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Ageing Better: Impact Evaluation Report

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Ageing Better: Impact Evaluation Report

Contents

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Executive summary

Ageing Better is an £87 million, seven-year, programme funded by TNLCF. The programme aims to improve the lives of people aged 50 and over by addressing social isolation and loneliness, improving social connections, and enabling people over 50 to be more engaged in the design of services for their communities. It also aims to challenge negative narratives around ageing and promote a positive image of later life[1].

This Impact Evaluation Report explores evidence gathered from the Ageing Better local partnership areas during the first five years of the programme's operation. It draws on data gathered from the programme's Common Measurement Framework (CMF) to explore the profile of people engaging in Ageing Better and the kinds of activities that attracted them. The report also explores the impact – or effect – of taking part in Ageing Better activities. This impact analysis compares the results for people taking part in Ageing Better with other people to see whether participating in Ageing Better activities helped people to have more social contact and wellbeing, and to feel less lonely.

We found that from October 2015 up until the start of the COVID-19 pandemic in March 2020, Ageing Better engaged almost 150,000 people and made measurable improvements in participants' social contact and wellbeing.

Our data also shows that people who took part in Ageing Better activities tended to become less lonely over time. However, we could not link this change to participation in Ageing Better as people who didn't take part in any programmes also became less lonely over time. Our findings provide further evidence that the links between social contact and both wellbeing and loneliness are complex.

Ageing Better worked creatively to engage people over 50 years old. It engaged people who were experiencing loneliness, and had low levels of social contact and wellbeing. It also reached people over 50 in groups that are particularly at risk of loneliness and social isolation, such as LGBTQ+ people and people from ethnic minorities.

[1] 'Big Lottery Fund. Fulfilling lives: Ageing Better: About Ageing Better', The National Lottery Community Fund. Available at: https://www.tnlcommunityfund.org.uk/funding/strategic-investments/ageing-better. Accessed on 23/7/2021

The core principles of the Ageing Better programme were:

- Partnerships should work with the strengths and assets of people over 50 and their local communities
- Project activities should be co-designed and delivered with people over 50, and people over 50 should drive the decision-making and governance of their local programmes
- Approaches to social isolation should be proactive and preventative
- Programmes should be delivered through partnerships across the public, private and voluntary sectors

The 'asset-based' and co-designed nature of Ageing Better meant the approach was different in each of the 14 local partnership areas. Each local partnership delivered a range of projects, including developing new activities or groups, linking people to support in their community, providing intensive one-to-one support, developing outreach programmes, and engaging people in community development activities.

Our evidence suggests that offering different ways to take part helped a wide range of people get involved in the programme. Ageing Better engaged a higher proportion of older people from ethnic minorities, older LGBTQ+ people, and more lonely people than there were among the over-50 population in local partnership areas.

The evidence does not support any strong conclusions around the specific types of interventions that were most effective at engaging particular groups. Instead, it shows that diversity of provision was important in engaging people.

Similarly, our findings on impact do not support strong conclusions around what types of approaches are most helpful in addressing social isolation and loneliness. While there was evidence that 'asset-based community development' projects were relatively more helpful in improving outcomes, in general we could not clearly identify particular project types that should be prioritised for particular groups.

Instead, our evidence backs up the value of the core approaches built into the Ageing Better programme – the importance of engaging people over 50 in co-design and co-production, shifting the narrative on ageing from 'deficit' to a 'strengths-based' approach.

The programme was explicitly intended to test out different approaches, and learn and adapt along the way. Local partnerships have learnt a lot about what works in their own local contexts to engage people, and have made measurable differences to people's wellbeing and social contact. However, there is still more to be done to understand how different interventions impact on people's subjective experiences of loneliness and to understand what works, when, and for whom.

Based on our findings we outline the following recommendations:

- Organisations interested in addressing social isolation and improving wellbeing should draw on the learning from the Ageing Better programme to inform their work, particularly in understanding how programmes and activities can best support people aged 50 and over
- There should be continued investment in long-term monitoring of the impact of interventions to address loneliness drawing on both qualitative and quantitative evidence
- The Government, Office for National Statistics and other experts should continue to review the suite of measures available for assessing levels of loneliness and consider their effectiveness for evaluating interventions
- Organisations interested in addressing loneliness and social isolation and improving wellbeing in communities should consider how they can ensure that there is a diverse offering of activities available to attract and engage a wide range of people, including those at particular risk of loneliness and isolation
- Organisations wishing to address loneliness and social isolation amongst people over 50 should take an 'asset-based' approach, drawing on the strengths and assets of local people and communities, and ensuring that people over 50 can help co-design and co-produce activities

1.0
Introduction

About this report

This Impact Evaluation Report sets out our findings about the impact of the Ageing Better programme during its first five years, up until the start of the COVID-19 pandemic. It also explores the profile of the projects that made up the programme and the people who took part in them. The findings in this report draw on quantitative monitoring data collected between the launch of the Ageing Better programme in 2015 and March 2020 and an impact study using that data. It considers the impact – or effect – that taking part in Ageing Better activities had on people's social contact, wellbeing, and loneliness. This report focuses on the impact, rather than providing detail on the full breadth of ways that Ageing Better has worked to engage and help participants.

The impact study was designed to test the high-level hypothesis (set out in the programme's Theory of Change) that taking part in Ageing Better activities leads to positive change in people's social contact, in turn leading to improvements in their loneliness and their wellbeing. Projects took their own approaches to achieving this change, each working with people based on their own needs and wishes, and creating responses that were tailored to local circumstances. These approaches are explored in the next section.

The data tables on which this report draws can be found in the separate Methods Note, with references to relevant tables in the main body of this report. The Methods Note also includes information on the overall methodology for the quantitative data collection elements of the national evaluation of Ageing Better.

About the Ageing Better programme

Ageing Better is a £87 million, seven-year, programme funded by The National Lottery Community Fund (TNLCF). The programme started in 2015 and is running until 2022, with an extension from the initial six-year term to take account of the impact of the COVID-19 pandemic on the programme's work.

The aim of Ageing Better is to improve the lives of people aged 50 and over, by addressing social isolation and loneliness, improving social connections, and enabling people over 50 to be more engaged in the design of services for their communities. The programme also aims to challenge negative narratives around ageing and promote a positive image of later life.

The starting hypothesis of the programme was that reducing social isolation among people over 50 would improve their loneliness and wellbeing and give them the confidence and support to be more active in their neighbourhoods. Ageing Better recognised that people over 50 were assets and, to achieve its aims, it would be critical to give them a voice.

As a national strategic programme, Ageing Better aims for its work through local partnership areas to influence wider efforts to address isolation and loneliness and the approach to ageing, both locally and nationally.

The funding outcomes for the programme are:

1. People over 50 are less isolated and lonely
2. People over 50 are actively involved in their communities with their views and participation valued more highly
3. People over 50 are more engaged in the design and delivery of services that improve their social connections
4. People over 50 are recognised for their positive contribution to society
5. Services that help to improve social connections are better planned, co-ordinated and delivered
6. Better evidence is available to influence the services that help reduce isolation for people over 50 in the future

How Ageing Better works

Ageing Better is a strategic programme delivered by 14 Voluntary, Community and Social Enterprise (VCSE) sector-led partnerships in England. The partnerships have developed and delivered plans to create new and enjoyable ways for people over 50 to be actively involved in their communities, helping to combat social isolation and loneliness.

The core principles of the programme include:

- Partnerships should work with the strengths and assets of people over 50 and their local communities
- Project activities should be co-designed and delivered with people over 50, and people over 50 should drive decision-making and governance of their local programmes

- Approaches to social isolation should be proactive and preventative
- Programmes should be delivered through partnerships across the public, private, and voluntary sectors

Another core feature of the Ageing Better programme was its 'test and learn' approach – giving local partnerships the flexibility to try out a range of approaches, recognising and sharing when things didn't go as intended, as well as when they were successful, so that the programme created practical learning for others.

Through this approach, Ageing Better aimed to improve the wider understanding of how services and interventions addressing social isolation and loneliness could be delivered, and to contribute to an evidence base for future service development.

From the perspective of the evaluation, this approach meant that different projects have operated at different times within different communities and with different groups. This means that the data gathered over the first five years of the programme covers a very wide range of evolving approaches, providing a wealth of learning about what does and doesn't work, and why [2].

What does Ageing Better do?

Ageing Better local partnerships use a variety of models for commissioning and resourcing activities to reduce social isolation and support community engagement and development including:

- Commissioning services from local providers through contracts
- Service delivery by organisations within the partnerships
- Funding for grassroots activity

Over the first five years of operation, Ageing Better local partnerships delivered a range of projects including:

- New activities and groups through which people can come together and socialise – including 'pure' social groups, as well as creative activities, exercise classes and sports groups and opportunities for people to learn together

[2] Much of the learning and evidence can be found on the Ageing Better website at: https://www.tnlcommunityfund.org.uk/funding/strategic-investments/ageing-better#section-2

- Community connector/social prescribing services – which aim to link people who are experiencing or at risk of social isolation with activities and support in their community that can address their social needs and any practical or emotional barriers they may face
- Intensive one-to-one support – recognising that those people who are the most socially isolated (where social isolation is entrenched and embedded) will need a level of personalised one-to-one support to help address their social isolation
- Outreach programmes – to identify people at risk of or experiencing social isolation and loneliness and connect them with sources of support
- Community development activities – through which people within a local area come together to understand their local strengths and needs and to develop local solutions

The programme has also invested in work to build local partnerships and to ensure that the voices of people over 50 are heard within local decision-making structures. Several local partnerships adopted community development principles. Many other local partnership areas funded projects which focus on awareness-raising to achieve a system change as well as challenge perceptions of the role of 'older people' in our society. All partnerships are actively working to make their area 'age-friendly' with many working towards the specific World Health Organisation (WHO) framework[3].

When the COVID-19 pandemic hit in March 2020, most Ageing Better partnerships were due to enter what was originally scheduled to be the final year of their delivery. Local partnerships were involved in the immediate pandemic response – supporting people in their communities during a very challenging time, working to adapt their projects around new restrictions, and in some cases developing new projects to meet local needs. These new and urgent priorities and the practical constraints resulting from the pandemic meant that data collection was suspended.

As the impact of the pandemic on isolation and loneliness became clear, TNLCF decided to extend the Ageing Better programme into a final and seventh year to allow local partnerships to continue their vital work and to give them more time to develop learning and evidence and share it widely with key stakeholders and decision makers.

[3] 'The eight domains of Age-Friendly' An introduction to the eight World Health Organisation domains that make an Age Friendly Community. Centre for Ageing Better, 2021, Available at: https://www.ageing-better.org.uk/age-friendly-communities/eight-domains

This report reflects the work of the partnerships from its outset to the start of the pandemic. The work of the partnerships through the pandemic will be reflected in future reports.

About social isolation, loneliness, and wellbeing

Defining social isolation, loneliness, and wellbeing

While distinct, the terms 'social isolation' and 'loneliness' are often used both interchangeably and together to describe an individual's social and/or emotional state. Loneliness is defined as 'a subjective, unwelcome feeling of lack or loss of companionship' that occurs when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want[4]. In contrast, social isolation is an objective measure of the number of social contacts that an individual has, concerned solely with the quantity of relationships and not the quality. Social isolation may, in theory, be overcome with relative ease, by increasing the quantity of social contact. Loneliness is more complex, in that a person may feel deeply lonely despite being surrounded by family and friends.

The Ageing Better programme set out to address both loneliness and social isolation by seeking to improve people's levels of social contact. A minority of projects within the programme sought to address loneliness by changing people's feelings about their relationships or about themselves (e.g., through counselling or other positive mental health support).

As an overarching concept, the term 'wellbeing' covers how a person feels and their ability to function well. It includes 'an individual's experience of their life; and a comparison of life circumstances with social norms and values'[5]. How people feel about their wellbeing – including whether they feel useful, their life satisfaction, and if they feel their life has meaning – is called ***subjective wellbeing***. A person's circumstances – including physical health, life expectancy, and access to education – is called ***objective wellbeing***.

[4] 'Toward a Social Psychology of Loneliness', Daniel Perlman & Letitia Peplau. In 'Personal Relationships: 3. Relationships in Disorder' edited by Robin Gilmour and Steve Duck, 1981 (pages 31-56)

[5] 'Wellbeing. Why it matters to health policy', Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277566/Narrative__January_2014_.pdf

This report focuses predominantly on 'mental wellbeing' – which is a part of subjective wellbeing. Mental wellbeing is defined as 'a positive state of mind and body, underpinned by social and psychological wellbeing'. Evidence shows that having good mental wellbeing can facilitate good relationships, improve resilience, and improve health[6].

Social isolation, loneliness, and wellbeing in Government policy

When TNLCF developed the Ageing Better programme, social isolation and loneliness did not attract the same level of attention in national Government policies as they do today. At the time of Ageing Better's launch, action on loneliness and social isolation was primarily led at a local level.

By investing significant sums in 14 local partnership areas across England, the Ageing Better programme was able to bring a range of partners together to develop a coordinated and collaborative local response to social isolation and loneliness, creating a system-wide response that went beyond individual interventions. The long-term commitment of Ageing Better was intended not only to support action on social isolation and loneliness in local partnership areas, but also to test and learn about what works and to provide an evidence base for wider action.

In the areas in which it has operated, Ageing Better has supported the work of the VCSE sector in bringing people together, building their knowledge and skills to recognise the challenges of social isolation and loneliness, and tackling these issues by strengthening communities and reaching isolated people and groups[7]. By sharing its learning as it went it has also sought to influence national action on loneliness.

While loneliness has long been understood as a significant issue, particularly among older adults, the case for action on loneliness as a public policy challenge was given a significant boost by the launch in 2011 of the Campaign to End Loneliness. The Campaign to End Loneliness focused its early work on loneliness as a public health issue and campaigned for local Health and Wellbeing Boards in England to make addressing loneliness a priority, as well as for national Government action on loneliness.

6 'Wellbeing and Health', Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/225525/DH_wellbeing_health.PDF

7 'Toward a Social Psychology of Loneliness', Daniel Perlman & Letitia Peplau. In 'Personal Relationships: 3. Relationships in Disorder' edited by Robin Gilmour and Steve Duck, 1981 (pages 31-56)

This national agenda for action on loneliness was galvanised and accelerated by the work of the Jo Cox Commission on Loneliness which called for national leadership on loneliness. The first national strategy for loneliness in England was published in October 2018. ***A connected society: a strategy for tackling loneliness – laying the foundations for change*** sets out priorities for tackling loneliness across a range of Government departments[8].

Since then, there has been an ongoing focus on the need for local action on loneliness and to build evidence around what works. Ageing Better has continued to share its learning to inform new programmes of work, for example, NHS England's roll-out of social prescribing, the Department for Transport's inclusive travel strategy, and continuing work to help implement the Government's loneliness strategy.

The Government renewed its commitments to tackling loneliness in response to the COVID-19 pandemic, including investing in emergency support for those experiencing loneliness as part of the Coronavirus Response Fund and creating the Tackling Loneliness Network, which brings together over 70 organisations from the public, private and voluntary sectors[9]. The devastating effect of the pandemic on people's collective mental health and wellbeing, partly as a result of reduced opportunities for face-to-face contact, has been well documented[10].

Although this report analyses pre-pandemic data, it provides insights into the difference face-to-face contact makes to people over 50, and highlights learning that will be valuable as the work to recover from the pandemic continues.

8 'A connected society: a strategy for tackling loneliness - laying the foundations for change', HM Government. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/936725/6.4882_DCMS_Loneliness_Strategy_web_Update_V2.pdf. Accessed on 23/7/2021

9 'Loneliness Annual Report January 2021', Department for Media, Culture, and Sport. Available at: https://www.gov.uk/government/publications/loneliness-annual-report-the-second-year/loneliness-annual-report-january-2021. Accessed on 23/7/2021

10 'Loneliness Annual Report January 2021', Department for Media, Culture, and Sport. Available at: https://www.gov.uk/government/publications/loneliness-annual-report-the-second-year/loneliness-annual-report-january-2021. Accessed on 23/7/2021

Over the same period there has also been increasing attention paid to wellbeing, and to using measures of wellbeing to assess the difference that public services make to people's lives[11]. Work to develop measures of wellbeing and national data collection on wellbeing have contributed to a more holistic understanding of the state of society and national progress, helping to provide a more balanced view of the nation than traditional figures such as Gross National Product[12].

Prevalence and effect of social isolation, loneliness, and wellbeing

The case for action on loneliness has been built on recognition of its damaging impacts. There is growing evidence that chronic loneliness harms physical and mental health as we grow older. Being socially isolated and feeling lonely has been linked to an increased risk of coronary heart disease and stroke[13], and a lower life expectancy on a par with obesity or smoking[14].

Loneliness has been widely linked to several poor health outcomes. Loneliness is linked to depression[15], cognitive decline[16] and an increased risk of dementia[17]. Those who are lonely are also at a greater risk of experiencing social anxiety[18].

11 Commission on Wellbeing and Policy, https://li.com/wp-content/uploads/2019/03/commission-on-wellbeing-and-policy-report-march-2014-pdf.pdf

12 National wellbeing collection, Office for National Statistics. Available at: https://www.gov.uk/government/collections/national-wellbeing

13 'Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies', Nicole K Valtorta et al., 2017

14 'Loneliness and social isolation as risk factors for mortality: a meta-analytic review', Julianne Holt-Lundstad et all, 2015

15 'Perceived social isolation makes me sad: 5-year cross-lagged analyses of loneliness and depressive symptomatology in the Chicago Health, Aging, and Social Relations Study', John Cacioppo, Louise Hawkley, Ronald Thisted, 2010. Psychology and Aging; 25(2): pages 453-463

16 'Loneliness and risk of Alzheimer disease', Robin Wilson, Kristin Krueger, Steve Arnold, 2007. Archives of General Psychiatry; 64(2): pages 234-240

17 'Perceived social isolation and cognition', Louise Hawkley and John Cacioppo, 2009

18 'Loneliness and cortisol: Momentary, day-to-day, and trait associations', Leah Doane and Emma Adam, 2010. Psychoneuroendocrinology; 35(3): pages 430-441

While very high levels of loneliness can be damaging, it is important to note that most people do not experience this level of loneliness. The prevalence of high levels of loneliness among the older population stayed constant throughout the first 15 years of the 21st century, with around 1 in 12 people aged 50 or over saying that before the pandemic they often felt lonely, amounting to around 1.4 million older people. However, estimates at the time suggested the number of older people often feeling lonely could increase to two million by 2026 if remedial action was not taken[19]. We also know that social isolation is widespread. Before the pandemic, half a million older people said they went at least 5 or 6 days a week without speaking to anyone at all.

As with loneliness, high wellbeing is associated with positive health outcomes and life expectancy, including in older people. It is estimated that high levels of subjective wellbeing can increase life expectancy by 4 to 10 years compared with low levels of subjective wellbeing. For people over 65 years old, higher wellbeing is associated with having a stronger immune system and reduced mortality[20]. This means people are less likely to fall ill and are more likely to recover from physical health issues, such as heart or kidney problems[21].

Our wellbeing tends to follow a 'u-shape' curve across the life course – with young people and those over 65 having higher wellbeing than those in the middle age range. Among those over 65, there is a decline in wellbeing over the age of 80[22]. There is mixed evidence on the association between age and wellbeing. Some studies have found little association between wellbeing and age, while others have found higher odds of low wellbeing for young people[23]. These differences may, in part, be due to studies measuring different aspects of subjective wellbeing.

19 'All the lonely people: loneliness in later life', Age UK. Available at: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/loneliness/loneliness-report_final_2409.pdf. Accessed on 18/8/2021

20 'Wellbeing. Why it matters to health policy', Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277566/Narrative__January_2014_.pdf. Accessed on 16/9/2021

21 'Wellbeing. Why it matters to health policy', Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277566/Narrative__January_2014_.pdf. Accessed on 16/9/2021

22 'Predicting wellbeing', NatCen Social Research. Available at: https://www.natcen.ac.uk/media/205352/predictors-of-wellbeing.pdf. Accessed on 16/9/2021

23 'Predicting wellbeing', NatCen Social Research. Available at: https://www.natcen.ac.uk/media/205352/predictors-of-wellbeing.pdf. Accessed on 16/9/2021

Understanding how different people experience social isolation, loneliness, and wellbeing

Anyone can experience social isolation and/or loneliness in later life. However, research suggests some characteristics are associated with people being more likely than others to experience social isolation and/or loneliness. Groups at particular risk of loneliness include people with a caring responsibility, people from some ethnic minorities, LGBTQ+ people, and those living with a disability or chronic illness[24].

In addition to personal characteristics, some life experiences or 'triggers' may leave people more vulnerable to social isolation and/or loneliness[25]. These life events can cause a sudden change in personal circumstances, affect significant relationships, or reduce meaningful connections, leading to loneliness and/or social isolation. Triggers associated with social isolation and loneliness for those aged 50 and over include bereavement, relationship breakdown, retirement, and a decline in their own health, or the health of a partner. An Age UK study found that older adults were more likely to feel lonely if they did not have someone to open up to, had lost their spouse, were in poor health or unable to do the things they would wish to, felt they did not belong in their community, or lived alone[26].

Understanding the circumstances and characteristics that can leave us at risk of loneliness is helpful because socially isolated and lonely people may be difficult to identify and engage due to the stigma associated with loneliness[27].

[24] 'Evidence Review: Loneliness in Later Life', Age UK. Available at: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/rb_june15_lonelines_in_later_life_evidence_review.pdf. Accessed on 23/7/2021

[25] 'Isolation and loneliness: An overview of the literature', Hardeep Aiden, British Red Cross. Available at: https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-and-social-care/co-op-isolation-loneliness-overview.pdf. Accessed on 23/7/2021

[26] 'All the Lonely People: Loneliness in Later Life', Age UK. Available at: https://www.ageuk.org.uk/latest-press/articles/2018/october/all-the-lonely-people-report/. Accessed on 23/7/2021

[27] For example, the NHS highlights that older people experiencing loneliness may be reluctant to ask for help because of associated stigma and pride https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/feelings-and-symptoms/loneliness-in-older-people/

To respond to the range of factors that lead to loneliness and social isolation, Ageing Better aimed to ensure that approaches were tailored and person-centred, responding to individual needs and circumstances.

Experiences of discrimination can negatively impact on a person's mental health and wellbeing. People may experience discrimination due to a range of factors including age, gender, sexual orientation, ethnicity, and physical ability, or a combination of these factors[28].

Adults who identify as LGBTQ+ have a higher prevalence of mental health issues such as depression and anxiety disorders, than those who identify as heterosexual. These issues are even more acute in LGBTQ+ people over 55-years-old, who experience double the rate of poor mental health compared with their heterosexual peers[29]. Older LGBTQ+ people have lived through periods of greater discrimination or have had to surpress their sexual identity for longer.

Older people who are carers can experience lower levels of wellbeing, potentially linked to experience and feelings of isolation due to caring responsibilities as well as the demographic characteristics of this group. They may also neglect their own health to focus on the person they care for[30].

[28] 'Promoting mental health and wellbeing in later life', Age Concern. Available at https://www.mentalhealth.org.uk/sites/default/files/promoting_mh_wb_later_life.pdf. Accessed on 16/9/2021

[29] 'LGBTI Populations and Mental Health Inequality', LGBT Health, 2018. Available at: https://www.lgbthealth.org.uk/wp-content/uploads/2018/08/LGBTI-Populations-and-Mental-Health-Inequality-May-2018.pdf. Accessed on 16/9/2021

[30] 'Ageing Well', Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277584/Ageing_Well.pdf. Accessed on 16/9/2021

People from Black, Arab, Bangladeshi, Pakistani, and Indian backgrounds have been shown to have significantly lower wellbeing than White people[31]. They are more likely to experience several factors that have a negative impact on wellbeing including poor housing, lower socio-economic status, poor health and discrimination[32], as well as barriers to accessing mental health or situational support services (e.g., carers)[33].

Factors that have been linked to a positive impact on wellbeing include living in a rural area, being employed (if of working age), being retired, being financially secure, and having a partner[34].

31 'Wellbeing patterns uncovered', New Economics Foundation, 2012. Available at: https://neweconomics.org/2012/11/well-patterns-uncovered. Accessed on 16/9/2021

32 'Which ethnic groups have the poorest health?', Joseph Rowntree Foundation, 2013. Available at: https://hummedia.manchester.ac.uk/institutes/code/briefingsupdated/which-ethnic-groups-have-the-poorest-health.pdf. Accessed on 16/9/2021

33 'Assessing the mental health needs of older people' Social Care Workforce Research Uni, 2005. Available at: https://www.scie.org.uk/publications/guides/guide03/files/research.pdf. Accessed on 16/9/2021

And 'Barriers to belonging', the British Red Cross. Available at: https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/barriers-to-belonging. Accessed on 16/9/2021

34 'Predicting wellbeing', NatCen Social Research. Available at: https://www.natcen.ac.uk/media/205352/predictors-of-wellbeing.pdf. Accessed on 16/9/2021

2.0
How we approached this evaluation

This report draws on quantitative data gathered from the participants in the work of the Ageing Better programme across its 14 local partnership areas. It also includes findings from an impact study which set out to test the high-level hypothesis that participating in Ageing Better would lead to improvements in levels of social contact, loneliness and wellbeing compared to not taking part in any projects.

How we assessed the impact of the programme

To test the hypothesis that Ageing Better would lead to improvements compared to not taking part in activities, we needed to measure both the change experienced by individuals taking part in Ageing Better and how far any changes were specifically due to participation in the programme. We did this by comparing the outcomes of Ageing Better participants with those of a comparison group of older people who had not participated in Ageing Better. Both groups answered questionnaires at regular intervals, with Ageing Better participants completing an Ageing Better participant questionnaire, and the comparison group completing a comparison questionnaire. Both questionnaires contained the same key questions, allowing us to track how social contact, loneliness and wellbeing changed for all respondents. Because the demographics and 'baseline' outcomes of the comparison group closely match those of the Ageing Better participants, we can reasonably conclude that any difference in the progress made between the two groups can be attributed to participation in Ageing Better.

We used the same approach to briefly explore a secondary hypothesis that Ageing Better would lead to improved outcomes compared to taking part in other programmes. We compared the outcomes of Ageing Better participants with a secondary comparison group of those who took part in other, non-Ageing Better projects.

Carrying out an impact study designed to measure the overall effect of Ageing Better on outcomes including social isolation, loneliness and wellbeing was challenging. Impact studies are most feasible for programmes where the activity being evaluated is separate to other services, not likely to change during delivery and takes place in a stable programme context. They are also more feasible when there is already a good understanding of the potential difference that activities will make and where it is possible to collect data systematically from both participants and a similar group of people who are not taking part. The Ageing Better impact study faced challenges in all these areas (Methods Note: Chapter 3).

The large-scale Ageing Better participant survey that we carried out required a considerable time commitment from everyone who agreed to provide their information. It was also a major undertaking for local Ageing Better partnerships to organise the data collection from 2015 to March 2020 while simultaneously delivering an intensive programme.

Measures

Both the Ageing Better participant and comparison group questionnaires used scales and questions about social contact, wellbeing, and loneliness to measure the outcomes and impact of Ageing Better. Using scales made our evaluation more rigorous as they provided standard measures of the type of change we were measuring, letting us assess how much change has taken place. We used scales that had been developed and used widely in national surveys and/or by academics.

All the data from the Ageing Better participant survey was combined with additional data on project participation, with this dataset providing all the information required in the programme's overall Common Measurement Framework (CMF). The CMF was designed to support ongoing monitoring by projects and areas, and provide key data for the evaluation on who took part and the extent of any change in outcomes. The agreed impact measures included in both the Ageing Better participant questionnaire and comparison survey were:

- The amount of **social contact** that people were having. This was measured using three questions covering the following areas:
  - **How often someone meets with family or friends**
  - **How often someone speaks on the phone with family or friends**[35]
  - **How often someone speaks to anyone who is not a family member**
- **Wellbeing.** This was measured using the **Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)**
- **Loneliness.** This was measured using two different scales:
  - The **UCLA Loneliness Scale** consists of three questions. The impact of participating in Ageing Better has been measured using the standard split

[35] The CMF and comparison survey also included among their outcome measures the frequency of texting and writing with family and friends. These are reported in the Methods Note

between those with a more positive outcome and those with a less positive outcome [36, 37]

- The **De Jong Gierveld (DJG)** scale captures both social and emotional loneliness using six items. Across the full set of items, each person has a score which is defined as either 'no loneliness' or 'some loneliness' [38]

Both the UCLA and DJG measures were included as there was no standard national measure of loneliness when the CMF was being developed. DJG was selected as this measured both social and emotional loneliness, had a mixture of positive and negative questions, and had a strong theoretical basis. The UCLA measure was added subsequently, with it becoming one of the UK Government's recommended measures of loneliness in 2018 (alongside an additional single question direct measure of loneliness[39]).

Full results for all of these measures can be found in the Methods Note (Chapter 2).

Ageing Better participant and comparison group data collection

People taking part in Ageing Better completed an Ageing Better participants' questionnaire when they started attending Ageing Better activities, with further surveys during their engagement, when they stopped their engagement and afterwards. People who were taking part in one-off awareness-raising activities and some other smaller activities were not required to complete the full survey because outcomes for one-off events could not be measured over time. Almost 36,000 participants completed a questionnaire. Of those, 23,000 (64%) completed a full questionnaire, while others completed shorter versions containing fewer questions (Methods Note: Table 2).

[36] 'Social isolation, loneliness, and all-cause mortality in older men and women', Andrew Steptoe, Aparna Shankar, Panayotes Demakakos, and Jane Wardle, 2013. Proceedings of the National Academy of Sciences. 110(15): pages 5797–5801.

[37] More recently, the UK Government recommends that national surveys measure loneliness by a single measure "How often do you feel lonely?" alongside the three UCLA items.

[38] '6-Item Scale for Overall, Emotional, and Social Loneliness: Confirmatory Tests on Survey Data Research on Ageing', Jenny de Jong Gierveld, and Theo van Tilburg, 2006. 6 28(5): pages 582-598.

[39] 'Measuring loneliness: guidance for the use of national indicators on surveys'. Office for National Statistics. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/measuringlonelinessguidanceforuseofthenationalindicatorsonsurveys. Accessed on 19/8/2021

To understand whether Ageing Better made a difference, we carried out surveys with a similar group of people who lived in Ageing Better partnership areas. These comparison surveys were only carried out in parts of those areas with little or no Ageing Better activities, so we could reach more people who did not take part in Ageing Better. We also asked everyone questions about the activities in which they took part. This allowed us to put people into comparison groups: the primary comparison group consisting of those who did not take part in any activities at all; and a secondary comparison group consisting of those who took part in other, non-Ageing Better activities. Anyone who had taken part in Ageing Better was moved into the Ageing Better participant group.

Both comparison groups were interviewed as part of the same comparison survey, with survey waves taking place in July 2018 and then around 6 and 12 months later.

Data analysis for primary and secondary comparison groups

Once the Ageing Better participant and comparison surveys were complete, we checked that the group of people taking part in Ageing Better were as similar as possible to the people in the primary comparison group (those not taking part in any activities) and to the secondary comparison group (those taking part in other, non-Ageing Better activities). We used a matching process to make sure the groups were as similar as possible across a wide range of criteria[40], including their initial levels of social contact, wellbeing, and loneliness, and basic demographics. Matching the groups meant that any differences in outcomes between the two groups are more likely to be due to Ageing Better than due to there being different types of people in each group.

We then compared the results for people taking part in Ageing Better to the results for people in the primary comparison group who had not taken part in any activities at all and those in the secondary group who took part in other, non-Ageing Better activities. We were able to compare the results at 6 months and at 12 months after taking part in Ageing Better. We also compared results for specific types of people, for example, females, older and younger participants, people living alone, or people with a disability.

We have also looked in detail at those taking part in Ageing Better to understand the link between the type of project they attended and their social contact, wellbeing, and

[40] These included initial scores on social contact, wellbeing, loneliness (both scales), age, gender, ethnicity, living status, disability, carer status, length of involvement in Ageing Better (where known), whether involvement was ongoing or not, 1-2-1 or group activity, and a basic measure of project intensity. Data was manipulated and weighed to achieve a good match.

loneliness. We examined this at an overall level, and among different groups of people to provide a full picture of what might work best for various people.

To help understand the findings about the impact of Ageing Better, we drew on additional external learning, where relevant, to interpret the survey findings. The report follows on from other reports and learning papers produced as part of our overall evaluation[41].

Data limitations

Some limitations of the impact study are common in evaluations and some are specific to this study. Impact evaluation requires outcome measures to be fixed at the start and this presents challenges in the context of an evolving programme, particularly when there is also a high degree of variation in local projects. Ageing Better adopted a set of common principles to guide delivery but it was not prescriptive about how loneliness, isolation and wellbeing would be addressed, including the approach to targeting participants and the types of activities funded. The impact study measures the overall impact of Ageing Better against pre-defined outcomes rather than the difference that individual projects made.

The design of our impact evaluation prioritised understanding the overall effect of Ageing Better over the individual effects of different types of activity. Projects may have resulted in meaningful differences in people's lives that are not captured by the impact measures, particularly as the Ageing Better 'test and learn' approach may have resulted in new, unanticipated changes being achieved.

Some limitations arose from the approach to data collection. The study was not designed to cover all Ageing Better participants and so the findings are not fully representative of all the people that took part. People were only asked to complete questionnaires if they attended a regular project and not one-off engagement activities, and some projects and people were excluded[42]. As both projects, and people within projects, were not randomly sampled, results cannot be assumed to be representative of Ageing Better as a whole. Some people may not have taken up the option of using a translated questionnaire, meaning certain ethnic minority groups may be under-represented.

[41] Much of the learning and evidence can be found on the Ageing Better website at: https://www.tnlcommunityfund.org.uk/funding/strategic-investments/ageing-better#section-2

[42] For example, where people were unable to consent to interviews or where projects or people chose not to take part

Although the Ageing Better programme includes activities open to people aged 50 and over, a decision was made to focus on people aged 64 and over when comparing the outcomes of Ageing Better participants to those who did not take part[43]. Our findings about the overall impact of Ageing Better on social isolation, loneliness, and wellbeing therefore relate to those aged 64 and over – this group made up 68% of those completing an Ageing Better participant questionnaire (Methods Note: Table 6).

Some of the limitations of our impact analysis are limitations that are generally found in this type of evaluation. The comparison group was relatively small, and this is likely to have made it more difficult to prove that change had occurred. This was particularly the case for outcomes after 12 months and for analysis for smaller sub-groups within the comparison group.

The analysis used matching to make sure that the people taking part in Ageing Better and the comparison group were as similar as possible. This matching used large weights so that each group was represented in the right proportion in the data. This affects our ability to identify differences. While we matched people across a wide range of important characteristics, we could not include everything that may have changed outcomes, for example whether certain people were particularly motivated to take part in activities.

The analysis also looks at binary outcomes, for example whether more people were above a certain level of loneliness after 6 months than below it, rather than looking at more granular change across the entirety of any scale.

Understanding Ageing Better projects

This report uses a typology of loneliness interventions that was developed by the Ageing Better programme. This typology categorised projects being undertaken by Ageing Better local partnerships.

The typology was developed because it became clear as the programme progressed that local partnerships referred to similar types of interventions and activities in different ways. This created challenges for capturing and sharing learning across the programme. To try to understand the common themes emerging across the national programme,

[43] Restricting the focus reduced the data collection costs, with comparison data collected only from those aged 64 and over.

TNLCF worked with local partnerships to develop a common set of terms or a 'typology' of project types[44].

We have used this typology to see if there are differences in the impact and reach of different types of projects.

Variables used to categorise projects within the Ageing Better programme

Variable	Explanation	Categories
Target group	The target group of people over 50 that each of the projects aim to support A primary and secondary target group were identified for each project	◆ All people over 50 ◆ People over 50 at risk of social isolation/loneliness ◆ People over 50 currently experiencing social isolation/ loneliness ◆ Demographic focus ◆ Living situation ◆ Health focus ◆ Transitions ◆ Distinct groups
Type of intervention	The nature of the intervention taking place	◆ IT intervention ◆ Asset-based (ABCD) ◆ Creative activity ◆ Social intervention ◆ Culture change ◆ Information-sharing/building knowledge ◆ Social prescribing ◆ Mental health ◆ Physical health ◆ Transport

[44] Gibson S, Hotham S, Wigfield, A (2020), Categorisations of Ageing Better Programme interventions designed to reduce loneliness and/or social isolation, A report for the National Lottery Community Fund (unpublished)

Variable	Explanation	Categories
Aim of intervention	The main aim of the project/ intervention, which includes a primary and secondary aim for each project	◆ Empowering people over 50 to become more involved ◆ Improving mental health ◆ Improving physical health ◆ Learning or improving skills ◆ Promoting a positive image of ageing
Level of impact	The level at which the project aims to influence change	◆ Individuals ◆ Interpersonal ◆ Community ◆ Organisational ◆ Public policy
Method of delivery	The way in which the project is delivered	◆ Face-to-face ◆ Telephone ◆ Internet
Type of support	The type of support the projects offer	◆ Group ◆ One-to-one
Location of delivery	The type/s of location where the project is delivered	◆ Business venue ◆ Community venue ◆ Outdoor space ◆ Public transport ◆ Provider's venue ◆ Participant's home

It is important to note, however, that even within these categories there is a huge diversity of provision.

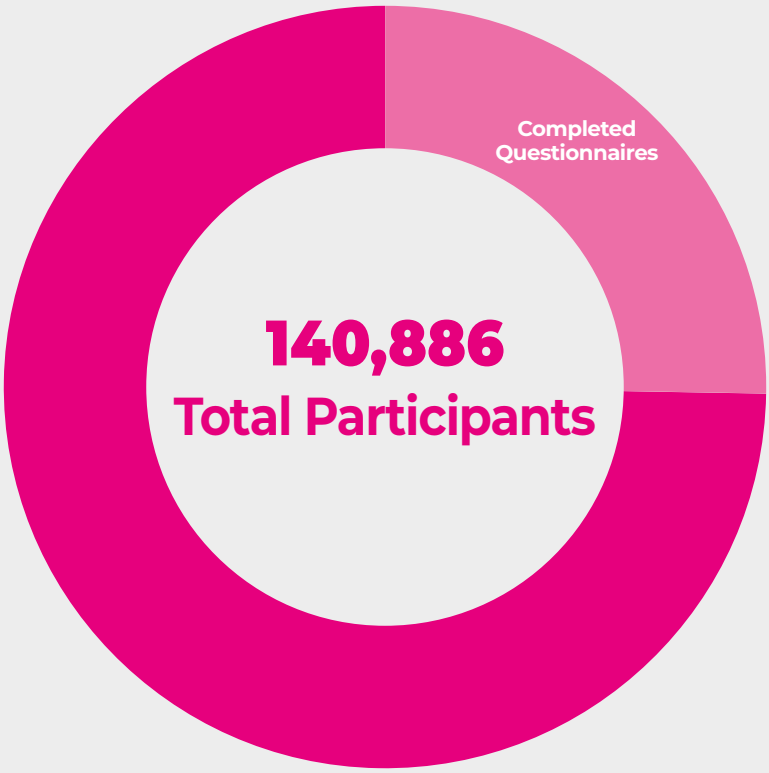
3.0
Our findings: Who took part in Ageing Better?

Key findings:

- 140,886 participants engaged in Ageing Better between the start of the programme in October 2015 and March 2020.
- Ageing Better was effective in engaging people experiencing social isolation and loneliness, and those who felt they took part in social activities less often than their peers.
- Ageing Better participants were relatively socially isolated compared to similar people in England. They were half as likely as their peers to meet family and friends at least every week, and were significantly less likely to be members of a club or society (62%) than their peers (71%).
- Ageing Better was effective in engaging people with low wellbeing.
- Exactly a quarter (25%) of people in Ageing Better had low wellbeing, defined as a score from 7 to 19 out of 35 on SWEMWBS.
- Significantly more females than males took part in Ageing Better, with around two thirds of those taking part identifying as female and one third as male.
- People taking part in Ageing Better were more than twice as likely to come from ethnic minorities (25%) than their peers in the same areas (11%).
- In total, 4% of Ageing Better participants identified as lesbian, gay, bisexual, or other sexuality (LGBTQ+), compared to just over 1% in England among a similar age group.

In this section we explore the profile of people taking part in Ageing Better and the groups that the programme seemed to engage most effectively. Understanding the characteristics shown in this section of those who took part in Ageing Better can help us make sense of the changes in outcomes that we see in later sections of this report.

140,886 participants engaged in Ageing Better between the start of the programme in October 2015 and March 2020. This includes anyone who took part in Ageing Better at all, regardless of whether they took part regularly in a long-running project or simply attended a one-off event.



35,926 participants out of the **140,886**, representing **366 projects**, completed Ageing Better participant questionnaires to provide data for the national evaluation.

People experiencing or at risk of social isolation and loneliness

Ageing Better was effective in engaging people experiencing social isolation and loneliness. The programme supported people over 50 who were experiencing or at risk of social isolation and loneliness.

Exactly half of people (50%) starting an Ageing Better project were lonely according to their UCLA scale response. Comparative data from a survey of people aged 63 and over in England showed that 17% were lonely, showing that Ageing Better engaged a greater percentage of people who were lonely than were found among the wider population (Methods Note: Table 8).

Ageing Better participants were more socially isolated than their peers in England. They were half as likely as their peers to meet family and friends at least every week (34% compared to 74%), and were also significantly less likely to be members of a club or society (62%) than their peers (71%) (Methods Note: Table 8).

Many Ageing Better participants had risk factors for loneliness and social isolation. They were almost twice as likely to live alone (49% compared to 27%) and were also significantly more likely to have poor mental wellbeing than others of the same age living in areas across England (see following section). They were only slightly more likely to have a longstanding illness or disability compared with people over 50 across England (59% compared to 54%) (Methods Note: Table 6).

Ageing Better was also successful in engaging some groups that are particularly at risk of loneliness and isolation, in particular people from ethnic minorities and LGBTQ+ people (see below). This successful engagement was generally helped by providing a mix of activities that were specifically targeted, and more general activities.

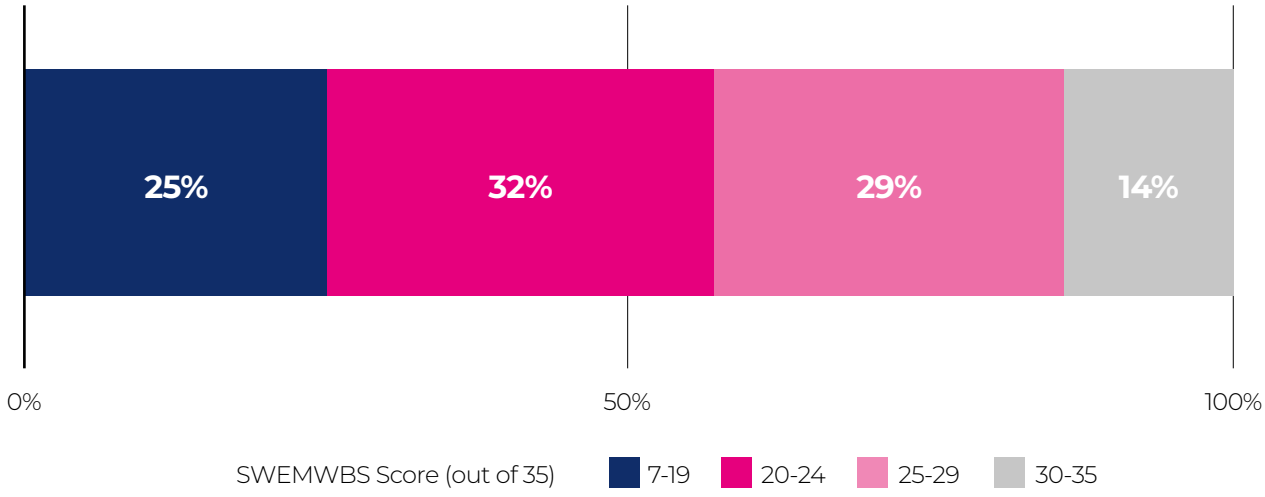
In Chapter 4 we set out in more detail the kind of activities that were most effective in engaging certain groups of people.

People experiencing low wellbeing

Ageing Better was effective in engaging people with low wellbeing. Exactly one quarter of people (25%) in Ageing Better had low wellbeing, defined as a score from 7 to 19 out of 35 on SWEMWBS. Around a third (32%) had slightly higher wellbeing (a

score of 20–24), another third (29%) had a score of 25–29, with a smaller percentage (14%) having relatively high wellbeing at a score of 30–35 (Methods Note: Table 7).

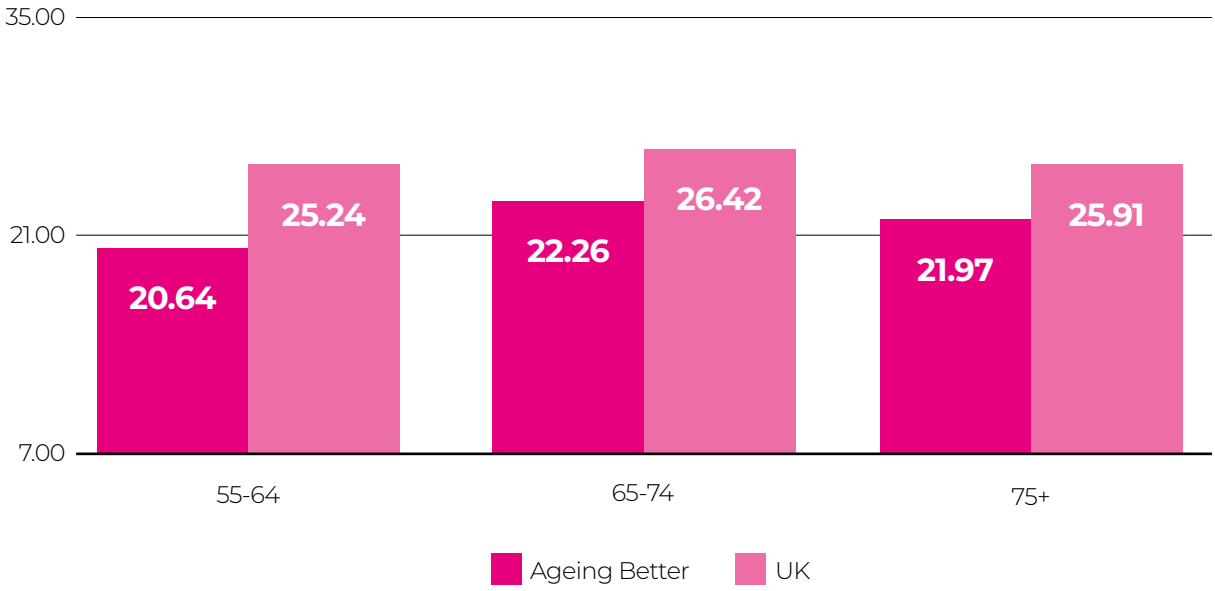
Wellbeing among Ageing Better participants (WEBWEMS)



Base (Ageing Better participants): 18,818

People taking part in Ageing Better tended to have significantly lower wellbeing than their peers across the UK. This was the case regardless of age, with people taking part in Ageing Better aged 55–64, 65–74, and 75 or over all having lower wellbeing than their peers (Methods Note: Table 8).

Wellbeing by age among Ageing Better participants and UK population (SWEMWBS)



Base (Ageing Better participants): 4,822, 5,836, 5,460

Males and females

Significantly more females (68%) than males (32%) took part in Ageing Better (Methods Note: Table 6). This under-representation of males within the programme was something that partnerships noted and sought to respond to by adapting approaches and developing new ones over the life of the programme, as part of the 'test and learn' approach.

In line with the wider evidence in this area, our data showed that males tended to have less social contact than females[45]. Males in Ageing Better had similar levels of wellbeing to females (mean SWEMWBS 21.5 for males and 21.6 for females), with no notable difference between them in loneliness (mean of 3.2 for males compared to 3.1 for females in DJG and both at 5.4 in UCLA) (Methods Note: Tables 11, 10, 9). This compares to large-scale data across England that shows that more females than males tend to be lonely, but that more males than females tend be socially isolated[46].

People from ethnic minorities

Exactly a quarter (25%) of people taking part in Ageing Better were from ethnic minorities, compared to just over a tenth (11%) of their peers in the same areas. This was the case for all ethnic minorities with the exception of those with a Mixed ethnic background where the proportion of Ageing Better participants was similar to the proportion among their peers in the same areas (both at 1%) (Methods Note: Table 6).

We know from previous research that people from ethnic minorities are more likely to be lonely than people who are not, and that loneliness particularly affects some ethnic minorities, such as Chinese people, more than others[47]. We also saw this pattern in our research (Methods Note: Table 10), with higher levels of loneliness when starting Ageing Better among Asian (mean DJG score of 3.7), Mixed (3.5) and Other groups (3.6), than among White (3.0) or Black (3.2) participants.

[45] 'Gender and Loneliness', Campaign to End Loneliness. Available from: https://www.campaigntoendloneliness.org/frequently-asked-questions/gender-and-loneliness/. Accessed on 23/7/2021

[46] 'Gender and Loneliness', Campaign to End Loneliness. Available from: https://www.campaigntoendloneliness.org/frequently-asked-questions/gender-and-loneliness/. Accessed on 23/7/2021

[47] 'Loneliness in mid-life and older adults from ethnic minority communities in England and Wales: measure validation and prevalence estimates', Christina Victor, et al, European Journal of Ageing 18, 5–16 (2021). Available at: https://link.springer.com/article/10.1007/s10433-020-00564-9#citeas

LGBTQ+ people

In total, 4% of Ageing Better participants identified as lesbian, gay, bisexual, transgender, queer, or other sexuality (LGBTQ+), compared to just over 1% in England among a similar age group (Methods Note: Table 6).

The higher percentage of LGBTQ+ participants among those taking part in Ageing Better is important as wider research suggests those who identify as LGBTQ+ may be particularly vulnerable to loneliness and are also less likely to engage with local services due to historical experiences of discrimination[48].

Those who don't usually take part in activities

When asked, exactly half of Ageing Better participants (50%) felt they took part in social activities less or much less often than their peers, compared to 44% of people aged 63 and over in England (Methods Note: Table 8). This data offers some weight to the hypothesis that Ageing Better has successfully engaged people who may not otherwise have taken part in social activities.

[48] 'Lesbian, Gay, and Bisexual people in later life', Stonewall. Available at: https://www.ageuk.org.uk/bp-assets/globalassets/shropshire-telford--wrekin/original-blocks/our-services/useful-links/stonewall-lesbian-gay-and-bisexual-people-in-later-life.pdf. Accessed on 19/8/2021

4.0
Our findings: The diversity of approaches across Ageing Better

Key findings:

- Most Ageing Better projects involved group-based, face-to-face activities that took place in shared spaces
- The most popular projects in terms of the activities they provided were social activities, physical health, and creative activities, with sizeable percentages of participants attending projects which included various other activities, including knowledge sharing, 'asset-based community development', and social prescribing, among others
- Most projects attracted a similar gender balance of attendees (two thirds female and one third male), although mental health projects attracted slightly more men than other projects (4 in 10 participants were male and 6 in 10 were female)
- Transport projects were particularly successful at engaging people aged 75 and over
- Projects with a focus on culture change had a relatively young and White profile
- People attending social prescribing projects were more likely to be aged 75 and older, and also to be White
- People from ethnic minorities were more likely to be engaged in 'asset-based' projects (those that aimed to empower people over 50), physical activities, and mental health activities
- Projects aiming to empower people also tended to have a slightly older participant age profile
- Transport activities attracted participants who were likely to live alone and have higher levels of loneliness
- Mental health projects engaged those who are lonelier than the average Ageing Better participant
- Culture change projects attracted people who tended to be less lonely and less likely to live alone than other types of projects
- More people took part in a project targeting all people over 50 (30%) than any other type of project
- While only 16% of projects targeted people experiencing social isolation and loneliness, 29% of people attended these projects, suggesting these had high attendance and may be important

One of the successes of the Ageing Better programme was that it enabled a wide range of people to get involved in activities.

The individual Ageing Better programmes in the 14 areas were unique, with each local partnership developing their own approaches tailored to the strengths, needs and circumstances of their local communities.

The programme's 'test and learn' approach meant that areas tried different ways of working at different times over the course of the five years for which data was collected, trying to find approaches that were effective, and adapting to the changing needs and wishes of participants.

This section sets out what the data tells us about the kinds of projects the programme delivered, and which projects and activities were most likely to engage which people.

Diversity of provision

One of the initial assumptions of the Ageing Better programme, rooted in the evidence around addressing loneliness and social isolation, was that it was important to tailor approaches to individual programme participants[49]. Ageing Better projects offered a wide range of ways for people to get involved. Projects spoke to people over 50 and local stakeholders to understand what would make a real difference in the area, before developing their project plans.

The pre-COVID project approach

Data from the CMF shows that most Ageing Better projects involved group-based, face-to-face activity that took place in shared spaces. However, projects took different approaches:

- Almost half (47%) of Ageing Better participants attended projects offering one-to-one support, and three quarters attended projects offering group support
- About a quarter (26%) of participants attended projects that used the telephone. In the main, these projects were not solely telephone-based – they also used

[49] 'Tackling Loneliness: Review of Reviews', What Works Wellbeing. Available from: https://whatworkswellbeing.org/resources/tackling-loneliness-review-of-reviews. Accessed on 23/7/2021

other approaches. Feedback suggests they mainly used the phone to make initial contact and check if people were OK if they did not attend. However, there were also a small number of telephone befriending services

- In total, 14% of participants attended projects that used the internet
- Around a third of participants (37%) attended projects that took place outdoors, just under half (44%) at a business venue, and one in three (34%) at the participant's home (Methods Note: Table 29)

This breadth of approaches supported the widest possible engagement – allowing projects to engage people who were living alone, had longstanding illnesses, were particularly lonely or isolated, had low wellbeing, or lacked confidence in group environments.

When the pandemic started, project approaches were adapted to take account of social distancing requirements and the needs of participants. More information about how projects adapted is available in the Ageing Better programme's learning reports[50].

The activities that were offered

A strength of Ageing Better is that it allows projects to take different approaches to improving social contact, wellbeing, or loneliness, with a huge range of activities being offered through the programme. Offering this range was deliberate, so that the programme could support as many people to take part as possible, especially those who didn't routinely engage in activities.

The wide range of Ageing Better activities meant people could find projects and activities that suited their needs and interests. Those involved in running projects felt that the range of activities kept people engaged and contributed to positive outcomes.

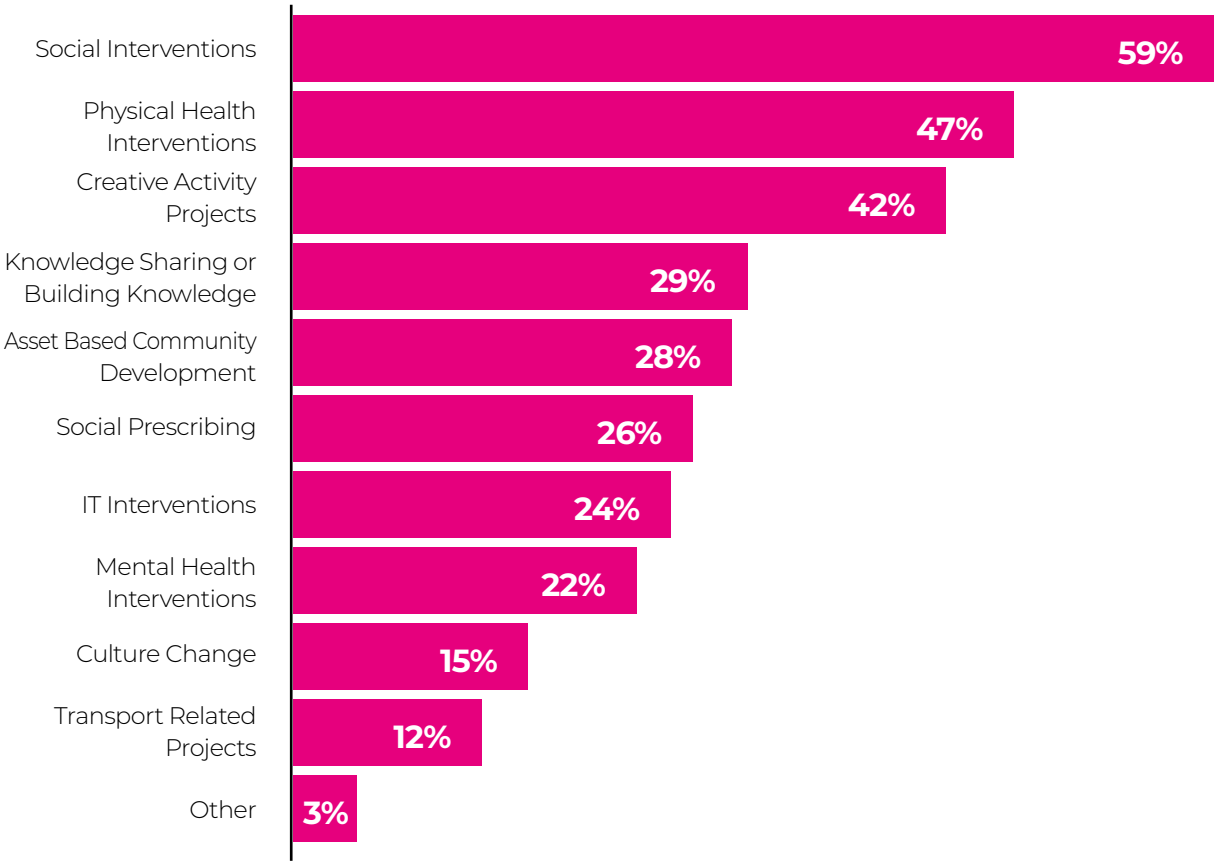
The most popular activities were social activities, physical health, and creative activities. Over half (59%) of all Ageing Better participants were involved in projects classified as including social activities, almost half (47%) took part in projects with physical health activities, and 42% in those with creative activities (Methods Note: Table 29).

[50] 'Ageing Better', The National Lottery Community Fund. Available at: https://www.tnlcommunityfund.org.uk/funding/strategic-investments/ageing-better. Accessed on 23/7/2021

- Social activities were designed by local people for their peers, often through older people's consultations and forums. The activities people over 50 chose helped to challenge assumptions about people over 50's preferences and increased the diversity of social activities available locally. These activities included everything from Egyptology to Zumba
- Physical health activities ranged from gardening, food growing and healthy eating initiatives through to walking groups and exercise classes. Some used local competitions as a way of sustaining commitment
- Creative activities included art classes, book clubs and creative writing groups. Participants played a central role in commissioning, developing, and running many of these activities, keeping them relevant and inspiring for everyone

The following figure shows the percentage of Ageing Better participants that attended projects offering certain types of activity.

Participants attending projects providing certain activities



Base (Ageing Better participants): 27,382 Multicoding permitted

Most people were recorded as taking part in one Ageing Better project. However, some projects involved more than one different type of activity – for example, some projects involved providing transport to a social activity or group. The average programme participant took part in a project offering just over three types of activities (Methods Note: Table 29).

The people who took part in activities

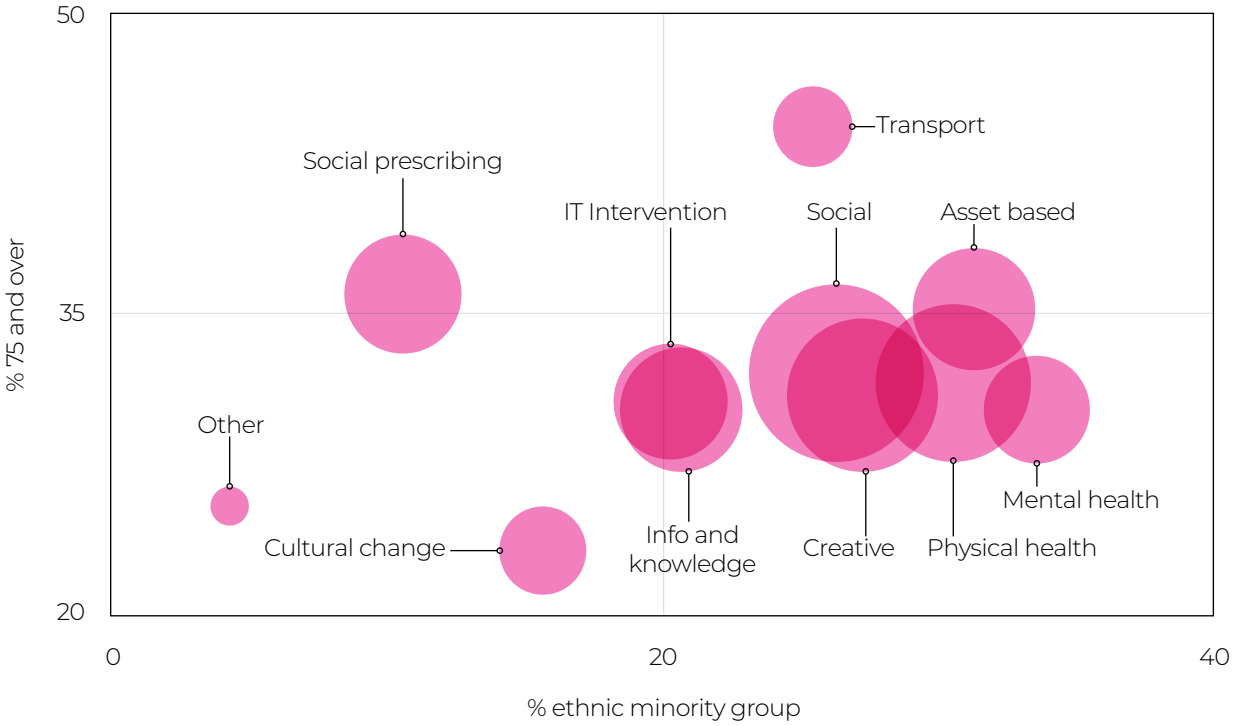
Most types of projects attracted a similar gender balance of attendees (around two thirds female and one third male), although mental health projects attracted slightly more males than other projects (37% male and 63% female) (Methods Note: Table 30).

However, there were more differences across types of projects when we looked at activities by age and ethnicity (Methods Note: Table 30).

The 'bubble chart' that follows shows the types of activities and the percentage of attendees who were aged 75 or over or from an ethnic minority group. The size of each bubble shows the number of people attending a project with a certain activity, with the position of the bubble on the bottom (x-axis) showing the percentage of people in an ethnic minority group, and the position on the side (y-axis) showing the percentage who are aged 75 and over.

As an example, we see that social prescribing is one of the project types with a roughly average number of people attending (the size of the bubble being similar to others), that people attending were less likely to be from an ethnic minority compared to other projects (the bubble is to the left of most bubbles on the x-axis), and slightly more likely to be aged 75 or over (slightly higher than most bubbles on the y-axis).

Participants attending projects providing certain activities by age and ethnic group



Base (Ageing Better participants per project type): 985-16,692

From this data we can see that:

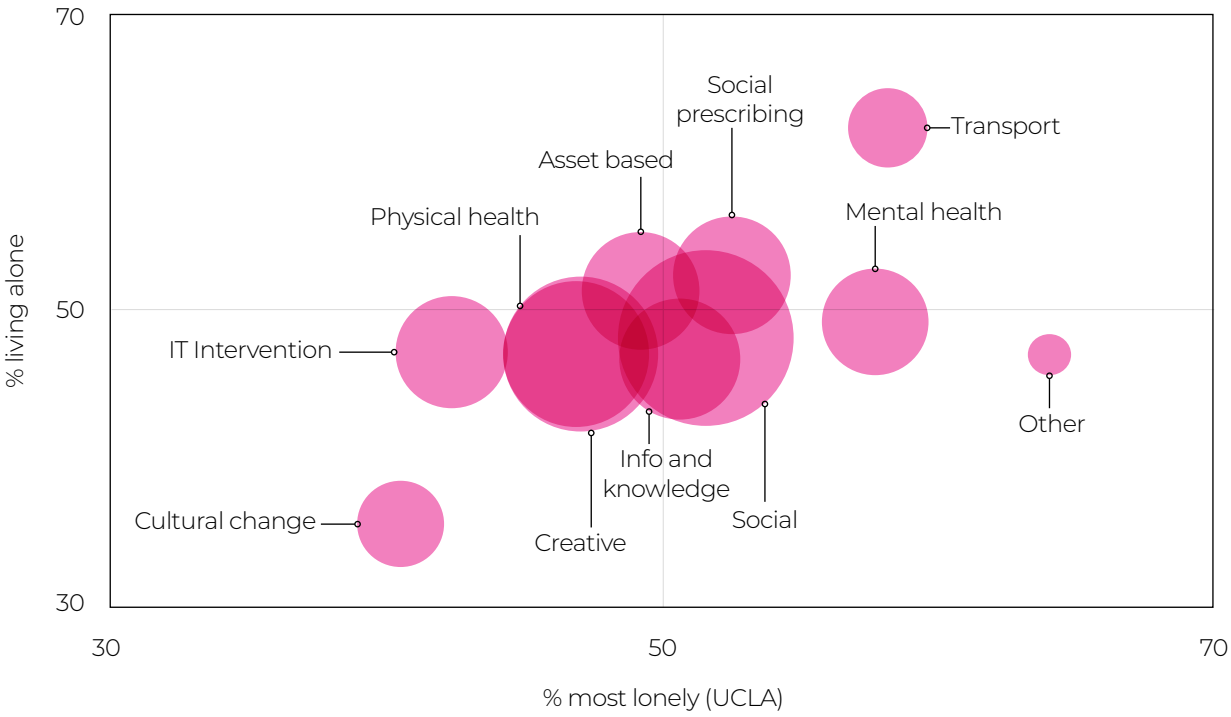
- **Transport projects particularly engaged people aged 75 and over**
- **People attending projects with a focus on culture change[51] had a relatively young profile, and were less likely to identify as being from an ethnic minority**
- **People attending social prescribing projects were particularly likely to be aged 75 and older, and also less relatively likely to be from an ethnic minority**
- **People from ethnic minorities were more likely to be engaged in 'asset-based' projects (those that aimed to empower people over 50), physical activities, and mental health activities**
- **Projects aiming to empower people tended to have a slightly older participant age profile**

[51] For example, Ageless Thanet's Active Citizenship project empowered volunteers to work towards cultural change and community engagement by leading social activities include picnics, coffee get-togethers, and social strolls. Aims to reduce social isolation and encourage community involvement and engagement.

Activity by loneliness and living alone

The following bubble chart shows the different types of projects engaged with by the percentage of people who were lonely (x-axis) and the percentage of people who live alone (y-axis). As before, the size of the bubble shows the number of people attending (Methods Note: Tables 33 and 30).

Activities by loneliness and living alone



Base (Ageing Better participants per project type): 534-16,692

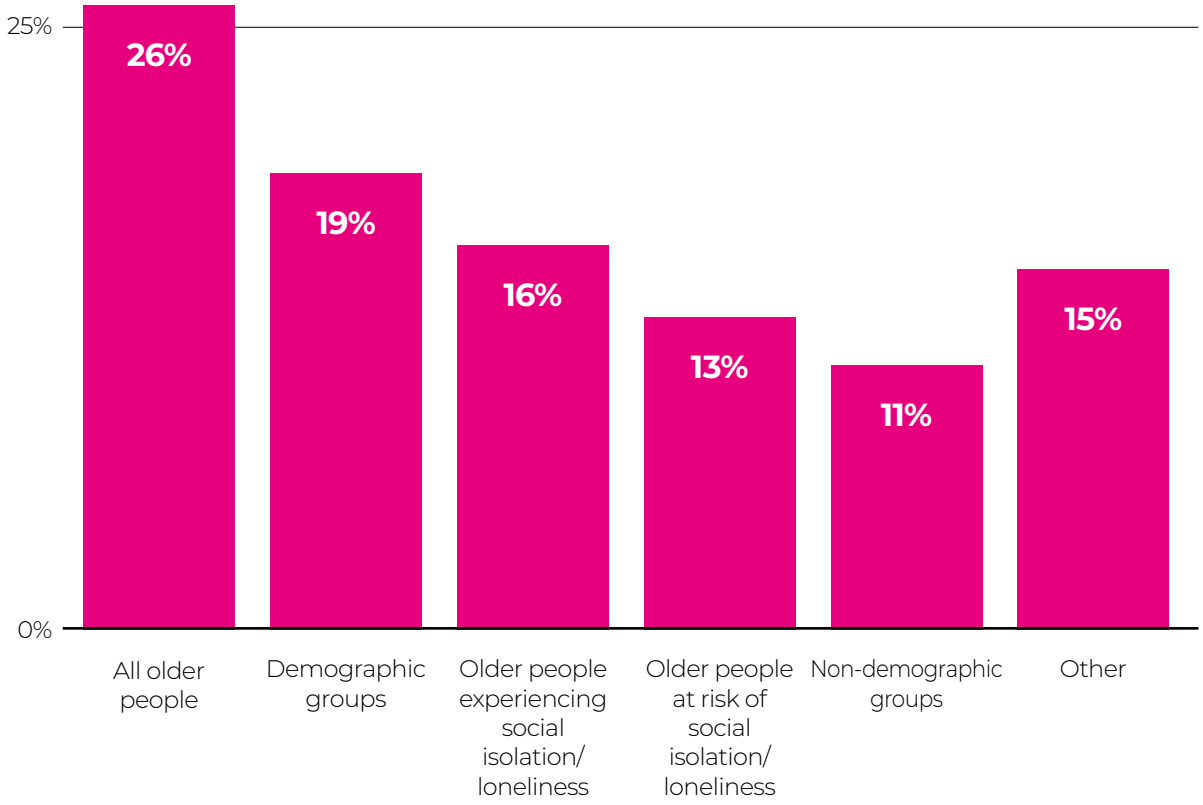
The more common types of projects (the largest bubbles) had very similar profiles in terms of people's loneliness and living status. The fact that most projects were in the centre suggests that they engaged an average spread of people. There were some projects that appeared to engage different types of people who may be particularly in need of support:

- **Transport activities attracted participants who were particularly likely to live alone and have higher levels of loneliness**
- **Mental health projects particularly engaged those who are lonelier than the average Ageing Better participant**
- **Culture change projects attracted people who tended to be less lonely and less likely to live alone than other types of projects**

Targeting specific groups

The following figure shows the percentage of projects that targeted specific groups within the population of people over 50.

Percentage of projects by targeting approach



Base (projects): 296

Around a quarter of projects (26%) did not target a specific group, but aimed to work with anyone over 50 regardless of their demographics, levels of wellbeing, loneliness, or other circumstances (Methods Note: Table 29).

About a fifth of projects (19%) aimed to work with a specific demographic group, such as people from certain ethnic minorities, or males. When we examined who attended these demographic-targeted projects, 60% of participants attended a project targeting on the basis of ethnicity, 17% attended a project targeting males or females, and 11% attended a project targeting LQBTQ+ people. The projects targeting people on the basis of their ethnicity generally engaged a higher percentage of those with low wellbeing and high levels of loneliness than other projects, suggesting these successfully reached people in particular need (Methods Note: Tables 29 and 36).

One in six projects (16%) targeted people who were already experiencing social isolation or loneliness. While projects were designed to reach people in these circumstances, this was rarely made explicit, as most partnerships found that open references to loneliness could be stigmatising and put people off attending (Methods Note: Table 29).

Just over a tenth of projects (13%) targeted people at risk of social isolation or loneliness. Most of these projects took a broad approach to increasing resilience and strengthening protective factors for loneliness, including through promoting intergenerational activities, and raising awareness through outreach activities, festivals, and public events (Methods Note: Table 29).

Another way in which people were targeted was in relation to their membership of a 'non-demographic' group. These were groups that were linked by a shared interest or set of circumstances, rather than by gender, ethnicity, or other demographics. About a tenth of projects (11%) targeted participants in this way (Methods Note: Table 29).

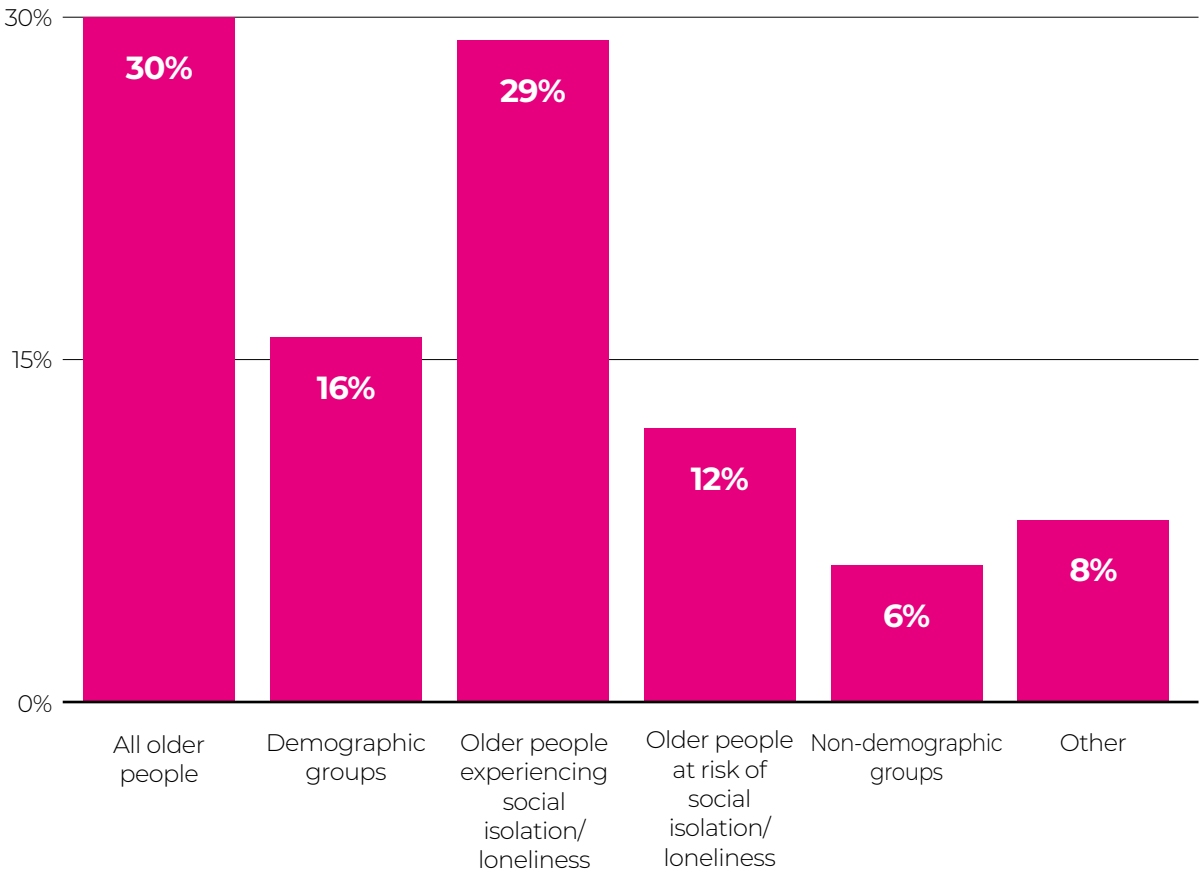
Almost half of people (48%) taking part in these 'non-demographic' projects were carers. The high involvement of carers explains our finding that people attending these 'non-demographic' targeted projects were more likely to be female and less likely to live alone than those attending other projects. Previous research with carers highlights the importance of supporting carers to build social connections to strengthen their wellbeing and their ability to maintain their caring role[52] (Methods Note: Tables 29 and 31).

Around one in seven projects took an 'other' approach to targeting people, often focusing specifically on health or people over 50 living alone and offering specific activities tailored to this group, including therapy or counselling (Methods Note: Table 29).

We also examined exactly what targeting approaches projects tended to take (Methods Note: Table 29).

[52] 'Working and engaging with carers – learning from Ageing Better', The National Lottery Community Fund. Available from: https://www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing-Better-working-engaging-carers.pdf?mtime=20201016160941&focal=none. Accessed on 23/7/2021

Percentage of people attending projects by targeting approach



Base (Ageing Better participants): 27,276

Our analysis shows that **most people took part in a project that targeted all people over 50 (30%).**

While only 16% of projects targeted people experiencing social isolation and loneliness, 29% of people attended these projects, suggesting they may have had particularly high levels of attendance per project, and hence that these may be particularly important (Methods Note: Table 29).

Our data shows that one in three people attended a project that was targeted towards people experiencing social isolation or loneliness. Our evidence shows that projects aiming to target people experiencing social isolation and loneliness did not engage more of these people than other types of projects. For example, people attending 'demographic focus' projects had roughly similar levels of loneliness and social isolation as those attending projects targeting people experiencing social isolation and loneliness (Methods Note: Tables 29 and 35).

We saw the opposite pattern with the projects that targeted 'non-demographic' and 'other' groups. Non-demographic projects made up 11% of projects, but only 6% of people attended these projects. The 'other' projects made up 15% of projects, but only 8% of people attended them. This suggests that these types of projects may have had relatively low levels of attendance. This may be because 'non-demographic' groups may be small, and because 'other' projects targeted particularly niche groups. While 'non-demographic' and 'other' projects do not attract large numbers of participants, they may still be an important way of reaching people who may not have been reached otherwise (Methods Note: Table 29).

5.0
Our findings: The overall impact of the Ageing Better programme

Key findings:

- People taking part in Ageing Better became more likely to meet family and friends at least once a week than those not taking part in any activities
- Taking part in Ageing Better had a positive effect on people with low wellbeing
- Our data does not show that taking part in Ageing Better reduces loneliness among participants in relation to the comparison group of those not taking part in any activities
- Males were under-represented as participants in the Ageing Better programme overall, making up just under one third of all participants – as a result the findings around impacts for males are not statistically significant
- When starting Ageing Better, carers were very similar to non-carers in their levels of social contact, wellbeing, and loneliness. Carers broadly benefitted as much from Ageing Better as non-carers, with the possible exception of seeing less change in loneliness
- Certain activities were associated with positive changes in outcomes for those with low wellbeing. In particular, therapy and counselling, and community involvement were linked to greater improvements for this group
- Over half (59%) of those completing an initial participant questionnaire had a disability or long-standing illness. People attending Ageing Better with a disability or long-standing illness had considerably worse loneliness, wellbeing, and social contact than others. The positive changes seen across all participants were also seen among those with a disability or long-term illness
- People taking part in Ageing Better who started with low wellbeing significantly improved both their face-to-face contact with friends and the frequency that they spoke to non-family members locally. Their loneliness did not change.
- The most lonely[53] appear to be helped relatively more by community involvement and skills development, and relatively less by technology projects and intergenerational activity
- While taking part in Ageing Better had a positive change on social contact and wellbeing, taking part in other similar activities had a greater change on the same outcomes. This may be because Ageing Better approaches are more effective at reaching groups that have particular needs.

[53] A score of 7 to 9 on the UCLA scale (scale 3 to 9)

A key question for the evaluation was whether social contact, wellbeing, and loneliness changed more for people taking part in Ageing Better than for people in our primary and secondary comparison groups. We focus mainly on the difference between people taking part in Ageing Better and the primary comparison group of those who don't take part in any other activities, and also look at the difference compared to the secondary comparison group of those who take part in other, non-Ageing Better activities.

We use significance tests to check the difference between groups compared to a hypothesis that there was no change at all. When a finding is statistically significant it means we can be reasonably confident there is a real difference between the groups and that it is not due to chance.

Our impact results compare results from the Ageing Better and comparison groups at three time periods: a baseline period, and then subsequent periods at around 6 and around 12 months later[54].

The full results from the impact study are available in the Methods Note.

Impact on social contact

People taking part in Ageing Better became more likely to meet family and friends at least once a week than those not taking part in any activities. After 6 months, there was more of a change for Ageing Better participants (74% to 80%) than for those in the primary comparison group who did not take part in any activities (73% to 70%), with a similar pattern after 12 months (Methods Note: Table 19 and 21).

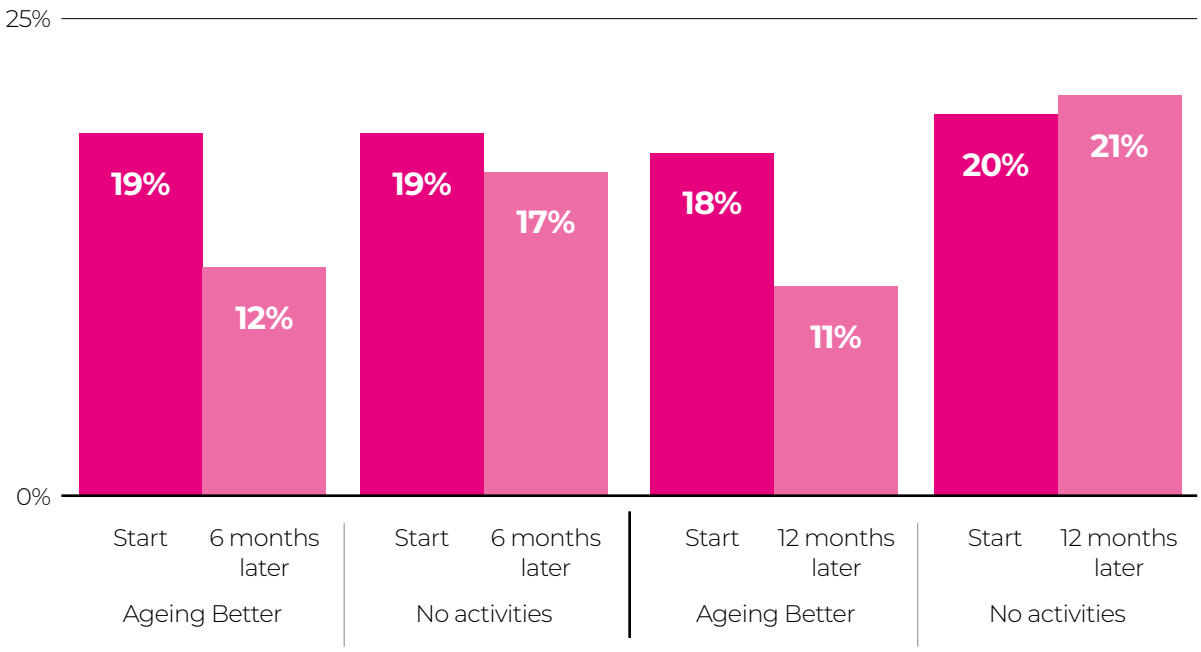
Ageing Better also led to some longer-term improvements in text and written communication when comparing participants to the comparison group. The percentage of Ageing Better participants who texted friends and family at least weekly did not change after 12 months (45% to 46%) but declined for those in the comparison group (31% to 25%). There was a similar pattern for writing or receiving letters (30% to 31% for Ageing Better participants compared to 30% to 16% for the comparison group) (Methods Note: Table 21).

[54] To maximise the available sample size the CMF data included anyone interviewed around 4 to 8 months (for the '6 months' period) and nine to 15 months ('12 months'). Due to the different methodology, the impact periods were around 5 to 7 months ('6 months') and 10 to 14 months ('12 months').

Impact on wellbeing

Taking part in Ageing Better had a positive effect on people with low wellbeing. In total, 19% of people starting the programme had low wellbeing. Six months later, only 12% who had taken part in Ageing Better had low wellbeing, a bigger improvement than among people in the comparison group (19% to 17%). This difference was still seen after 12 months (18% to 11% for Ageing Better participants compared to 20% to 21% for the comparison group) but, with fewer people providing data, this finding is not statistically significant so we can't say that it is an impact of their involvement in the programme (Methods Note: Tables 19 and 21).

Change in low wellbeing



Base (Ageing Better participants): 6 months: 1,198, 12 months: 623

(No activities): 6 months: 300, 12 months: 153

Impact on loneliness

Ageing Better participants were less likely to be lonely 6 (44% to 37% lonely on the UCLA scale) and 12 months (45% to 36%) after starting the programme. However, the same was true of people who did not take part in any activities, with an unexpected similarly large decline in loneliness for these people (43% to 38% for 6-months, 47% to 36% for twelve months). The same pattern was seen for the DJG measure of loneliness we used. **This means that we could not say that taking part in Ageing Better reduced loneliness among participants (Methods Note: Tables 19 and 21).**

These findings are in line with other studies which suggest that the relationship between loneliness and levels of social contact is not straightforward. Other factors in individuals' lives, beyond their social contact may be more important in determining their levels of loneliness. We look at this in more detail later in this section.

Changes experienced by different groups

We looked in detail at results for males, carers, and people with disabilities, three key groups of people aged over 50 that are at risk of social isolation, low wellbeing, and loneliness. This included looking at impact data examining their change compared to a comparison group, and looking at data from the participant questionnaires showing what types of activities may be more helpful than others.

Males

As shown in section 3c, **males were under-represented as participants in Ageing Better,** with those who took part having lower levels of social contact than females, similar levels of wellbeing, and similar levels of loneliness .

We saw positive changes in social contact and wellbeing for males. These were not statistically significant when compared to males in the comparison group (those for females were) but this was likely to be due to the small sample size for males (Methods Note: Table 23). We did not find any evidence that males in Ageing Better would not see the same positive changes after 6 months in social contact and wellbeing that we saw for females.

We found that the type of activities that people took part in appeared more important to males than to females, with more activities standing out for males than females as being particularly positive or negative. This suggests that particular care is needed to make sure the right activities are in place for males, with more practical activities such as skill development, designing and delivering services, technology, transport, and physical activities all being relatively more helpful than others. (Methods Note: Tables 41 and 42).

Disability or long-standing illness

There are two main reasons for looking in detail at people with a disability or long-standing illness. We know there is a link between health and loneliness, although more

work is needed to understand the relationship[55], and we know people with a disability or long-standing illness constitute a large percentage of the older population[56]. Our research backs this up. **People attending Ageing Better with a disability or long-standing illness had considerably worse loneliness (UCLA mean of 5.9 compared to 4.8), wellbeing (SWEMWBS mean of 20.5 compared to 23.2), and social contact (76% meeting family/friends at least weekly compared to 67%) than those without a disability or long-standing illness (Methods Note: Tables 9, 11, 12). Over half (59%) of those completing an initial questionnaire had a disability or long-standing illness (Methods Note: Table 6).**

Our data suggests that the positive changes seen across all participants were also seen among those with a disability or long-term illness. Compared to people with a disability or long-term illness who did not take part in any activities, Ageing Better participants with a disability or long-term illness had significantly improved weekly face-to-face contact with friends/family, with their positive change in wellbeing approaching significance (Methods Note: Table 24).

We found generally improved outcomes for people with a disability associated with transport-related projects, with these projects often providing travel support to/from other activities (Methods Note: Table 24). The role of travel-related activities will be explored in more detail in a future evaluation report.

Carers

Just over a fifth of all people (21%) completing an initial questionnaire were carers (Methods Note: Table 6). **When starting Ageing Better, carers were very similar to non-carers in their levels of social contact (70% with weekly face-to-face contact with friends/family compared to 71%), wellbeing (SWEMWBS mean of 21.5 compared to 21.6), and loneliness (UCLA mean score of 5.4 compared to 5.5), except**

[55] 'Isolation and loneliness: An overview of the literature', Hardeep Aiden, British Red Cross. Available at: https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-and-social-care/co-op-isolation-loneliness-overview.pdf. Accessed on 23/7/2021

[56] Among the UK population, those with a long-standing illness rose from 38% among those aged 50-54 to around 70% among those over 80. 'Proportion of people with a long-standing illness and limiting long standing illness by age and sex, 2011', Office for National Statistics. Isolation and loneliness: An overview of the literature', Hardeep Aiden, British Red Cross. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/adhocs/005477proportionofpeoplewithalongstandingillnessandlimitinglongstandingillnessbyageandsex2011. Accessed on 15/9/2021

that they were more likely to text someone at least once a week (60% compared to 51%) (Methods Note: Tables 12, 11, 9).

Carers broadly benefitted as much as non-carers from Ageing Better, with the possible exception of seeing less change in loneliness (Methods Note: Tables 38 and 39). The key difference for carers compared to the other groups examined was that there were no particular activities that were clearly relatively more or less valuable than other activities (Methods Note: Table 43). We know that caring takes up a lot of time[57], potentially making it difficult for carers to access activities. It is particularly important that carers are able to access activities that meet their needs.

Supporting those with lower wellbeing and high levels of loneliness

Our data enables us to look in detail at those who started the programme with lower wellbeing, and those with particularly high levels of loneliness. As with the previous analysis for males, people with disabilities and carers, this analysis includes looking at impact data examining change compared to a comparison group, and CMF data looking at what types of activities may be more helpful than others. CMF data showed that both groups included similarly high percentages of people aged under 64, living alone or with family, and with a long-standing illness (Methods Note: Tables 9, 10, 11).

People with lower wellbeing

Compared to peers not taking part in any activities, people taking part in Ageing Better who started with lower wellbeing[58] significantly improved both their face-to-face contact with friends and the frequency that they spoke to non-family members locally. Their loneliness did not change. Their change in wellbeing was not significant but this is likely due to a small sample size (Methods Note: Table 25).

Certain activities were associated with positive changes in outcomes for those with low wellbeing. In particular, therapy and counselling, and community involvement

[57] 'Personal Social Services Survey of Adult Carers in England, 2016-17' Adult Social Care Statistics Team, NHS England. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-survey-of-adult-carers/personal-social-services-survey-of-adult-carers-in-england-2016-17. Accessed on 21/10/2021

[58] A score of 7 to 27 on SWEMWBS (scale 7 to 35)

were linked to greater improvements for this group. Practical services, engagement services, and technology activities were less helpful, possibly as they involved less direct communication and social exchange (Methods Note: Table 45).

People who were more lonely

Compared to those not taking part in any activities, Ageing Better participants who were at least somewhat lonely[59] did not improve their levels of loneliness over time. However, their wellbeing improved significantly after 6 months, and improvements in social contact, whether weekly face-to-face contact with family/friends or speaking to non-family members, fell just short of being significant (Methods Note: Table 26).

The most lonely[60] appear to be helped relatively more by community involvement and skill development, and relatively less by technology projects and intergenerational activity (Methods Note: Table 44).

Overall results for these two groups show that the improvements across Ageing Better in wellbeing and social contact for the general population are also seen for the most lonely and those with the lowest wellbeing. Our analysis provides some pointers towards the types of activities that may work best for these groups, suggesting that community involvement may be relatively important as it works for both groups.

How Ageing Better activities compare to other activities

Our main impact analysis focused on the primary hypothesis that Ageing Better would lead to improvements compared to not taking part in activities, comparing outcomes for Ageing Better participants to outcomes for people in the primary comparison group who did not take part in any activities. As noted in Chapter 2, a secondary hypothesis for the evaluation was that Ageing Better would lead to improved outcomes compared to taking part in other, non-Ageing Better projects. To explore this, we compared results for Ageing Better participants to the matched secondary comparison group of those who took part in other projects, to explore how social contact, wellbeing and loneliness changed for each group.

[59] A score of 4 to 9 on the UCLA scale (scale 3 to 9)

[60] A score of 7 to 9 on the UCLA scale (scale 3 to 9)

What might we expect to see?

It is important to note that there are two ways of thinking about what this data might show us.

On one hand, if the Ageing Better programme's approach represents 'best practice' then we might expect to see similar, or even greater, improvement in outcomes in the Ageing Better participant group relative to the 'other activity' comparison group.

However, on the other hand, if the Ageing Better programme has engaged people over 50 who would normally not participate (as tentatively suggested in Section 3.e) and who may face more challenges, even if the level of impact is not quite as great as for activities with broader reach, achieving some change may still be considered a success.

What we found

We found that the change in proportion of people with low wellbeing after 6 months was similar for those taking part in Ageing Better (19% to 12%) and the group of people taking part in other activities (21% to 16%). After 12 months, the proportion of people taking part in other activities with low wellbeing (24% to 6%) improved significantly more than among those taking part in Ageing Better (18% to 11%) (Methods Note: Tables 19 and 21).

As noted in the previous section, people taking part in Ageing Better were less lonely both 6 and 12 months after starting the project. We saw similar declines in loneliness for those taking part in other, non-Ageing Better activities. People were less lonely up to a year later regardless of whether they took part in Ageing Better, other activities, or no activities at all (Methods Note: Tables 19 and 21).

These overall results show that people taking part in Ageing Better experienced positive improvements in social contact and wellbeing, but that the people taking part in other similar activities saw even larger improvements. This difference may be because Ageing Better approaches are more effective at *reaching* groups that have particular needs.

As seen in Chapter 3, Ageing Better engaged a higher percentage of older people from ethnic minorities and the LGBTQ+ community, than were in the over-50 population in local areas, as well as more people who were lonely and felt they took part in social activities less than other people.

We know that Ageing Better has enabled a greater number of people to engage in activities that can make a difference to social contact and wellbeing and has been effective in engaging a diverse range of individuals in its work.

The complexity of reducing loneliness

Our analysis shows that Ageing Better has a clear and positive impact on wellbeing, but we are not able to evidence an impact on loneliness.

In recent years there has been an increasing focus on loneliness, particularly in light of its links to many adverse health conditions[61]. We have also seen increased attention to wellbeing. Our analysis suggests that while wellbeing and loneliness are connected, what works to improve wellbeing doesn't necessarily change loneliness.

The links between social contact, wellbeing, and loneliness

Our evaluation sheds light on the relationship between social contact and both loneliness and wellbeing. While not all Ageing Better projects aimed to improve wellbeing and/or loneliness through increasing social contact, we can look across all projects to understand more about the complex relationship between these factors.

We investigated our data to understand why social contact and wellbeing improve for Ageing Better participants compared to people not doing any activities, but loneliness does not improve. When we looked at the change in face-to-face contact and change in loneliness levels for every survey respondent to measure the association between the two, we found there was only a small link. This was true for both the UCLA scale and the overall DJG scale and its component social and emotional sub-scales[62].

[61] 'Risk to Health', Campaign to End Loneliness. Available at: https://www.campaigntoendloneliness.org/threat-to-health/. Accessed on 23/7/2021

[62] The Pearson correlation (a measure of the association between two variables) was 0.225 for the association between face-to-face contact and UCLA loneliness, and 0.164 with DJG loneliness (0.132 for emotional loneliness subscale and 0.127 for social loneliness subscale). One set of guidelines considers any Pearson correlation between 0.1 and 0.3 as 'small'.

We also looked at the association between face-to-face contact and wellbeing, and found only a small link between the two[63], and between wellbeing and loneliness, where there was a bigger association, with the link being moderate rather than small[64].

In other words, we see through Ageing Better that improving social contact is linked to improving wellbeing and loneliness, but the link is small. This data adds to the wider evidence that there is a complicated relationship between social contact, wellbeing, and loneliness[65,66]. Social contact is not the only influence on people's experience of loneliness or wellbeing. Lots of things can make people feel lonely or have lower wellbeing, such as their personality, their values and their home, financial and relationship situation.

There is lots still to learn about how interventions can help people feel less lonely. There is little rigorous evidence at the moment of interventions or programmes clearly reducing loneliness[67], possibly as few studies have taken place with enough data to draw firm conclusions. More research is needed to work out whether and how loneliness can be improved.

63 The Pearson correlation (a measure of the association between two variables) was 0.190 for the association between face-to-face contact and SWEMWBS wellbeing. One set of guidelines considers any Pearson correlation between 0.1 and 0.3 as 'small'.

64 The Pearson correlation (a measure of the association between two variables) was 0.317 for the association between SWEMWBS wellbeing and UCLA loneliness, and 0.453 with DJG loneliness (0.429 for emotional loneliness subscale and 0.296 for social loneliness subscale). One set of guidelines considers any Pearson correlation between 0.1 and 0.3 as 'small', and between 0.3 and 0.5 as 'moderate'.

65 'All the Lonely People: Loneliness in Later Life', Age UK. Available at: https://www.ageuk.org.uk/latest-press/articles/2018/october/all-the-lonely-people-report/. Accessed on 23/7/2021

66 'The Psychology of Loneliness: Why it matters and what we can do', Campaign to End Loneliness. Available from: https://www.campaigntoendloneliness.org/wp-content/uploads/Psychology_of_Loneliness_FINAL_REPORT.pdf. Accessed on 23/7/2021

67 'An overview of reviews: the effectiveness of interventions to address loneliness at all stages of the life-course', What Works Wellbeing. Available at: https://whatworkswellbeing.org/wp-content/uploads/2020/01/Full-report-Tackling-loneliness-Oct-2018_0151580300.pdf. Accessed on 23/7/2021

6.0
Our findings: Which approaches helped most in changing outcomes?

Key findings:

- Our results suggest the most important thing is providing activities that can engage people – the precise nature of the activities is less important
- Broadly speaking, targeting activities at certain groups did not seem to make a huge difference to outcomes
- Our evidence suggests that the key strength of diversity of provision is in the way it supports ***reach*** by enabling people to find something that works for them, rather than because targeted approaches are more effective overall.
- Generally, the type of intervention projects deliver doesn't make a big difference to outcomes
- Projects which were explicitly focused on 'asset based community development' appear to be more helpful in improving wellbeing compared to other types of projects

Chapter 5 focused on the impact of participating in Ageing Better[68]. This chapter explores the CMF data, looking further into which elements of Ageing Better provision are reaching different groups and which are associated with greater improvements in wellbeing and social contact, and reductions in loneliness.

We explored the links between different types of projects and positive changes for people taking part in them. We also explored whether the data could tell us what kinds of approaches were most effective for which groups, but we did not see sufficiently strong links between project type and better outcomes to back up any existing hypotheses about the programme. **Our results suggest that in reality the most**

[68] More precisely, provision that provided CMF data with relevant baseline and 6 or 12-month follow up data.

important thing is finding something that engages people – not precisely what they do.

Our findings speak to the power of offering a diversity of person-centred and strength-based approaches, tailored to the individual. They also speak to the complexity of changing social contact, wellbeing, and loneliness – what may work well for one individual or group may not work so well for another individual or group.

Does targeted support change outcomes?

We explored whether participants in certain targeted groups were likely to have better outcomes than those in other targeted groups. **Broadly speaking, we saw that the approach to targeting did not seem to make a huge difference to outcomes.**

However, we found that projects that targeted all people over 50 seemed to be more helpful, and projects that targeted people with certain demographic characteristics or by their health seemed to be less helpful in comparison. Also, relatively helpful were projects that targeted 'non-demographic' groups (e.g., carers).

There are suggestions in large-scale reviews that 'reconnecting' those who are experiencing loneliness with their community (however defined) may be a potential mechanism for successful loneliness interventions. **Our evidence suggests that this may be that case but the key strength of diversity of provision is in the way it supports reach by enabling people to find something that works for them, rather than because targeted approaches are more effective overall (Methods Note: Table 69).**

Which projects made the most difference to outcomes?

Types of projects

Generally, we found that the type of intervention projects deliver doesn't make a big difference to outcomes. While we did find some differences in the outcomes between different types of project, these differences were not large. Certain types of projects were more likely to be associated with improved social contact, wellbeing, and loneliness. This includes those that mainly provided physical health activities, those aiming to improve social connections, and those aiming to empower people (i.e.

those categorised as 'asset-based community development' activities – see below). The types that appeared relatively less helpful in improving those key outcomes were transport, mental health interventions, and creative activities. This does not mean that these projects were not helpful at all – they were just less helpful than other types of interventions (Methods Note: Table 69).

Improving mental health

While our findings suggested projects classified as 'mental health interventions' were relatively less helpful in improving outcomes than other interventions, our analysis also showed that the broader set of projects that ***aimed to improve mental health*** worked as well as other types of projects in changing outcomes (Methods Note: Table 63, 64, and 70)[69]. Both 'mental health interventions' and projects aiming to improve mental health engaged with similarly high percentages of people with low social contact, low wellbeing, and high levels of loneliness (Methods Note: Tables 50 and 51), making it important to understand why there may be different results.

Although it is difficult to pinpoint any exact cause, the relatively better results of projects generally aiming to improve mental health may be partly due to the blend of approaches which tended to include more social, creative, and physical health activities as well as specific mental health interventions (Methods Note: Table 63).

Taking an 'asset-based' approach

Virtually all projects within the Ageing Better programme tried to get people actively involved, mainly in helping to design or deliver the project, or, to a lesser extent, through evaluation activities or helping manage the project.

One of the core principles of Ageing Better was that projects would take an 'asset-based' approach, using the skills, resources, and insights of local people to develop services that would meet the needs of their communities. As a result, these approaches were in evidence right across the programme. However, some projects were explicitly categorised as 'asset-based community development' activities.

[69] Around half of all projects that aimed at all to improve mental health said they used specific mental health interventions, suggesting others were taking less direct approaches to improve wellbeing (Methods Note: Table 63).

Around a quarter (28%) of participants took part in a project that was explicitly categorised as an 'asset-based community development' activity (Methods Note: Table 29). These projects took the core 'asset-based' principle of Ageing Better and applied it to specific community-development activities. The people who were supported to get involved in these projects were slightly more likely to identify as Asian or Asian UK (20%) than those taking part in other projects (1-19%) and slightly less likely to identify as White (69% compared to 66-99% for other project types) (Methods Note: Table 30).

We found that projects which were explicitly focused on 'asset-based community development' appeared to be more helpful in improving wellbeing compared to other types of projects (Methods Note: Table 69).

These findings provide the opportunity for other projects and programmes to investigate similar approaches, working out how people can be empowered in their local communities.

We undertook a range of further analyses to see if we could identify which types of projects were most helpful and for which groups of people. Overall, we did not generally find strong links between the type of project and difference it made for people (Methods Note: Section 4.6).

Conclusions

Ageing Better has shown that developing ways to engage people over 50 in activities can increase their social contact and can also improve wellbeing among those whose wellbeing is low. People are more socially connected after taking part in Ageing Better activities. We know from our qualitative research that people derive fulfilment from the activities they take part in, helping them feel and function better[70].

We recommend that organisations interested in addressing social isolation and improving wellbeing should draw on the learning from the Ageing Better programme to inform their work.

People who took part in Ageing Better tended to become less lonely over the period of their involvement, but we did not find evidence that this was necessarily due to Ageing Better.

We found that there is only a small association between changes in social contact that people experience and changes in wellbeing or loneliness. Our findings suggest that the relationships between loneliness and social isolation are complex, and that organisations should examine the evidence from Ageing Better and other programmes as part of their planning.

Demonstrating impact on a complex and fluctuating subjective experience such as loneliness is always going to be complex, and our findings suggest that there is a need for further work to unpack the interaction between social contact, wellbeing, and loneliness, drawing on long-term quantitative and qualitative data.

We recommend that there is continued investment in long-term monitoring and evaluation of the impact of interventions to address loneliness, drawing on both qualitative and quantitative evidence.

We recommend that the Government, Office for National Statistics and other experts continue to review the suite of measures available for assessing levels of loneliness and consider their effectiveness in the context of interventions.

[70] 'Learning Paper No.5 Micro-funding: Empowering Communities to Create Grassroots Change', Ecorys & The National Lottery Community Fund. Available from: https://www.tnlcommunityfund.org.uk/media/documents/ageingbetter/Ageing_better_learning_report_5_evaluation_report.pdfhttps://www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing_better_learning_report_5_evaluation_report.pdf?mtime=20200313112227&focal=none. Accessed on 23/7/2021

Our data shows that the Ageing Better programme was effective at engaging a diverse range people over 50, including people from groups known to be at particular risk of loneliness such as LGBTQ+ people and people from ethnic minorities, and that it was effective at engaging people who were already experiencing loneliness and those who had lower social contact.

There were signs that some types of projects seemed to be particularly effective at engaging the groups at risk of loneliness. For example, transport projects and mental health projects were effective at engaging people who were more lonely.

However, in general our findings do not support prioritising a specific set of loneliness interventions in a community. Instead, our findings suggest that it is not the type of activity that is most important. The breadth of activities offered, responsiveness to local needs, and opportunities for people over 50 to get involved are critical.

We recommend that organisations interested in addressing loneliness and social isolation and improving wellbeing in communities should consider how they can ensure that there is a diverse offering available to attract and engage a wide range of people including those at particular risk of loneliness and isolation.

We saw some promising evidence that aiming to empower participants through 'asset-based community development' approaches seems to make more of a difference to wellbeing than other types of projects, suggesting that investment in these approaches may be particularly valuable. The role of these 'asset-based' approaches will be explored further through additional evaluation work during the final year of the Ageing Better programme.

We recommend that organisations wishing to address loneliness and social isolation among people over 50 should take an 'asset-based' approach, drawing on the strengths and assets of local people and communities, and ensuring that people over 50 can be involved in co-producing approaches.

Finally, we hope that the findings of our analysis of the impact of the Ageing Better programme will support the case for further work to understand the impact of different interventions on social contact and on loneliness, drawing on both qualitative and quantitative data.

Our forthcoming reports will explore aspects of the Ageing Better programme's work in more detail, drawing out more nuanced findings about the different approaches being taken across the programme.

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