twice a week	14.71%	17.83%	16.98%
Three or more times a week	51.96%	55.33%	54.41%
Grand Total	**100.00%**	**100.00%**	**100.00%**