



Ageing Better: Supporting meaningful connections through social prescribing- Methods Note

Ecorys: Kath McKenna,
Jenny Williams, Amy Humphreys,
Diarmid Campbell-Jack, Korina Cox

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Introduction

Purpose of the Methods Note

This paper accompanies a research report exploring the variety of approaches aligned to social prescribing delivered by Ageing Better partnerships. The report explores the projects pursued by Ageing Better partnerships under the 'social prescribing' banner, shares reflections on the process of implementing these projects, and sets out how these projects led to changes in practice and whether these are sustainable. The report explores the benefits of these approaches for individuals in supporting social connections, physical and mental health, and wellbeing.

Following an introduction to the programme, this Methods Note summarises the research approach, details the data collection methods used, and presents the full data tables referenced in the report. It also provides a statement on research ethics and data protection and concludes with a glossary of terms associated with the report.

The Ageing Better programme

Ageing Better was a £87 million, seven-year programme funded by The National Lottery Community Fund (The Fund). It started in 2015 and ran until March 2022. The programme funded voluntary sector-led partnerships in 14 areas across England.

The partnerships were:

- ◆ Ageing Better Birmingham
- ◆ Bristol Ageing Better
- ◆ Ageing Better in Camden
- ◆ Brightlife (Cheshire)
- ◆ Talk, Eat, Drink (TED) (East Lindsey)
- ◆ Ambition for Ageing (Greater Manchester)
- ◆ Connect Hackney

- ◆ Age Friendly Island (Isle of Wight)
- ◆ Time to Shine (Leeds)
- ◆ Leicester Ageing Together
- ◆ Ageing Better Middleborough
- ◆ Age Better in Sheffield
- ◆ Ageless Thanet
- ◆ Ageing Well Torbay.

The Fund commissioned Ecorys UK, Bryson Purdon Social Research LLP, and Professor Christina Victor from Brunel University's Institute for Ageing Studies to carry out a national evaluation of the programme. This paper was written by Ecorys, who conducted the research on social prescribing approaches.

Research process

Research aims

The overarching aim of the research report was to inform external policy and practice about social prescribing and community connector activities to improve connections for people over 50 by sharing how partnerships support meaningful connections through personalised social prescribing approaches, and the difference this makes to people over 50, their communities, and wider systems.

Rationale for approach

The research on social prescribing and community connector activities used a mixed method. It draws on evidence collected through qualitative research with Ageing Better stakeholders which considered the implementation of Ageing Better's variety of social prescribing and community connector activities. It explored both the processes involved in designing and developing activities and the outcomes achieved from 'test and learn' approaches, including the co-production of activities with people over 50.

This report also draws on quantitative data about who took part in Ageing Better's social prescribing projects and how outcomes changed over time. Although a counterfactual study was conducted at a programme level, it is not possible to use this evidence specifically for social prescribing and community connector activities, so any change in outcomes that we see for participants in these projects cannot be attributed to Ageing Better.

The qualitative evidence is used to explain possible reasons for the changes observed in the quantitative survey data. By triangulating the evidence from these different sources, we consider how the programme may have supported participants to experience change.

Qualitative evidence gathering

The following methodology was used to construct the research report on social prescribing and community connector approaches:

Desk research

- ◆ A call for evidence exercise was undertaken, which invited partnerships to supply relevant evidence on social prescribing and community connector activities to the national evaluation team. This activity was voluntary and was complemented by information shared by The Fund's learning team.
- ◆ An evidence review was then undertaken, exploring evidence on social prescribing and community connector approaches produced by individual Ageing Better partnerships. The review of evidence from Ageing Better partnerships' local evaluations, website content, and other materials assimilated programme-level learning to inform the primary research.
- ◆ A review of the wider evidence base on social prescribing approaches was undertaken to situate Ageing Better evidence within broader policy and practice. This review identified key policy developments, initiatives and stakeholders working on the social prescribing theme. The findings of this review helped identify ways in which the Ageing Better national evaluation could contribute to the wider evidence.
- ◆ The desk research above was used to identify key lines of enquiry for further investigation through the primary research.
- ◆ A team briefing was held to reflect on key learning from the evidence review. The team briefing also introduced semi-structured topic guides to be used for the primary research to ensure question validity and consistency across the consultation process.

Primary research

- ◆ Interviews and workshops were undertaken with 35 stakeholders in total. This included the following:
 - ◆ Five stakeholders with a policy remit covering social prescribing
 - ◆ 12 partnership leads and two learning leads from 12 Ageing Better partnerships
 - ◆ Eight people involved in delivering projects
 - ◆ Eight participants

- ◆ The sampling framework used a snowballing approach to reach projects, delivery partners and participants through the partnership lead organisations.
- ◆ The primary research was undertaken remotely through Microsoft Teams video and audio consultations and telephone interviews.
- ◆ Team debriefs were held at a mid-point and following completion of the primary research to reflect on immediate learning and inform the analysis.

How we defined a social prescribing project

We used two methods to identify social prescribing and connector projects. The starting point was a typology of loneliness interventions that was developed by researchers commissioned by The Fund, which categorised social prescribing-related interventions or projects being undertaken by Ageing Better local partnerships (Annex A: Table A1)¹.

The category 'Social prescribing' was used to identify an initial list of social prescribing projects. This list was then cross-referenced and extended using information from the call for evidence and evidence review outlined above.

This approach identified 42 projects that had collected survey data (for 10,415 participants, Table 1).

Table 1 Social prescribing and whole programme CMF projects and participants

	Social prescribing projects	Ageing Better programme	Social prescribing proportion of Ageing Better programme (%)
Number of projects	42	366	11
Number of participants	10,415	35,290	41

Participant survey data

This report draws on data from the Ageing Better Common Measurement Framework (CMF). During the first year of the Ageing Better national evaluation in 2014, the national evaluation team worked with the Fund and the 14 partnerships to

¹ Typologies report. 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).

agree a set of common outcome measures for the programme². This set of outcome measures formed the basis for a CMF, which was designed for two purposes:

- ◆ To monitor the Ageing Better programme during delivery
- ◆ To build up a dataset on participant outcomes for a final evaluation

Data was collected using paper questionnaires, as Ageing Better partnerships felt this approach was most suitable for their projects and participants rather than using online or other approaches. The questionnaires were adapted to suit local preferences and administered by the partnerships. The questionnaires were designed for self-completion by participants, with staff helping participants as required. Partnerships then entered participant data into a centralised online platform. Each participant was assigned a Unique Reference Number to track their participation, allowing us to link together surveys that had been completed by the same person at different times. Partnerships were asked to collect data at the following times:

- ◆ **Entry:** as soon as possible on entry to their first project to provide a baseline against which to measure later change
- ◆ **Exit or follow-up:** on exiting their first project, or on entry and exit of any additional projects
- ◆ **Long-term follow-up:** 6 and/or 12 months after exiting the programme to investigate any further change in outcomes for participants over this extended period

This data captures changes experienced by Ageing Better participants using a number of measures. For this report we have looked at:

- ◆ **Loneliness:** Measured by the University of California, Los Angeles (UCLA) loneliness scale³. The UCLA scale was developed to measure relational connectedness, social connectedness and self-perceived isolation. There are several versions, including a short three-item scale. The questions are all negatively worded. It has been widely cited, and it forms part of the English Longitudinal Study of Ageing (ELSA). Since 2018, the UCLA is the

² Guidance on the participant survey and outcome measures was available to participating organisations.

³ Loneliness is measured using the UCLA loneliness scale. See: <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/measuringlonelinessguidanceforuseofthenationalindicatorsonsurveys>

government's recommended indirect measure for loneliness. It is used as a measure of overall loneliness, providing one overall score between three and nine, with a score of nine representing the loneliest. Lonely is defined as scoring six or more on a scale from three to nine.

- ◆ **Wellbeing:** Measured by the Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS). This focuses on both mental and emotional wellbeing (how 'good' somebody feels) and psychological functioning (how well somebody thinks they are functioning). A higher score represents higher wellbeing. Low wellbeing is defined as a score of less than 20 on a scale from 7 to 35.
- ◆ **Social contact with children, family and friends:** This measure evaluated the impact of activities on social contact within existing social circles. Evidence shows lacking social contact is a distinct element of social isolation. An increase in the average score indicates greater social contact. To reduce the research burden on participants, this question is an adaptation of three questions used in ELSA (ELSA asks this question separately for children, family and friends).
- ◆ **Social contact with non-family members:** This measures social contact outside the family and with neighbours and the community, a lack of which is a potential precursor to social isolation. An increase in the average score indicates greater social contact.
- ◆ **Health:** Measured by the EQ-VAS scale⁴. This reports participants' self-rated health from 'best imaginable health state' (100) to 'worst imaginable health state' (0).

Analysis

The qualitative data was written up into an Excel table and contained detailed notes and verbatim comments, which were recorded (with appropriate permissions) to ensure data accuracy. Secondary thematic analysis was then undertaken, which involved looking across the evidence and highlighting evidence that:

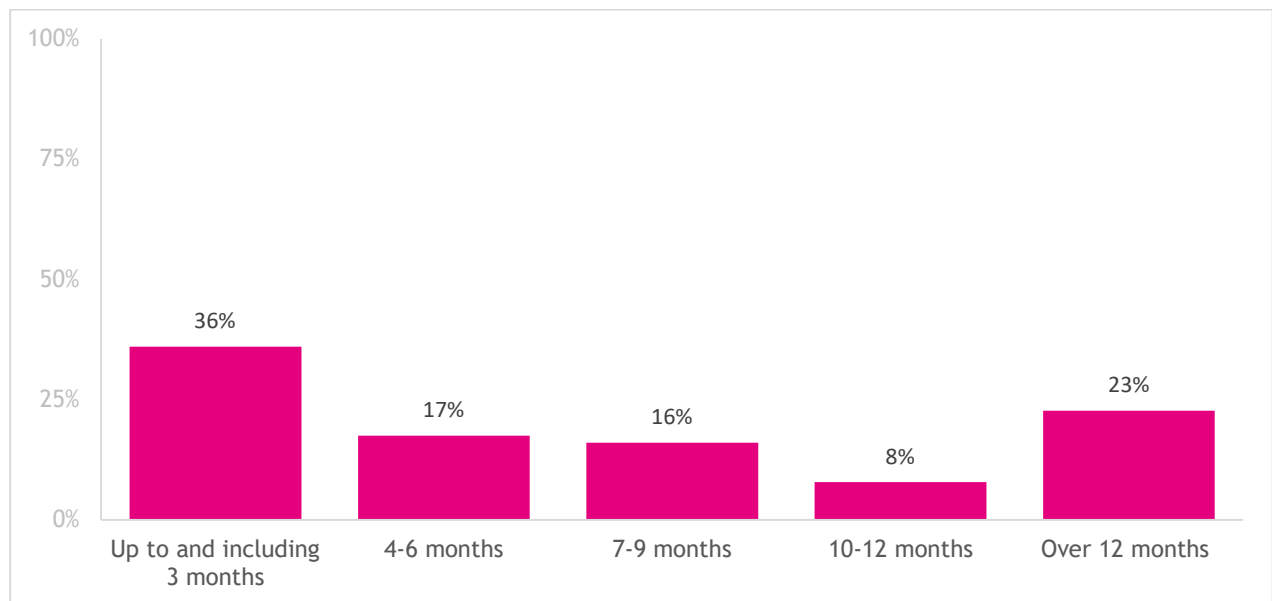
⁴EQ-VAS scale. See: <https://euroqol.org/eq-5d-instruments/eq-5d-3l-about>

- ◆ Describes emerging themes relevant to the focus of the study and the key research questions being addressed
- ◆ Identifies commonalities and differences in perspectives across interviewees and different stakeholder groups

The quantitative data analysed in the social prescribing research report includes participants that took part in at least one project that was identified as a social prescribing/community connector project. For this report, we analysed the change in CMF outcome measures (listed above) from baseline to most recent follow-up⁵. Just over two-fifths (43%) of social prescribing participants had follow-up data.

Of those with follow-up data, the average time between baseline and follow-up was almost eight months (236 days)⁶. Figure 1 shows the distribution of the time between participants' baseline and most recent follow-up. At the time of their most recent follow-up 30% of participants were still engaged with the programme (Table 2 'During' and 'Entry').

Figure 1 Time from baseline to most recent follow-up (n = 4,487)



⁵ A participant's 'most recent follow-up' is the last CMF questionnaire they completed prior to when data collection ended on 20 March 2020. There was no minimum length of involvement.

⁶ This is the time between when a participant started the programme and the collection date of their most recent follow-up. It does not show how long participants were engaged with the programme (30% were still engaged, and 15% had exited up to 12 months prior, Table 2).

Table 2 Stage of engagement at most recent follow-up

Follow-up stage of engagement	Proportion of social prescribing participants with follow-up data (%)
During existing project	25
Entry to another project	5
Exit	55
Long-term follow-up	15
<i>Base size</i>	2,913

We use significance tests to understand if the difference between baseline and follow-up CMF outcome measures are statistically significant (or likely due to chance). For the outcome analysis, we used the paired McNemar's test for categorical data and paired t-test for continuous data. For the sensitivity analysis, we used the z-test of proportions for categorical data and the two-sample t-test for continuous data.

The p-values we refer to in the tables below (Table A2 and Table A7 to Table A10) are the probability of an observed difference being due to chance, rather than being a real underlying difference between the baseline and follow-up measures. We follow the conventional approach to reporting on p-values, reporting on data as showing a change where there is a statistically significant difference (a p-value of less than 0.05).

Significance tests tell you (with a degree of confidence) whether a finding is *present* (as opposed to being due to chance), rather than whether it is *important*. Among other factors, whether a finding is significant or not is affected by the sample size of the data tested. The larger the sample size the smaller the absolute difference required to obtain a significant result. In this study, significance tests were run on data with large sample sizes (between 1,586 and 3,943 participants) meaning small absolute differences were found to be significant. Therefore, attention should be paid to how much each outcome measure has changed given what they are examining, and not just to whether the change is statistically significant.

Data limitations

As with any study, there are certain limitations to the data being presented.

The CMF was not intended to cover all Ageing Better participants, so the findings are not fully representative of all the people that took part in the programme or in social prescribing projects. Participants were asked to complete a CMF questionnaire if it was feasible (i.e., if the projects were able to administer the

questionnaires), if it was deemed appropriate given their mental health, and if they were able to provide informed consent. Where quantitative data is reported (for example, 1 in 5 projects, 68% of participants) it refers only to projects/participants that took part in the CMF survey. The qualitative data is based on interviews with a small number of people involved in the projects and used a snowballing approach to identify key stakeholders with learning to share. The snowballing approach does not attempt to be representative of all people who took part in relevant projects.

While a counterfactual study was run for the whole programme evaluation, the data from the counterfactual study is not suitable for analysing programme sub-themes, such as social prescribing approaches. No counterfactual data has been used in this analysis, meaning any change in outcomes cannot be directly attributed to participation in social prescribing projects. Additionally, social prescribing participants in this report may have taken part in non-social prescribing projects, which may have contributed to any change in the outcomes observed. Please see the Impact Evaluation Report for an analysis of the programme-level impact on key participant outcomes.

One potential limitation is that five projects account for around half (55%) of all participants attending social prescribing projects, with this potentially skewing results (Table A4). While there were several statistically significant differences between those attending the five larger projects and those attending other projects, these were largely due to the very large base sizes in both groups, although those attending the five largest projects tended to be younger, less likely to live alone or have long-term illnesses (Table A3). As we do not know how many people attended each project, we do not know to what extent the data for both groups is likely to represent those who attended.

Annex A: Data tables

This annex contains data tables based on the typology exercise and CMF survey data provided by Ageing Better participants.

An overview of Ageing Better projects based on intervention type

Table A1 Overview of types of interventions in the Ageing Better programme

Type of intervention	Participants (%)	Projects (%)
Social interventions	59	55
Physical health interventions	47	29
Creative activity projects	42	32
Knowledge sharing or building	29	16
Asset-based community development	28	26
Social prescribing	26	11
IT interventions	24	16
Mental health interventions	22	20
Culture change	15	9
Transport related projects	12	6
Other	3	3
<i>Base size</i>	<i>27,382</i>	<i>297</i>

An overview of largest social prescribing projects compared to other social prescribing projects

Table A2 Sensitivity analysis of demographic characteristics and outcome measures at baseline, comparing participants of the five largest social prescribing projects (n=5,745) and all other social prescribing projects (n=4,883)

Measure	Participants of 5 largest social prescribing projects	<i>Base size</i>	Participants of all other social prescribing projects	<i>Base size</i>	<i>P-value</i>
Female, proportion	70%	5,444	68%	4,687	0.03*
BME, proportion	7%	5,318	15%	4,514	<0.01*
Over 70, proportion	40%	5,065	58%	4,213	<0.01*
Live alone, proportion	47%	4,807	64%	3,939	<0.01*
With longstanding illness, proportion	63%	4,713	77%	3,914	<0.01*
LGBTQ+, proportion	3%	4,731	2%	4,025	<0.01*
Carer, proportion	22%	4,556	16%	3,839	<0.01*

Measure	Participants of 5 largest social prescribing projects	Base size	Participants of all other social prescribing projects	Base size	P-value
See family/friends at least once a week, proportion	62%	4,024	64%	3,210	<0.01*
Speak with someone locally at least three times a week, proportion	65%	4,271	56%	3,425	<0.01*
Loneliness, mean score (standard deviation)	5.6 (2.1)	2,252	6.1 (2.0)	1,350	<0.01*
Wellbeing, mean score (standard deviation)	21.0 (5.0)	2,254	20.3 (4.7)	1,668	<0.01*
Health, mean score (standard deviation)	52.3 (23.5)	438	55.9 (22.6)	1,230	<0.01*

An overview of social prescribing projects

Table A3 Number of social prescribing projects and participants in Ageing Better partnerships

Partnership	Number of social prescribing projects	Number of social prescribing project participants
Birmingham	0	0
Bristol	4	506
Camden	2	1,407
Cheshire	4	462
East Lindsey	1	178
Greater Manchester	1	113
Hackney	3	131
Isle of Wight	3	507
Leeds	10	440
Leicester	3	447
Middlesbrough	1	334
Sheffield	5	1,703
Thanet	2	3,094
Torbay	3	1,093
Total	42	10,415

Table A4 Scale of social prescribing projects, overall and in each Ageing Better partnership

	Scale of project (number of participants)																					Total
	1-50	51-100	101-150	151-200	201-250	251-300	301-350	351-400	401-450	451-500	501-550	551-600	601-650	651-700	701-750	751-800	801-850	851-900	901-950	951-1000	>1001	
Bristol	0	2	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Camden	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	2
Cheshire	2	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	4
East Lindsey	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Greater Manchester	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Hackney	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Isle of Wight	1	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Leeds	7	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Leicester	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Middlesbrough	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Sheffield	2	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	5
Thanet	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	2
Torbay	1	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	3
Total	16	7	5	1	1	0	2	3	0	1	1	1	0	0	0	1	0	0	0	0	3	42

Participants in social prescribing projects

Table A5 Characteristics (demographics) of social prescribing project participants and peer group comparator where relevant

Characteristic	Percentage of social prescribing project participants (%)	Percentage of over 50s in Ageing Better areas ⁷ , England ⁸ , or the UK ⁹ (%)
Gender		
Male	31	48 ⁷
Female	69	52 ⁷
<i>Base size</i>		9,926
Ethnicity		
Asian/Asian UK	6	6 ⁷
Black/African/Caribbean/Black UK	3	3 ⁷
White	89	89 ⁷
Mixed ethnic	1	1 ⁷
Other ethnic groups	1	1 ⁷
<i>Base size</i>		9,630
Sexual Identity		
Heterosexual	98	99 ⁸
Gay/Lesbian	1	<1 ⁸
Bisexual	1	<1 ⁸
Other sexuality	<1	<1 ⁸
<i>Base size</i>		8,593
Age		
Under 50	<1	-
50-59	20	36 ⁷
60-69	29	30 ⁷
Over 70	52	34 ⁷
<i>Base size</i>		9,089
Living arrangement		

⁷ National Census (2011). For more information, see: *2011 census data on Nomis*, Nomis Official Labour Market Statistics. Available at: <https://www.nomisweb.co.uk/census/2011>. Accessed on 23 July 2021.

⁸ Annual Population Survey (2017). For more information, see: *Sexual identity, subnational*, Office for National Statistics. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/datasets/sexualidentitysubnational>. Accessed on 23 July 2021.

⁹ Annual Population Survey (2019). Data available on request.

Characteristic	Percentage of social prescribing project participants (%)	Percentage of over 50s in Ageing Better areas ⁷ , England ⁸ , or the UK ⁹ (%)
Living alone	55	27 ⁷
With spouse/partner	30	
With family	12	
In residential accommodation	2	
Other living arrangement	2	
<i>Base size</i>		8,576
Longstanding illness / disability		
Has longstanding illness / disability	69	54 ⁹
No longstanding illness / disability	31	46 ⁹
<i>Base size</i>		8,456
Carer status		
Carer	19	17 ⁷
Not Carer	81	83 ⁷
<i>Base size</i>		8,235

Table A6 Characteristics (baseline outcomes) of social prescribing project participants

Characteristic	Percentage of social prescribing project participants (%)	<i>Base size</i>	Percentage of over 50s in England (%)
See family/friends once a week or more	67	6,770	74 ¹⁰
Speak to someone locally 3 times a week or more	61	7,409	NA
Are lonely (score of 6 or more)	56	7,106	17 ¹¹
Have low wellbeing (score of 19 or less)	32	7,588	NA

¹⁰ *Measuring national well-being: Domains and measures dataset*, Office for National Statistics. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/datasets/measuringnationalwellbeingdomainsandmeasures>. Accessed on 4 February 2022.

¹¹ *TNS Omnibus* (2016) (not published).

Changes in outcomes for participants in social prescribing projects: Overall

We looked at key outcomes, such as social contact with family and friends, social contact with people locally, health, wellbeing, and loneliness among participants in social prescribing projects.

When they started the programme, 68% of participants reported that they saw a family member or friend at least once a week. This increased to 72% at the time of their most recent follow-up. Similarly, 62% of participants said they spoke with someone locally at least three times a week when they joined the programme. This increased to 68% by the time of their most recent follow-up (Table A7).

Table A7 Change in social contact of social prescribing project participants. Significant changes, with p-value <0.05, are marked with *

Social contact measure ¹²	At entry (%)	At most recent follow-up (%)	Change (pp ¹³)	P-value	Base size
See family/friends once a week or more, proportion of participants (%)	68	72	5	<.001*	3,573
Speak to someone locally 3 times a week or more, proportion of participants (%)	62	68	5	<.001*	3,943

Participants were asked to rate their health on a scale from one to 100, with one being the 'worst imaginable health' and 100 being the 'best imaginable health'. When they started the programme, on average participants rated their health as 55.0 out of 100. This increased to an average of 60.5 out of 100 at the time of their most recent follow-up (Table A8).

¹²We have not calculated average scores for social contact, as this question asked respondents to give categories and not numbers (e.g., 'once a week', 'once a month', 'once a year').

¹³Percentage points (pp).

Table A8 Change in perceived health of social prescribing project participants. Significant changes, with p-value <0.05, are marked with *

Health measure ¹⁴	At entry	At most recent follow-up	Change	P-value	Base size
Perceived health score, mean score (standard deviation)	55.0 (22.9)	60.5 (21.8)	5.4	<.001*	1,586

One in three participants (33%) reported having low wellbeing when they joined the programme. By the time of their most recent follow-up, this had reduced to around one in five participants (19%) (Table A9)

Table A9 Change in wellbeing of social prescribing project participants. Significant changes, with p-value <0.05, are marked with *

Measure	At entry	At most recent follow-up	Change	P-value	Base size
Wellbeing score, mean score (standard deviation)	20.8 (4.9)	22.4 (4.9)	1.7	<.001*	3,815
Have low wellbeing, proportion of participants (%)	33	19	-13 pp	<.001*	3,815

When they started the programme, just over half of all participants (55%) reported being lonely. By the time of their most recent follow-up, this had reduced to 45% (Table A10)

Table A10 Change in loneliness of social prescribing project participants. Significant changes, with p-value <0.05, are marked with *

Measure	At entry	At most recent follow-up	Change	P-value	Base size
Loneliness score, mean score (standard deviation)	5.8 (2.1)	5.3 (2.0)	-0.5	<.001*	3,510
Are lonely, proportion of participants (%)	55	45	-9 pp	<.001*	3,510

¹⁴ We have not reported the proportion of participants with below average / average / above average health, as there are no standardly used categories for this measure.

Research ethics and data protection

Ecorys strictly adhere to academic and industry standard procedures to ensure the ethical underpinning of all our work. All Ecorys researchers working on this social prescribing research were DBS checked and cleared¹⁵ and had completed external training on research ethics and working with vulnerable adults before their involvement began. All research was conducted within Ecorys' safeguarding policies for vulnerable adults.

All individuals who took part in an interview or focus group provided their informed consent after we shared information with them on how their data would be processed and reassured them that their views would be confidential. Stakeholders were asked to provide consent for anonymised quotes to be used in reporting. All data used in the report was anonymised and individuals were not named. However, projects and partnerships were named.

¹⁵ A Disclosure and Barring Service (DBS) check enables employers to check the criminal record of someone applying for a role. Enhanced checks are available for people intending to work with vulnerable individuals or groups. See: <https://www.gov.uk/dbs-check-applicant-criminal-record>

Glossary

Asset-based community development (ABCD) – An approach based on the principle of identifying and mobilising individual and community ‘assets’, rather than focusing on problems and needs (i.e., ‘deficits’)¹⁶.

Community – This can refer to a geographical area or a community of interest. This group might be geographically related, such as a retirement community, or a community of interest dispersed across a wider area (in the context of Ageing Better, this includes a range of marginalised groups: Black, Asian and minority ethnic, LGBTQ+, carers, those living alone, and men).

Community connectors – Any mechanism that works to identify isolated people over 50 and works with them to facilitate a transition from isolated to less isolated through person-centred, structured support. This includes community navigators, social prescribing, and approaches that involve people overcoming a specific barrier (mental health issues, for example)¹⁷.

Community development – A process where members of a community come together to take action that is important to them, usually working together to make the community stronger or more resilient. ABCD is one approach to community development.

Co-production – An approach that can be applied to a wide range of different contexts. It involves professionals, citizens and other stakeholders sharing power to achieve something together, recognising that both have valuable contributions to make.

General practitioner (GP) – A medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients of all ages in a community setting.

Partnership – Partnership refers to the individuals and organisations (partners) that oversee and support the delivery of Ageing Better in each of the 14 programme areas. Each partnership selects a variety of projects that best meet local needs.

¹⁶ Frost, S., *Learning Network Development Manager for the Altogether Better Learning Network* (2011), Asset Based Community Development (ABCD).

¹⁷ Definition developed by Ageing Better partnerships with facilitation from Hall Aitken, Support and Development Contractor for the Ageing Better programme.

Project lead – Paid staff from local organisations who coordinate larger micro-funded projects. Project activities are led by micro-funded group leads, volunteers or participant volunteers.

Social isolation or loneliness – There is no single agreed definition of social isolation or loneliness. In general, social isolation refers to the number and frequency of contacts with other people that a person has, and loneliness refers to the way that a person views this contact (for example, whether it is a fulfilling connection). Social isolation is an objective state, whereas loneliness is subjective.

Social prescribing – Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services¹⁸.

Test and learn – ‘Test and learn’ gives partnerships the flexibility to try out a range of approaches. It also means recognising and sharing when things have not gone as intended, as well as when they have been successful, to create practical learning for others. Using this learning, the programme aims to improve how services and interventions to tackle loneliness are delivered, and ultimately contribute to an evidence base to influence future service development¹⁹.

VCSE sector – Voluntary, community, and social enterprise sector.

Wellbeing – Wellbeing means feeling good, functioning well and being able to respond to challenges in life positively.

¹⁸ The Kings Fund (date unspecified), *What is social prescribing?* Available at: www.kingsfund.org.uk/publications/social-prescribing

¹⁹ Ageing Better and the Big Lottery Fund, May 2018, *Knowledge and Learning Programme Briefing*, p.2.



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