ECORYS Answering tomorrow's challenges today

COMMUNITY FUND

Ageing Better: Summative Report – Methods Note

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

Independent Evaluation for The National Lottery Community Fund

June 2022

Contents

Tables

Introduction

Introduction

Purpose of the Methods Note

This Methods Note accompanies the Summative Evaluation Report that sets out our findings about the Ageing Better programme. It provides an overview of the programme and the different partnerships within it, and explores overarching findings from across the programme in four key areas:

- Programme reach (those who engaged or didn't engage with Ageing Better)
- The difference Ageing Better made for people who were involved
- What changed for organisations involved in terms of how they worked and what they delivered
- How Ageing Better changed the wider local systems in the areas in which it worked and how it contributed to national system change

Following an introduction to the programme, this Methods Note summarises the research approach, details the data collection methods used, and presents the data tables referenced in the Summative Report. It 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 in Birmingham
- Bristol Ageing Better
- Ageing Better in Camden
- Brightlife (Cheshire)
- Talk, Eat, Drink (T.E.D) (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.

Research process

Research process

Research aims

The overarching aim for the Summative Report is to present evidence that will be of interest to The Fund decision makers over time, as well as external commissioners, policy makers, and managers planning delivery.

The research aims are to:

- Understand what the Ageing Better programme was about and its key achievements
- Explore the difference Ageing Better funding has made and where things didn't change as The Fund hoped
- Provide evidence that enables decision makers (commissioners and policy makers) to improve outcomes for individuals, services, and their local systems, based on what worked and what didn't

The Summative Report explores the following overarching **research questions**:

- What changed as a result of Ageing Better Funding? Why does it matter?
- What didn't change or didn't work and why?
- What changes have become embedded in local practise or systems (i.e. what changes have stuck)?[1]
- Where is work still needed or needed most?

The Summative Report reflects on the programme's Theory of Change and report at three levels:

Individuals

1. Who engaged with the programme, who didn't? Describe the reach of the funding and number who engaged.

[1] Reporting needed to take account of the level of change and flux in the system, particularly because of the pandemic, i.e., complexity evaluation. Partnerships collected clear evidence around their informing/influencing role – but there may be limited evidence of sustainability within/ by LAs or older people's organisations.

2. To what extent have ambitions for individual outcomes been achieved? For whom (are there differences)? Why might this be and why it matters.
3. What was not possible (or very hard) to change? Were there any negative or unforeseen changes that have occurred? Why might this be?
4. What changes for individuals have been maintained?
5. Where is work still needed or needed most?

Service – Local partnerships

6. Describe the focus or key achievements of each partnership so we can better understand the things that happened under the Ageing Better umbrella.
7. How did the funding change the capacity of organisations (i.e. grant holders, partnerships, delivery organisations)? How many staff? How many volunteers?
8. What changed as a result of the funding in how organisations operate or work in partnership?
9. What changed as a result of the funding in terms of what services were delivered and how they were delivered?
10. What was not possible (or very hard) to change? Were there any negative or unforeseen changes that occurred? Why might this be?
11. What changes for organisations/services have been maintained/embedded in local practise?
12. Where is work still needed or needed most?

Systems – The local community and ecosystem

13. Describe the systems that Ageing Better operated within, and the system change goals/priorities of the programme/areas.
14. What changed in the system(s) and what did that lead to for people and service/organisation delivery? For example:
    - Is there better identification and reach for older people?
    - How have relationships and partnerships changed within or between local systems?

- Is support for older people or those at risk of isolation more joined up?

15. What was not possible (or very hard) to change? Were there any negative or unforeseen changes that have occurred?
16. To what extent did Ageing Better contribute to changes, and to what extent did the wider context contribute?
17. Where is work still needed or needed most?

Research approach

There was significant emphasis across the Ageing Better programme on generating evaluation and learning evidence. This included a large-scale national evaluation, as well as individual partnerships commissioning their own local evaluations and producing a large number of learning reports, toolkits and resources building on the test and learn approach. The Summative Report brings together this varied evidence with some additional evidence gathered by the national evaluation team as the programme closed in order to provide a full summative assessment of the programme.

The following methodology was used to gather and assess evidence for the Summative Report:

Primary research

- Over the course of the Ageing Better programme evaluation, qualitative research activity was conducted by the national evaluation team to investigate particular themes or areas of activity. This involved qualitative interviews and focus groups with partnership management teams, delivery organisations, volunteers and participants.
- In addition, interviews and workshops were undertaken with 59 stakeholders in total to capture reflections as the programme neared the end. This included:
  - Three stakeholders with a policy remit related to people over 50
  - 28 partnership leads and learning leads from 13 Ageing Better partnerships
  - 25 delivery partners (people managing or delivering individual projects)
  - The Ageing Better Head of Funding and three Fund Relationship Managers (from The Fund) who managed a caseload of partnerships

- The sampling framework used a snowballing approach to reach delivery partners 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.
- 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 kept 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.

Desk research

- A Year 7 **call for evidence** exercise was undertaken, to collect recent local evidence from Ageing Better partnerships. This local evidence included evaluations conducted or commissioned by partnerships covering their activity as a whole or specific Ageing Better projects, learning reports, and media coverage. Additionally, in conjunction with the partnerships, The National Lottery Community Fund (The Fund) produced a range of learning reports on a variety of themes that reflect common principles that recurred and ran throughout the programme. A review of this local and programme wide evidence was conducted by the national evaluation team to feed into this report. Evidence collected through previous thematic research was also reviewed by the national evaluation team. The evidence map cross-referenced themes to outputs produced by the partnerships, and can be viewed here.
- **A team briefing** was held to reflect on key learning from the evidence review. The team briefing also introduced the semi-structured topic guides to be used for the primary research to ensure question validity and consistency across the consultation process.

Quantitative Data Sources

The national evaluation had a strong focus on generating **quantitative data**, which was used in the Summative Report to understand:

- The **total reach** and **reach among key demographic groups** of the programme and of the 14 partnerships. The reach analysis was conducted for this report, combining data collected in Years 1–6 and Year 7 of the programme. The reach analysis was conducted using data from the following sources:
  - Ageing Better Common Measurement Framework (CMF) questionnaires were completed by participants during Years 1-6 of the programme. These included questions on participant demographic characteristics, outcomes, and the types of activities that participants took part in.
  - Programme monitoring data (PMD), which included data on area level attendance, was collected on an ongoing basis by project staff. This was completed by each partnership in Years 1–6.
  - The Year 7 participant information, which included information on participant demographic characteristics only.
- The **impact** of the programme activities on individuals' outcomes. This draws on findings from the impact study, central to the seven-year national evaluation, which was designed to test the hypothesis 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 wellbeing. The full findings are available in the Impact Evaluation Report and details on the methodology in the accompanying Methods Note. The impact analysis, taken from the Impact Evaluation Report, is based on data from the CMF and Programme Monitoring (outlined above), as well as data from the Comparison Participant Survey and Typology Questionnaire. A full description of these, including data collection methods, can be found in the Impact Evaluation Report Methods Note.
- In Year 7 of the programme, Project Managers were asked to provide data on key participant demographics, including those that are known risk factors of social isolation and loneliness, such as living alone and having a longstanding illness or disability. Project Managers were encouraged to provide data for all participants that attended. However, in interviews it was highlighted that some managers were not able to provide information for all participants due to delivery not being face to face, some provision being more ad hoc or informal, and reduced staffing capacity resulting from the pandemic. Three partnerships – Bristol, the Isle of Wight, and Sheffield – did not carry out participant activities in Year 7 and therefore did not collect any Year 7 participant information.

A summary of the different analyses and the quantitative data sources used is presented in Table 1.

Table 1 Data sources used in the Summative Report

Focus of analysis	Data source used
Programme and partnership total reach	PMD, Year 7 participant information
Programme and partnership reach among participant groups	CMF Participant Survey, Year 7 participant information
Outcomes and impact	CMF Participant Survey, Comparison Participant Survey, Typology Questionnaire

Analysis

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

- 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

Table 2 overleaf sets out the number of participants recorded in the monitoring system for the Ageing Better national evaluation for Year 1-7, and the number and proportion of participants completing CMF questionnaires during Years 1-6 of the programme. This data formed the core dataset for analysis to calculate the **total reach of the programme and of each partnership area** (Table 4). As Year 7 data was not provided for all participants, it is likely Year 7 participant numbers are an underestimate[2].

[2] The partnership profiles in the Summative Report may feature higher participant numbers than the national monitoring data, because not all local data for Years 1-6 participants was entered into the central monitoring system by partnerships, and not all Year 7 participant data was made available to the national evaluation team. Additional participants recorded at the local level tended to be associated with the following activities: micro-funding, one-off events, age-friendly actions, COVID-19 support, and remote or hybrid activities introduced at pace during the pandemic. One partnership recorded a lower participant total locally at the end of their programme, owing to complications in disaggregating Ageing Better participant data from participants funded through other sources.

Table 2 Participant data collection

	Number	Percentage of number involved (%)	Percentage of CMF questionnaires (%)
Years 1–6			
Participants involved in Ageing Better until March 2020	140886		
Participants that completed a CMF questionnaire	35920	25	-
Participants that completed CMF including demographics (based on gender)	33765	24	9
Participants that completed CMF including outcomes at baseline (based on contact with family and friends)	21046	15	59
Participants that completed CMF including outcomes at any follow-up (based on contact with family and friends)	8085	6	23
Base size		*140866*	*35920*
Year 7			
Participants for which there is Year 7 Participant information	8554		

To calculate the **reach of the programme among the key demographic groups**, we compared the proportion of participants in Ageing Better to the proportion of the over 50s population in (where possible) Ageing Better areas and (where data at this level was not available) England or the UK (Table 3). In both cases, for the three partnerships that did not have participants in Year 7, we analysed the data from Years 1–6 only.

Table 3 Area of peer group comparator

Area	Characteristics
Ageing Better areas	Gender, ethnicity, age, living arrangements, carer status
England	Sexual identity
The UK	Longstanding illness or disability

The combined data from the CMF and Year 7 participant information and the comparable England and UK data is presented in Table 5 below.

We used z-test of proportions to understand if the difference between the proportion of Ageing Better participants with a characteristic and the proportion of people in the relevant comparison group is statistically significant (or likely due to chance).

The p-values we refer to in Table 5 below are the probability of an observed difference being due to chance, rather than being a real difference between the proportions observed in the two populations. 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).

Where an observed difference is found to be significant, this does not mean it is large, important, or has real world-implications, and the magnitude of the difference (shown in 'Difference', Table 5) should be considered when interpreting the findings. Among other factors, whether a finding is significant or not is affected by the sample size of the data being tested. The larger the sample size, the smaller the absolute difference required to obtain a significant result; conversely, smaller sample sizes require larger absolute differences.

The analysis also provides an overview of the intervention types funded through the Ageing Better programme, based on the typology exercise (Table 6)[3].

Data limitations

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

Qualitative data:

- The qualitative data is based on interviews with a small number of people involved in Ageing Better partnerships and the projects, and uses 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. We were not able to complete interviews for one partnership.

Monitoring data limitations (PMD and Year 7 participant information):

- As noted above, where we report on total reach, these are estimates. While both datasets (PMD and Year 7 participant information) were intended to cover all participants, there may be instances where they do not due to the nature of working under difficult conditions. Additionally, both datasets were collected at a project (i.e. aggregated, rather than individual) level, and so could include non-

[3] 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. Further information on the typology exercise is available in the Impact Evaluation Report.

unique participants (i.e. one participant who took part in two projects), and Year 7 participants could have been participants in Years 1–6.

CMF data limitations:

- The CMF was not intended to cover all Ageing Better participants; participants were asked to complete a CMF questionnaire if it was feasible (i.e. if the projects were able to administer the questionnaires), deemed appropriate given their mental health, and if they were able to provide informed consent. There may have been unintentional bias in the way individual projects asked certain people to take part in data collection, which could mean that reach data is not representative of all the people that took part in the programme.
- The lack of monitoring data (e.g. demographic information) for all Ageing Better participants across all projects means we cannot assess the extent to which respondents included in the CMF analysis represent all 140,886 Ageing Better participants from Years 1–6, or the subset taking part in relevant projects (for example, projects that are not one-off events).
- For a full discussion on the data limitations of the Impact Evaluation Report analysis, please refer to the relevant Methods Note.

Data tables

The below tables cover programme and partnership reach based on the typologies exercise, Programme Monitoring Data, the CMF survey data, and Year 7 participant information.

For data tables relating to the impact analysis, please see the Impact Evaluation Report Methods Note.

Reach and participation

Table 4 Programme and partnership reach

Partnership	Number of participants Years 1–6	Number of participants with CMF data	Number of participants Year 7 Participant information
Birmingham	9327	2629	1848
Bristol	24151	2935	0
Camden	11756	4854	384
Cheshire	3689	1590	244
East Lindsey	6147	974	410
Greater Manchester	13449	6110	599
Hackney	6474	1953	589
Isle of Wight	17130	1232	0
Leeds	14170	1967	1912
Leicester	5870	2576	128
Middlesbrough	5981	1243	375
Sheffield	3221	3401	0
Thanet	5890	3106	147
Torbay	13631	1350	1918
Total	140886	35290	8554

Table 5 Demographic characteristics of Ageing Better programme participants and peer group comparators. Significant differences, with p-value <0.05, are marked with *

Characteristic	Percentage of Ageing Better project participants (%)	Percentage of over 50s in Ageing Better areas[4] (or England[5], or the UK[6]) (%)	Difference (pp)	*p*-value
Gender				
Male	32	48	14.7	<.001*
Female	68	52	-	-
Base size	*39722*			
Ethnicity				
Asian/Asian UK	14	6	6.8	<.001*
Black/African/Caribbean/Black UK	7	3	3.8	<.001*
White	75	89	12.9	<.001*

[4] Source: 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.
[5] Source: 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.
[6] Source: Annual Population Survey (2019). Data available on request.

Characteristic	Percentage of Ageing Better project participants (%)	Percentage of over 50s in Ageing Better areas[4] (or England[5], or the UK[6]) (%)	Difference (pp)	*p*-value
Mixed ethnic	1	1	0.3	<.001*
Other ethnic group	3	1	2.0	<.001*
Base size	*37573*			
Sexual identity				
LGBTQ+	5	1[5]	3.2	<.001*
Heterosexual	95	99[5]	-	-
Base size	*30848*			
Age				
Under 50	(2)[7]			-
50–59	(20) 20	36	15.4	<.001*
60–69	(30) 30	30	0.1	0.613
70–79	(27) 28	21	7.6	<.001*
Over 80	(21) 21	14	7.6	<.001*
Base size	*(30955) 30210*			
Living arrangements				
Living alone	49	27	21.6	<.001*
Living not alone (with spouse/partner, family, in residential accommodation, or other)	51	73	-	-
Base size	*27972*			
Longstanding illness/disability				
Has longstanding illness/disability	59	54[6]	5.6	<.001*
No longstanding illness/disability	41	46[6]	-	-
Base size	*27932*			
Carer status				
Carer	22	21	4.6	<.001*
Not carer	78	79	-	-
Base size	*26952*			

[7] Figures in brackets are age category percentages calculated including the under 50 cohort. Figures without brackets are the percentages without the under 50 cohort, in order to allow comparison to the peer group comparator.

An overview of Ageing Better projects based on intervention type

Table 6 Overview of types of interventions in the Ageing Better programme

Type of intervention	Participants (%)	Projects (%)
Social intervention	59	55
Physical health intervention	47	29
Creative activity project	42	32
Knowledge sharing or building	29	16
Asset based community development	28	26
Social prescribing	26	11
IT intervention	24	16
Mental health intervention	22	20
Culture change	15	9
Transport related project	12	6
Other	3	3
Base size	*27382*	*297*

Evaluation framework

	Can we answer this question?	Evidence sources					
Research question	Yes/no/partial	National Evaluation Reports	Local Evaluation Reports	Workshop with AB Head of Funding and FRMs	Self-completion proforma (completed by partnerships)	Partnership interviews and delivery partner consultations (clarification/ amplification)	External stakeholders
1. Who engaged with the programme, who didn't? Describe the reach of the funding and number who engaged.	Yes NB. Limited info on who didn't engage	Impact Report					
2. To what extent have ambitions for individual outcomes been achieved? For whom (are there differences)? Why might this be and why it matters.	Partial NB. More is known for some ToC outcomes	Impact Report Micro-funding Social prescribing	Qualitative evidence from partnerships (including participants)	Yes NB. explore perception re. 'right' things to measure		Yes	
3. What was not possible (or very hard) to change? Were there any negative or unforeseen changes that occurred? Why might this be?	Partial	Impact Report		Yes		Yes	
4. What changes for individuals have been maintained?	Partial	Impact Report	Qualitative evidence from partnerships (including participants)				
5. Where is work still needed or needed most?	Partial		Qualitative evidence	Yes		Yes	Yes

	Can we answer this question?	Evidence sources					
Research question	Yes/no/partial	National Evaluation Reports	Local Evaluation Reports	Workshop with AB Head of Funding and FRMs	Self-completion proforma (completed by partnerships)	Partnership interviews and delivery partner consultations (clarification/ amplification)	External stakeholders
Service – local partnerships							
6. Describe the focus or key achievements of each partnership so we can better understand the things that happened under the Ageing Better umbrella.	Yes		Qualitative evidence		Yes	Infographic info to be explored in/informed by interviews as well as self-completion (i.e. two-way process)	
7. How did the funding change the capacity of organisations (i.e. grant holders, partnerships, delivery organisations)? How many staff? How many volunteers?	Partial	CMF volunteering data	Qualitative evidence	Yes	Yes	Yes	
8. What changed as a result of the funding in how organisations operate or work in partnership?	Partial	Qualitative Reports (including COVID papers, social prescribing)	Qualitative evidence	Yes	Yes	Yes	
9. What changed as a result of the funding in terms of what services were delivered and how they were delivered?	Partial	Qualitative Reports (including COVID papers, social prescribing)	Qualitative evidence	Yes		Yes	
10. What was not possible (or very hard) to change? Were there any negative or unforeseen	Partial	Qualitative Reports (including COVID	Qualitative evidence	Yes		Yes	

	Can we answer this question?	Evidence sources					
Research question	Yes/no/partial	National Evaluation Reports	Local Evaluation Reports	Workshop with AB Head of Funding and FRMs	Self-completion proforma (completed by partnerships)	Partnership interviews and delivery partner consultations (clarification/ amplification)	External stakeholders
changes that occurred? Why this might be?		papers, social prescribing)					
11. What changes for organisations/services have been maintained/embedded in local practise?	Partial	Qualitative Reports (including COVID papers, social prescribing)	Qualitative evidence	Yes		Yes	
12. Where is work still needed or needed most?	Partial					Yes	Yes
Systems – The local community and ecosystem							
13. Describe the systems that Ageing Better operated within, and the systems change goals/priorities of the programme/areas.	Yes, although will rely on local evaluations and interviews for recent evidence	Qualitative Reports (including COVID papers, social prescribing)	Qualitative evidence	Yes		Yes	Yes
14. What changed in the system(s), and what did that lead to for people and service/organisation delivery? For example: ▶ Is there better identification and reach for older people? ▶ How have relationships and partnerships changed within or between local systems?	Partial	Qualitative Reports (including COVID papers, social prescribing)	Qualitative evidence	Yes		Yes	Yes

	Can we answer this question?	Evidence sources					
Research question	Yes/no/partial	National Evaluation Reports	Local Evaluation Reports	Workshop with AB Head of Funding and FRMs	Self-completion proforma (completed by partnerships)	Partnership interviews and delivery partner consultations (clarification/ amplification)	External stakeholders
▶ Is support for older people or those at risk of isolation more joined up?							
15. What was not possible (or very hard) to change? Were there any negative or unforeseen changes that occurred?	Partial	Qualitative Reports (including COVID papers, social prescribing)	Qualitative evidence	Yes		Yes	Yes
16. To what extent did Ageing Better contribute to changes, and to what extent did the wider context contribute?	Partial	Qualitative Reports (including COVID papers, social prescribing)	Qualitative evidence	Yes		Yes	Yes
17. Where is work still needed or needed most?	Partial	Qualitative Reports (including COVID papers, social prescribing)	Qualitative evidence	Yes		Yes	Yes

Glossary

Glossary

Age-friendly – This term refers to a wide range of services, structures and institutions that embrace the inclusion of older adults. However, the 'age-friendly' concept is most often associated with the Framework for Age-friendly Cities and Communities[8], which was developed by the World Health Organization (WHO) initially to support cities, and then communities more generally, to adapt to the context of population ageing, and to reframe the ageing of their populations as an opportunity. In the UK, implementation of the WHO framework is supported by the Centre for Ageing Better[9], which defines an Age-friendly Community as 'a place where people of all ages are able to live healthy and active later lives. These places make it possible for people to continue to stay in their homes, participate in the activities they value, and contribute to their communities for as long as possible.' The WHO has identified eight domains for Age Friendly Communities: outdoor spaces and building; transport; housing; social participation; respect and social inclusion; civic participation and employment; communication and information; and community support and health services.

Age friendly business – Businesses that are accessible and navigable for older people.

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')[10].

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, such as Black, Asian and minority ethnic people, LGBTQ+ individuals, 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,

---

[8] The WHO Age-friendly Cities Framework https://extranet.who.int/agefriendlyworld/age-friendly-cities-framework/
[9] Centre for Ageing Better, Age-friendly Communities https://www.ageing-better.org.uk/age-friendly-communities
[10] Frost, S., Learning Network Development Manager for the Altogether Better Learning Network, 2011, Asset Based Community Development (ABCD).

social prescribing, and approaches that involve people overcoming a specific barrier (mental health issues, for example)[11].

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.

Community transport – The development of flexible and accessible community-led solutions to address local transport needs. This represents the only means of transport for many vulnerable and isolated people, including older people or people with disabilities[12].

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.

Inclusive travel – Recognising what needs to be in place to enable people to feel safe travelling locally, including pavements that are well maintained and lit, bus stops that have reliable information and somewhere to sit, and bus drivers who are aware of mobility issues.

Integrated transport – Combining different modes of public transport (bus, train, tram, etc.) to create an efficient, safe, and convenient customer journey.

LGBTQ+ – Lesbian, gay, bisexual, transgender, and queer (or questioning)[13].

Local (context) – There is no agreed definition, although this refers to a geographic area. It can range from hyper-local (a group of houses, a street, or village) to a neighbourhood or ward level, and local authority area. This would not extend to a whole 'region'. The English regions, formerly known as the government office regions, are the highest tier of sub-national division in the country. Between

---

[11] Definition developed by Ageing Better partnerships with facilitation from Hall Aitken, Support and Development Contractor for the Ageing Better programme.
[12] Community Transport Association. See: https://ctauk.org/about-cta/what-is-community-transport/
[13] Definition from the Cambridge dictionary, see: https://dictionary.cambridge.org/dictionary/english/lgbtq

1994 and 2011, nine regions had officially devolved functions within government. Although they no longer fulfil this role, they continue to be used for statistical (and some administrative) purposes[14].

Participant volunteers – People who support project design and delivery, but also take part in its activities.

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.

Project lead – Paid staff from local organisations who coordinate larger micro-funded projects. Project activities are led by micro-funded group leads/volunteers/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 services[15].

Systems change – Seeking to address the root causes of social problems. Refers to an intentional process which seeks to alter the components and structures that cause systems to behave in a particular way[16]. Operationally, systems change is associated with creating a new power dynamic between individuals and organisations, which aims to empower people to help create solutions to local problems.

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 haven't 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

---

[14] See: https://www.ons.gov.uk/methodology/geography/ukgeographies/administrativegeography/england
[15] The Kings Fund (date unspecified) What is social prescribing? Available at: www.kingsfund.org.uk/publications/social-prescribing
[16] NPC, Systems change: what it is and how to do it. Available at: https://www.thinknpc.org/resource-hub/systems-change-a-guide-to-what-it-is-and-how-to-do-it/

interventions to tackle loneliness are delivered, and ultimately contribute to an evidence base to influence future service development[17].

Transport – A system of vehicles, such as buses, trains, or aircraft, for getting people or goods from one place to another[18].

VCSE sector – Voluntary, Community and Social Enterprise sector.

Volunteering – Any activity that involves spending time doing something unpaid that aims to benefit the environment or someone (individuals or groups) other than (or in addition to) close relatives. Central to this definition is the fact that volunteering must be a choice freely made by each person[19].

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

[17] Ageing Better and the Big Lottery Fund, May 2018, Knowledge and Learning Programme Briefing, p.2.
[18] Definition from the Cambridge Dictionary, see: https://dictionary.cambridge.org/dictionary/english/transport
[19] NCVO definition, see: https://www.ncvo.org.uk/policy-and-research/volunteering-policy

Website: tnlcommunityfund.org.uk/funding/strategic-investments/ageing-better

Twitter: @TNLComFund

Facebook: TNLCommunityFund

Instagram: tnlcommunityfund

LinkedIn: the-national-lottery-community-fund

June 2022
Author: Ecorys

COMMUNITY FUND