



ambition  
for  
ageing



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# **Ambition for Ageing**

## Baseline Data Analysis

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**March 2017**

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# Glossary

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

For full explanations of terms commonly used within this report, please see Appendix A.

# Section 1: Introduction

## Background

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

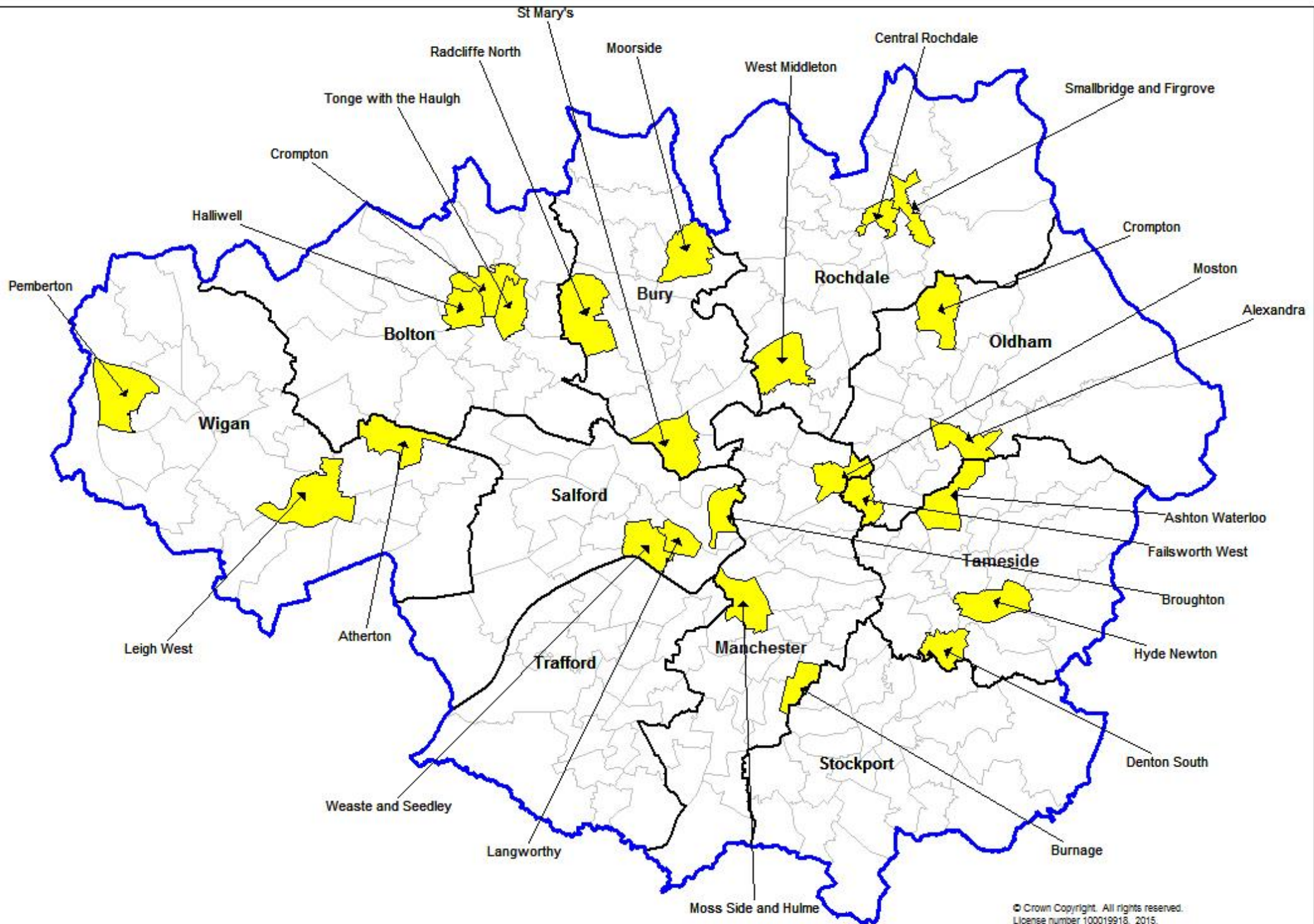
It is funded by the Big Lottery Fund's Ageing Better programme, which aims to reduce older people's social isolation.

Led by GMCVO, the 5 year programme is delivered by a cross-sector partnership with Local Delivery Leads (LDLs) leading on the work in 25 neighbourhoods (wards) across 8 local authorities in Greater Manchester:<sup>1</sup>

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

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<sup>1</sup> The local authorities of Stockport and Trafford do not meet the Big Lottery Fund's requirements for funding



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

An overview of each LDL's delivery approach is available in **Appendix C**.

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

The term 'older people' does not have a strict definition within the AfA programme. It is commonly understood to refer to people over 65 but as a label this is increasingly being questioned with the recognition that, often due to inequalities, people experience age related challenges at very different points in their lives. This is particularly true when considering Healthy Life Expectancy, which is 60.4 years in Greater Manchester.<sup>2</sup> Taking this into account, AfA uses the term 'older people' to refer to people aged 50 and above.

AfA's belief is that a series of small changes within our communities will bring large scale success in a practical and sustainable sense that will ultimately help to reduce social isolation. We will do this by providing small investments to help develop more age-friendly neighbourhoods in GM. We want communities to be more connected and for there to be more opportunities and activities for older people in the places they live.

This report provides an overview of all data collected thus far by LDLs in the programme for the evaluation. The report is structured as follows:

- Projects (investments) funded to date;
- Demographic characteristics;
- Perceptions of age-friendly neighbourhoods; and
- Subjective and objective measures of social isolation (social contact); and
- Conclusions & Recommendations.

In addition, there are three appendices to this report:

- Appendix A: Definition of Terms: this glossary defines terms commonly referred to within this report.
- Appendix B: List of all Investments Funded by AfA (Projects): this provides, in table format, a list of all projects funded by AfA LDLs in all areas over the past year.
- Appendix C: Summary of LDL Delivery Approaches: this describes each LDL's approach in each local area. This highlights the nuances in approach to funding and delivering AfA in each of the local authority areas.

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

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<sup>2</sup> ONS, HLE Healthy life expectancy (HLE) and life expectancy (LE) at birth by upper tier local authority (UTLA), England, downloaded February 2017, data is for 2012-2014



## Section 2: Methodology

New Economy is the evaluator for the Ambition for Ageing programme in GM.

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

AfA has a number of core outcomes against which it aims to show progress:

1. Wards in which the programme is delivered are more age-friendly
2. Older people in the designated wards have increased and improved social connections
3. AfA has influenced delivery of programmes affecting older people in a positive way
4. AfA has influenced strategy in GM relating to older people, social isolation and age-friendly neighbourhoods.

In order to evidence this progress, the evaluation is split into three core components:

- a) Programme evaluation: this focuses on measuring progress towards the first two outcomes (age-friendly neighbourhoods and social connections), as well as any unanticipated outcomes.
- b) Strategic evaluation: this focuses on measuring progress towards the latter two outcomes (influencing delivery and influencing strategy). It is likely that this will materialise towards years 3-4.
- c) Process evaluation: this will focus on questions relating to the process of how AfA has been implemented and run. It will include elements such as the impact of the Equalities Board and Older People's Network, whether the process has been participatory & representative, and partnership development.

**Table 2.1: Ambition for Ageing Outcomes**

Outcome	Indicators
<b>Programme Evaluation</b>	
Wards in which the programme is delivered are more age-friendly	The majority of older people in GM engaged by the programme will identify their neighbourhood as age friendly.
	The infrastructure conducive to an age-friendly

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

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

This report will focus almost entirely on data collection for the 'Programme Evaluation' section of the evaluation.

## Data Collection Methods

LDLs are required to collect key data from people and communities to demonstrate progress towards the outcomes. They submit this data to a central database managed by GMCVO and New Economy every quarter (April, July, October and January).

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

This is mostly made up of quantitative data. There are three sections to the data collection:

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



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

With an additional two layers:

- d) Events/Activity feedback: community level feedback/data on a small number of key questions and demographic data.<sup>4</sup>
- e) Case studies: qualitative feedback on any aspect of delivery.

Full copies of the questionnaires are available on request.

This report acts as a ‘baseline report’ to the extent that it will analyse all data collected in the first year of the programme, and only from ‘Baseline Questionnaires’ where applicable (i.e. Volunteers and Participants).

The report does not give any estimation of the impact of the programme. Very small numbers of questionnaires beyond Baseline (where applicable) were received, so judgements cannot be made on any changes in data.

## Sample Sizes

Data sample sizes vary by area, and the data presented throughout the report is not equally representative of all AfA areas. The data within this report is accurate at January 2017.

Table 2.2: Sample Sizes				
Area	Baseline Participant forms	Baseline Volunteer forms	Event feedback forms (evaluation)	Event feedback forms (demographics)
<b>Bolton</b>	14	16	133	10
<b>Bury</b>	5	5	17	8
<b>Manchester</b>	53 (+36) <sup>5</sup>	0	0	8 <sup>6</sup>
<b>Oldham</b>	60	37	301	132
<b>Rochdale</b>	18	12	26	1
<b>Salford</b>	16	44	7	20
<b>Tameside</b>	30	11	154	32
<b>Wigan</b>	64	5	101	16
<b>Total</b>	<b>296</b>	<b>130</b>	<b>739</b>	<b>227</b>

<sup>4</sup> The two forms are issued separately at events.

<sup>5</sup> There are 53 complete questionnaires for Manchester (comprised of demographic and questionnaire data i.e. in the same format as questionnaires from other areas). An additional 36 questionnaires were received without demographic information.

<sup>6</sup> Further demographic forms were collected by Manchester, but technical problems prevented these from being analysed in time for this report’s publication.

Note that sample sizes for each question vary, as individual respondents may not have answered every question. The above sample sizes are for the total number of questionnaires submitted, but there are gaps or missing answers within these questionnaires. Sample sizes for individual questions are provided throughout the report where applicable.

It should be noted that Manchester use a slightly different method of data collection to other areas. Appendix C provides full details of this, and this is why there are some discrepancies in sample sizes above. For example, the Manchester LDL uses participant questionnaires in all instances (not distinguishing between participants and volunteers) and does not distribute the event feedback questionnaires. As such, sample sizes for these are at zero.

LDLs also collect data for the national evaluation, including further demographic forms and questions bespoke to the national Ageing Better evaluation, such as on loneliness. National questionnaire data has not been analysed here as they are outside the remit of the local GM AfA evaluation, and are not relevant to the outcomes that AfA is working towards. This means that sample sizes in the above table will be larger when these are taken into account.

It is likely that there are some duplicates or slight errors within the data.<sup>7</sup> However, these are estimated to be at low levels and not likely to affect the percentages as indicative of overall trends provided throughout the report.

In addition, LDLs also submit case studies.

### **Project Highlight: Multiple Sclerosis Regional Therapy and Support Group in Pemberton, Wigan**

This project offers support, socialisation and a therapy to people living with MS and their carers in the local area. The members of the MST Support Group in Wigan approached Ambition for Ageing team for funding for a very specific piece of equipment.

The investment enabled the group to purchase a THERA-Trainer Balo-536, an electric lift and pelvis belt, software package, wide knee support, XL pelvis belt, extended warranty and service package. This equipment helps MS sufferers to exercise in a standing position, greatly benefiting their physical and mental health.

This piece of equipment can also be used by people with other severe mobility-limiting conditions and disabilities, and is a highly effective way of increasing quality of life for people with MS and their carers.

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<sup>7</sup> Arising from both user error and technical problems

## Section 3: Projects (Investments)

Over the last year, there have been 179 investments (projects with cost associated) across 7 areas.

There were an additional 51 projects with no allocated cost, mostly events or awareness sessions.

The total amount invested by the AfA programme directly into communities in the last year is £231,896. This has gradually increased with each quarter.

Table 3.1: Investment Spend by Quarter (rounded) <sup>8</sup>					
	Jan – Mar 16	Apr – Jun 16	Jul – Sept 16	Oct – Dec 16	Jan – Dec 16 (Total)
<b>Bolton</b>	0	£17,166	£9,338	£20,833	<b>£47,337</b>
<b>Bury</b>	NA	NA	0	£15,716	<b>£15,716</b>
<b>Manchester</b>	0	0	£15,875	£18,683	<b>£34,558</b>
<b>Oldham</b>	0	£13,755	£16,265	£14,299	<b>£44,319</b>
<b>Rochdale</b>	NA	NA	0	£10,903	<b>£10,903</b>
<b>Salford</b>	NA	NA	£391	0	<b>£391</b>
<b>Tameside</b>	0	£9,260	£4,817	£18,898	<b>£34,975</b>
<b>Wigan</b>	0	£8,722	£15,845	£21,130	<b>£45,697</b>
<b>Total</b>	<b>£0</b>	<b>£45,929</b>	<b>£62,307</b>	<b>£109,559</b>	<b>£231,896</b>

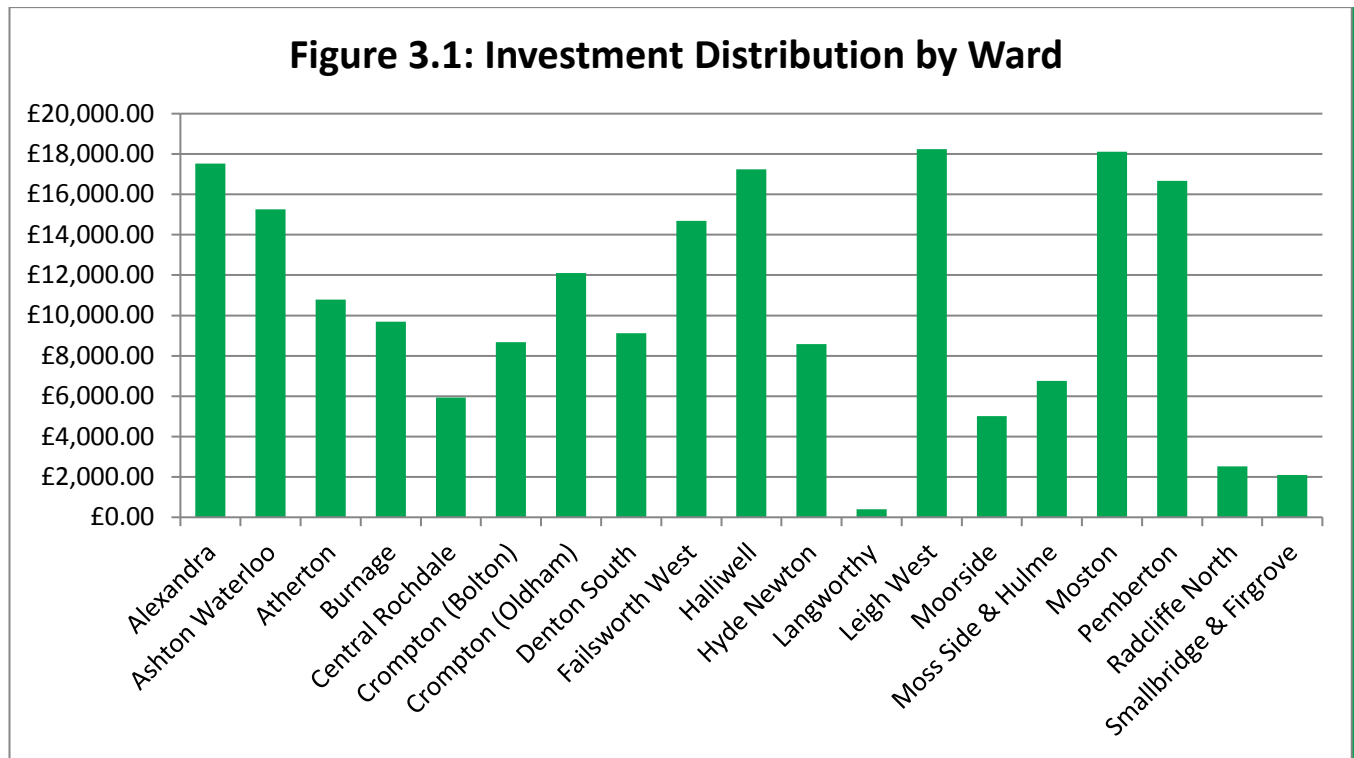
The map on the following page shows clusters where investments have been made. Each red marker is a unique investment

<sup>8</sup> Investments were committed to or approved during the specified quarter, but investment activity is likely to have taken place beyond that quarter.

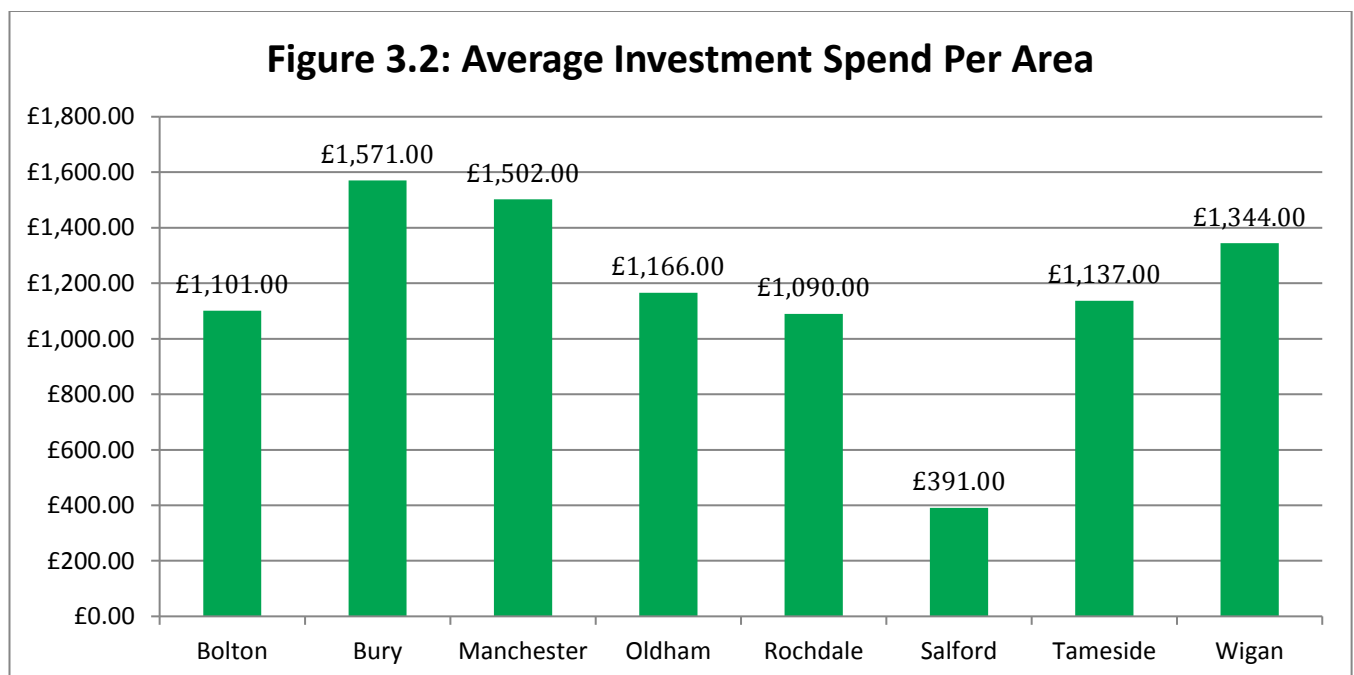




Figure 3.1 shows the total amount of project investment spend in each AfA ward (excluding Waste & Seedley and Broughton, which both have zero investment spend at the time of writing):



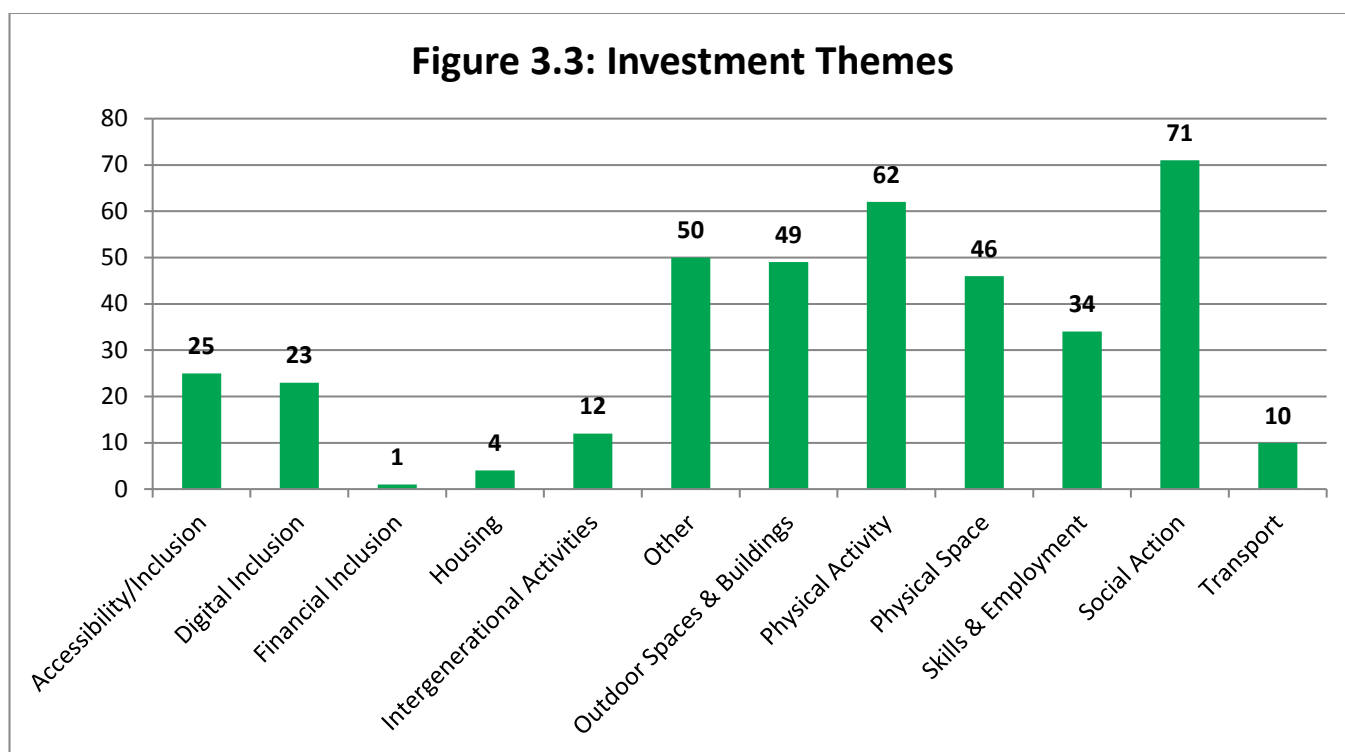
The average spend per investment was £1,241.53. Figure 3.2 shows average investment spend in each local authority area.



Projects fall under the themes represented in Figure 3.3 (on the following page). Note that more than one theme per project investment can be allocated, so the total number of themes will add up to more than the total number of projects.<sup>9</sup>

<sup>9</sup> Unfortunately, technical problems prevent us from analysing the information provided under 'Other' at this time.

**Figure 3.3: Investment Themes**



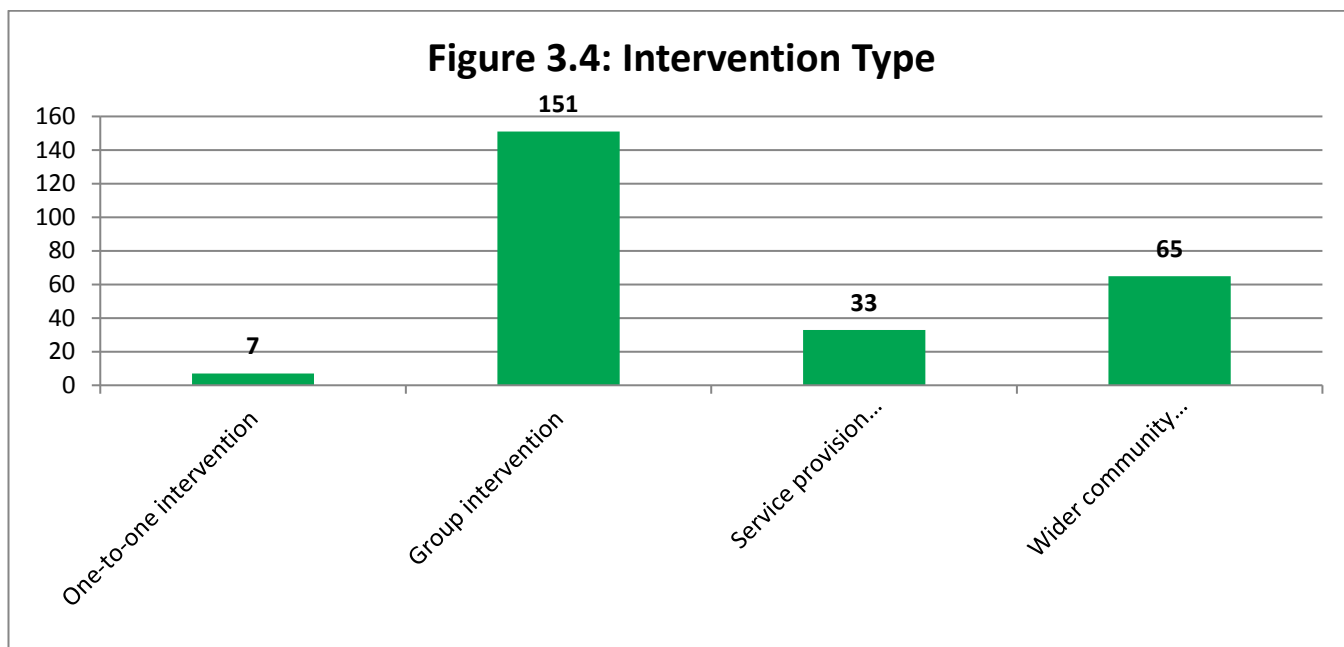
The most frequently allocated theme was Social Action, followed by Physical Activity and Outdoor Spaces & Buildings.

MICRA identify that there are commonly four types of intervention used to tackle social isolation.<sup>10</sup> These are:

- One-to-one interventions: these focus on targeting individuals and working with them on a one-to-one basis, such as home visits.
- Group interventions: interventions or programmes that bring older people together in groups to engage in activities and develop relationships.
- Service provision interventions: interventions that link older people to statutory services or provide a statutory service with the express aim of reducing social isolation.
- Wider community development/neighbourhood interventions: efforts that focus on the wider community and adapting this to become more age-friendly/removing barriers to social participation.

The most commonly allocated intervention type against AfA projects was *Group Intervention*. This is represented in Figure 3.4 on the following page.

<sup>10</sup> Full definitions available in *Social Isolation Among Older People in Urban Areas*, Tine Buffel, Samu el R emilliard-Boillard and Chris Phillipson, 2015.



Whilst this is promising considering that group interventions have largely been found to be effective at reducing social isolation, the latter category of intervention (wider community development/neighbourhood interventions) are largely considered to be more sustainable in the long-term.

3,095 older people were involved in the design and delivery of these investments. This was in a variety of ways, including:

- Planning events
- Proposing ideas for projects
- Designing the project e.g. choosing activities
- Implementing elements of the project e.g. running groups
- Volunteering in other ways with the project
- Less formal ways e.g. providing feedback

In addition, all investments need to be approved by older people, often through a panel mechanism.

Investment highlights are provided throughout the report. A full list of all AfA investments made to date is provided in **Appendix C**.



## **Jim's Dropped Kerb in Tonge with the Haulgh, Bolton**

A local resident who lives in Sheltered Flats in Tonge with the Haulgh, Jim, applied for an investment to install a dropped kerb to better accommodate disabled access for himself and others to the flats. He had previously tried to receive support from elsewhere to no avail.

Adapting the physical environment for accessibility is identified by the WHO as a key element of creating an age-friendly neighbourhood.

With the help of Bolton at Home, he submitted an investment proposal to Ambition for Ageing and was successful. The partnership has supported Jim to apply to the council for permission to install the dropped kerb. Planning permission is not required and the funding will be used to install the dropped kerb.

Work is ongoing to progress the investment, and Jim and other residents are looking forward to achieving their goal.

# Section 4: Characteristics

## Analysis

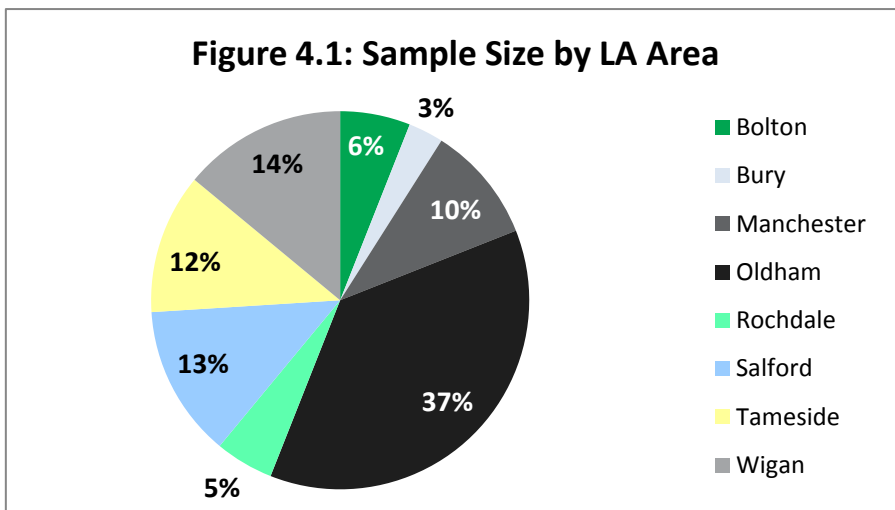
This section provides an overview of the characteristics of people involved in Ambition for Ageing. It gives a breakdown of those engaging with AfA as Participants, Volunteers and Event Attendees based on demographic data.

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

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

There were a total of 617 demographic forms<sup>11</sup>, made up of 227 (37%) event feedback forms, 260 (42%) participant forms and 130 (21%) volunteer forms.

The following demographic information is mostly representative of Oldham, with fairly even sample sizes for Manchester, Salford, Tameside and Wigan:



<sup>11</sup> This section analyses data within these demographic forms.

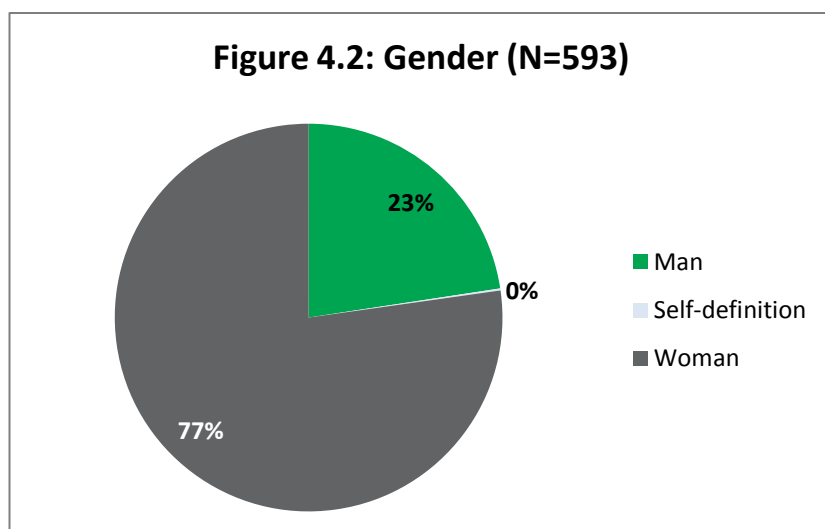
However, there are variations on these percentages depending on the types of data. Table 4.1 breaks down this sample size by data source.

Table 4.1: Sample Size by Data Type						
Area	Participants		Volunteers		Event Feedback	
	Number	Percent	Number	Percent	Number	Percent
Bolton	14	5%	16	12%	10	4%
Bury	5	2%	5	4%	8	4%
Manchester	53	20%	0	0%	8	4%
Oldham	60	23%	37	28%	132	58%
Rochdale	18	7%	12	9%	1	0%
Salford	16	6%	44	34%	20	9%
Tameside	30	12%	11	8%	32	14%
Wigan	64	25%	5	4%	16	7%

It should also be noted that the following data is not necessarily only representative of people directly involved in AfA projects. Where data comes from event attendees, these may or may not be directly involved in projects. The following data should be considered as a) indicative of the types of people engaging with AfA on no specific level and b) representing the people who have answered questions on age friendly neighbourhoods, social contact and neighbourhood attachment in the chapters following.

The average age of all respondents is **71**.

A large majority, over three quarters, are women. This is significantly higher than in the GM population, where 50% of people are women (ONS, 2015<sup>12</sup>).



<sup>12</sup> Office for National Statistics, Greater Manchester Labour Market Profile, downloaded from NOMIS: <https://www.nomisweb.co.uk/reports/lmp/lep/1925185547/report.aspx>

The average length of time that individuals have lived in their wards is 31 years.

**Table 4.2: How long have you lived in your ward? (N=524)**

Length of time	Number	Percentage
<5 years	55	10%
5-10 years	60	11%
11-30 years	162	31%
31-50 years	134	26%
>50 years	113	22%

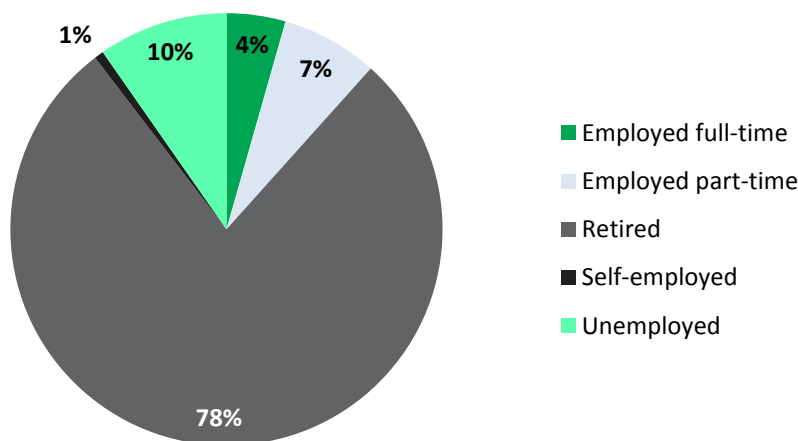
The large majority, 47%, of people have an O-level/GCSE or equivalent highest level of education. 22% of people have primary school education or no education. Comparison data (at national and GM levels) is collected by qualification level, as opposed to levels of schooling, so is not directly comparable.

**Table 4.3: What is your highest level of education? (N=433)**

Education level	Number	Percentage AfA
No schooling	17	4%
Primary	77	18%
Secondary/O-level or equivalent/Post 14 Apprenticeship	203	47%
A-level or equivalent/Post-16 Apprenticeship	49	11%
Degree level or equivalent	67	15%
Postgraduate degree level or equivalent	20	5%

The overwhelming majority, 78%, of respondents are retired. However, the second-largest group identified themselves as unemployed (see figure 4.3 on the following page)

**Figure 4.3: Employment Status (N=567)**



In order to compare levels of unemployment to the general population, age adjustment is required. This is because we need to determine how many of our respondents are working age

and identifying as unemployed. 4 out of the 48 people (who said that they were unemployed and provided their age) were over 64.

This leaves us with an adjusted unemployment rate of 8.5%<sup>13</sup>. This is slightly higher than in the general population; the unemployment rate for 16-64 year olds in Greater Manchester is 6.2% (ONS, 2016).

The large majority of respondents, 86%, are White or White British. This is followed by Asian/Asian British at 11% and Black/Black British at 3%. The profile is fairly similar to GM averages, displayed in Table 4.4 (ONS, 2011<sup>14</sup>).

Table 4.4: Ethnicity (N=573)			
	AfA Number	AfA Percentage	GM Percentage
Asian/Asian British	64	11%	10%
Black/Black British	16	3%	3%
White/White British	493	86%	84%
Mixed Ethnicity	0	0	2%
Other	0	0	1%

The large majority of respondents, 78%, identify Christianity as their religion. This is significantly higher than the GM average of 62%. This higher figure does not appear to be at the expense of people identifying with other religions, as these are all fairly in line with the GM average. However, there is a much lower percentage identifying that they have no religion than in the general population (6% compared to 21%) (ONS, 2011). This may be to do with AfA's older demographic than in the general population.

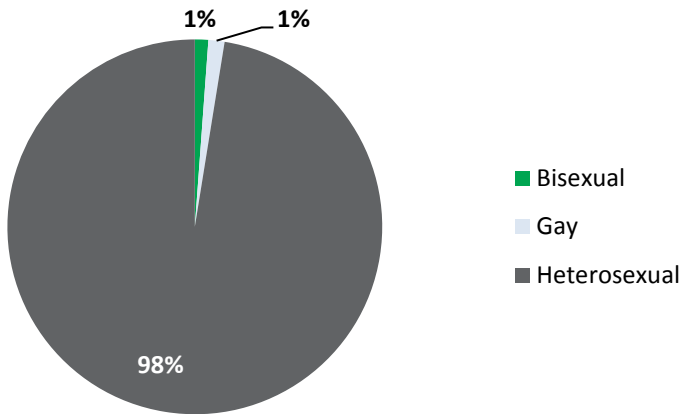
Table 4.5: Religion (N=544)			
	AfA Number	AfA Percentage	GM Percentage
Buddhist	1	0.2%	0.4%
Christian	423	78%	62%
Hindu	3	1%	1%
Jewish	0	0%	1%
Muslim	64	12%	9%
No Religion	34	6%	21%
Sikh	1	0.2%	0.2%
Other	18	3%	0.3%

The large majority of individuals identify as Heterosexual. 2% of respondents identified as Gay or Bisexual.

<sup>13</sup> Sample size reduces to 508 because it is dependent on people providing both their age and employment status. We do not know the age of the remaining 7 people who said that they were unemployed.

<sup>14</sup> Census data downloaded from NOMIS 2016

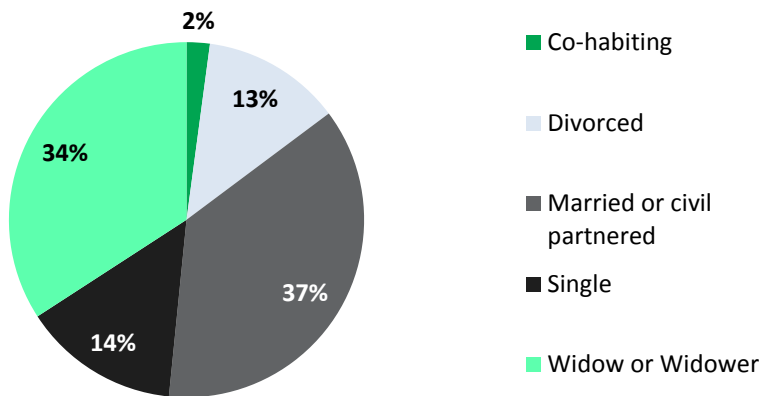
**Figure 4.4: Sexual Orientation (N=432)**



Sexual Orientation is not systematically recorded in most official data sources. As a result, accurate estimates of the number of people not identifying as heterosexual in the local and national population vary. The most reliable estimates indicate that those identifying as Lesbian, Gay or Bisexual represent between 5-7% of the population. However, we do not have a definitive GM benchmark.

The marital status of respondents is fairly evenly split. 37% are married or civil partnered, compared to 43% in GM. 34% are widowed, compared to 7% in GM. This discrepancy is likely to be expected when considering that the GM benchmark is true for all ages, not just older people.

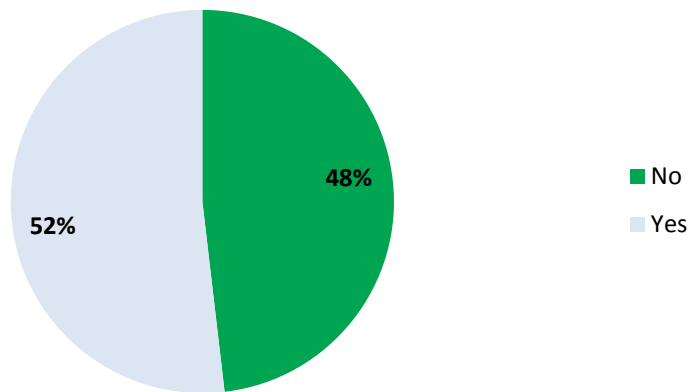
**Figure 4.5: Marital Status (N=568)**



The majority of people, 52%, have a long-standing physical or mental illness or disability.<sup>15</sup>

<sup>15</sup> Technical database problems currently prevent us from analysing what these conditions are. This is under development.

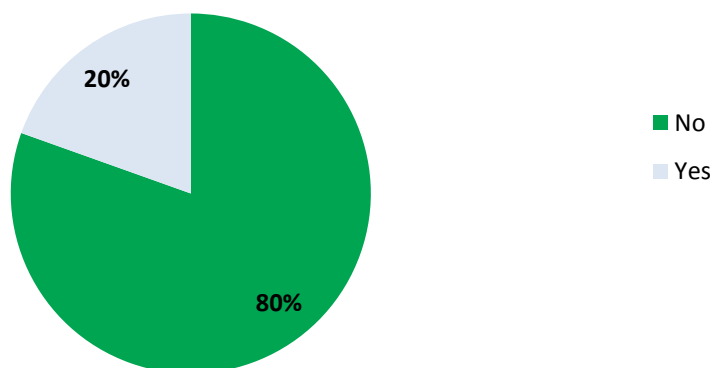
**Figure 4.6: Long-standing illness or disability  
(N=351)**



Direct GM comparison data is not available for this question. However, 19% of people in Greater Manchester have a disability, and 6% of people identify as being in bad or very bad health (ONS, 2011). This suggests that levels of long-standing poor health and disability are higher in the AfA cohort. This is not unexpected considering the older demographic of the cohort.

20% of respondents provided unpaid care or support to someone.

**Figure 4.7: Is there anyone sick, disabled or needs support whom you look after or provide support to?  
(N=527)**



Systematic benchmarking data on those acting as carers for someone else is not available. However, 2% of benefit claimants (of working age) were claiming a carer's allowance in May 2016 (ONS). The carer's trust estimates that about 10% of the population are carers (Carers Trust, 2017).

All these characteristics are important, not just because they provide us with a picture of who is engaging with AfA and providing data, but also because many of these characteristics are closely linked to being at risk of social isolation. For example, the higher numbers with a long-standing illness or disability can be considered positive, as it indicates that AfA is engaging with



those at higher risk of social isolation. However, some groups with risk factors appear to be under-represented, such as LGBT people and ethnic minorities.

However, these risk factors are not mutually exclusive, and the next section explores this in more detail.

## **Social Isolation Risk Factors**

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

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

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

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

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

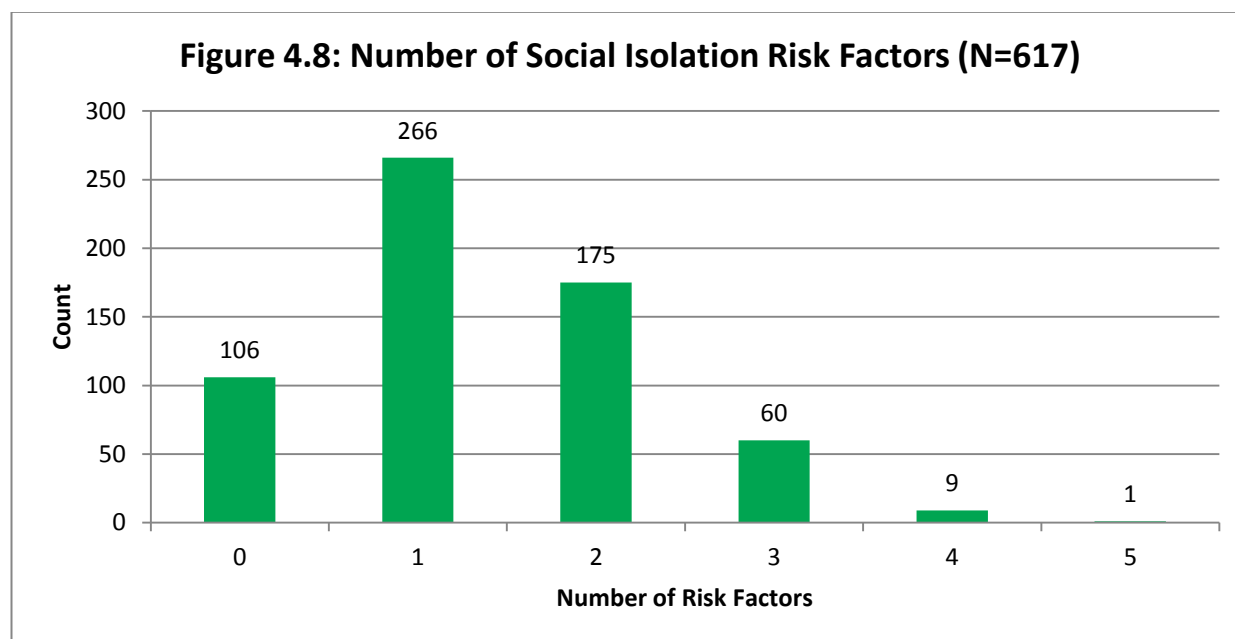
- Being male;
- Identifying a minority ethnicity or religion<sup>16</sup>;
- Identifying a minority sexual orientation or gender status;
- Being single or widowed;
- Having a long-standing physical or mental illness or disability; and
- Being a carer.

Age was excluded from this, given the demographic profile of respondents. In addition, living situation was excluded as the sample size for this question is very small.<sup>17</sup>

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<sup>16</sup> These were combined in the recognition that one is often strongly correlated with the other, so there is a risk of double counting risk factors by counting separately.

The average number of risk factors is 1.4, where the total could be 6 and the minimum 0. Amongst those who had risk factors (i.e. excluding those with 0), the average is 1.6.



The majority, 43%, of individuals have one risk factor, followed by 28% of individuals with two risk factors. 17% of individuals have no risk factors.

There are some caveats to this data:

- This analysis is a simple way of providing an indication of risk, and does not act as a comprehensive overview of who is at risk of social isolation and who is not. It is indicative only and does not mean that those with a higher number of factors are definitely socially isolated, or that those without any risk factors will not at some point experience social isolation.
- In addition, not all risk factors will carry 'equal weight' – some may place an individual at a higher risk than others, and this will vary from person to person based on their life experiences and situations.
- Finally, this data is only inclusive of those who have answered the question. Risk factors may be higher as not all individuals have answered all questions.<sup>18</sup>

Bearing these caveats in mind, it appears that the majority of the people with whom AfA is working have very few risk factors. There are very few people 3 or more risk factors – these are likely to be the most at risk of being isolated, and may already be so.

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

<sup>17</sup> Data on individuals' living situations is also collected. However, technical database problems mean that unfortunately this data was not captured for a substantial period. The sample size for this question is currently only 50, as a result it is not included in the analysis. Sample sizes for this question should be larger in future.

<sup>18</sup> I.e. Answered using the 'Prefer not to say' option

## **Project Highlight: Mingle and Meet Singles Event in Tameside**

As outlined above, being single is a key risk factor for social isolation amongst older people. Ambition for Ageing in Tameside had feedback from a number of older people in the area that they wanted spaces for single people to meet up, to make new friendships and form lasting relationships with others.

With the help of staff, Ambition for Ageing volunteers set about organising the first 'Mingle and Meet Singles Event', including finding a suitable venue, publicising it to others and putting up posters.

The event took place in January 2017 and was hugely successful, with over 55 attendees who chatted, met new people and danced together – and hopefully formed some lasting and meaningful relationships!

*"I have been looking for something like this for ages... my friend and I are both widowed – we have really enjoyed dressing up and coming out for a dance"*  
Attendee

## Section 5: Age Friendly Neighbourhoods

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

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

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

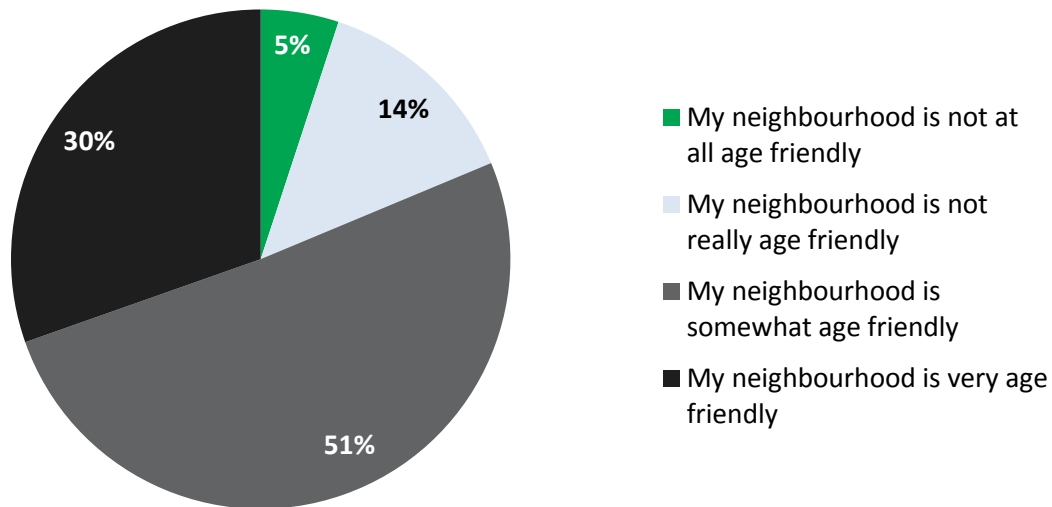
World Health Organisation

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

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

This question is included in Participant, Volunteer and Event Feedback forms. This provides a large sample size, of 1,010, for perceptions of age-friendliness. The data will initially be analysed all together, as opposed to breaking this down by data source (although this is provided in table 5.2).

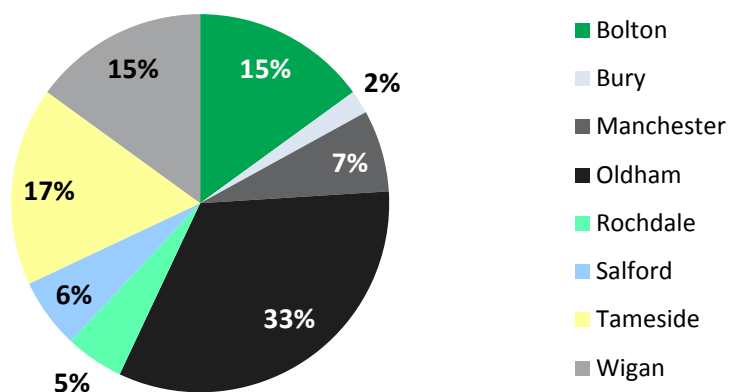
**Figure 5.1: To what extent do you live in an age friendly neighbourhood? (N=1,010)**



Findings show that just 19% of respondents across all areas identify that their neighbourhood is not at all or not really age friendly.

The data above is mostly representative of Bolton, Oldham, Tameside and Wigan.

**Figure 5.2: Sample Size by LA Area**



It is likely that there are geographical variations in answers. When looking at answers by geography, some small variations emerge. However, those with smaller sample sizes should not be used to draw conclusions.

**Table 5.1: To what extent do you live in an age friendly neighbourhood? (all data sets)**

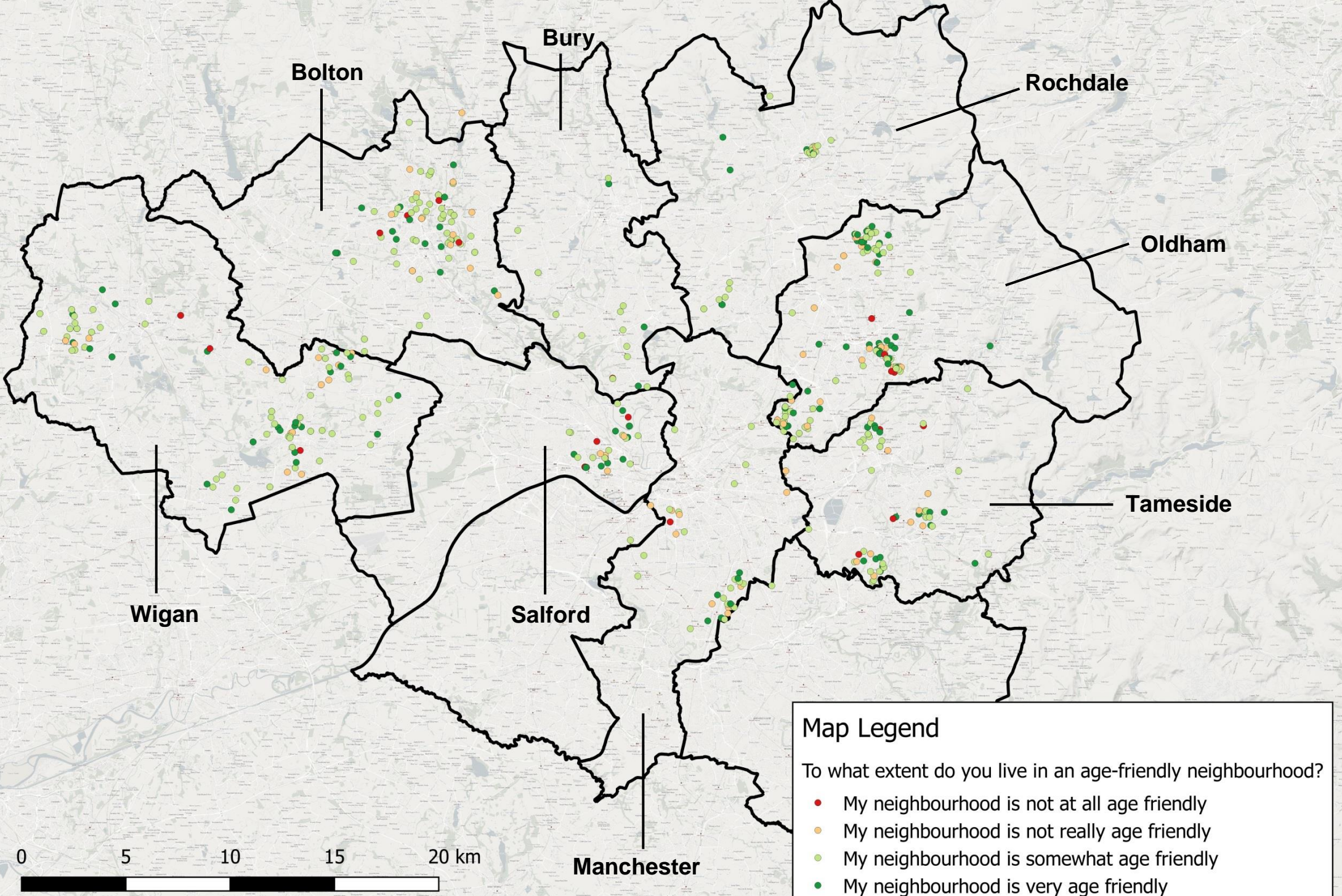
Area	Not at all age friendly	Not really age friendly	Somewhat age friendly	Very age friendly
Total (N=1,010)	5%	14%	51%	30%
Bolton (N=147)	10%	16%	58%	17%
Bury (N=24)	4%	8%	67%	21%
Manchester (N=74)	3%	18%	55%	21%
Oldham (N=334)	4%	14%	44%	37%
Rochdale (N=51)	2%	10%	59%	29%
Salford (N=60)	8%	15%	52%	25%
Tameside (N=173)	6%	12%	46%	36%
Wigan (N=147)	2%	13%	57%	28%

The most notable variations appear to be in Bolton. A higher percentage (double the average) of people in Bolton identify their neighbourhood as not at all age friendly, and a lower percentage in Bolton identify their neighbourhood as very age friendly (almost half the average).

Wigan has a much smaller percentage of people identifying their neighbourhood as not at all age friendly (as does Rochdale, although sample sizes are smaller).

The map on the following page has been created using this data alongside the postcodes of those individuals who responded to the question. It provides a localised view of areas where individuals have rated their neighbourhood's age friendliness.





**Map Legend**

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

- My neighbourhood is not at all age friendly
- My neighbourhood is not really age friendly
- My neighbourhood is somewhat age friendly
- My neighbourhood is very age friendly
- Greater Manchester districts





As stated, the points at which this data is collected vary. For example, the event feedback form is designed to measure community level change, rather than individual change. This enables us to gather data from those people who may be engaged with AfA on a more casual, less structured way. Or, they may have been involved in projects that do not have regular participants, and so are not suitable for the full questionnaire. As a result of the varying contexts in which an individual may complete a particular form, it is worth exploring whether there are differences based on this.

<b>Table 5.2: To what extent do you live in an age friendly neighbourhood? (all data sets)</b>				
<b>Questionnaire type</b>	<b>Not at all age friendly</b>	<b>Not really age friendly</b>	<b>Somewhat age friendly</b>	<b>Very age friendly</b>
<b>Total</b>	5%	14%	51%	30%
<b>Event feedback (N=638)</b>	5%	13%	50%	31%
<b>Participant questionnaire (N=257)</b>	4%	13%	52%	31%
<b>Volunteer questionnaire (N=115)</b>	6%	16%	50%	29%

This shows that there are no notable variations by questionnaire type.

It is also possible to match the demographic data from the previous section with this question. People with certain characteristics may feel differently about their neighbourhoods. For example, does having a disability mean that your neighbourhood is less age friendly? Or, does the length of time you have lived in your neighbourhood influence how you relate to it?

Table 5.3 shows that there are some variations based on the length of time that individuals have lived in their neighbourhoods for, though to be an influencing factor in neighbourhood attachment.

<b>Table 5.3: To what extent do you live in an age friendly neighbourhood? (N=304)</b>				
<b>How long have you lived in your ward?</b>	<b>Not at all age friendly</b>	<b>Not really age friendly</b>	<b>Somewhat age friendly</b>	<b>Very age friendly</b>
<b>Less than 5 years (n=32)</b>	6%	6%	56%	31%
<b>5 – 10 years (n=41)</b>	12%	12%	49%	27%
<b>11 – 30 years (n=95)</b>	4%	16%	56%	24%
<b>31 – 50 years (n=78)</b>	3%	19%	46%	24%
<b>Over 50 years (n=58)</b>	2%	14%	55%	29%

However, these variations do not necessarily flow in a continuum. There is no trend indicating that those who have lived in their ward longest identify it as the most age friendly, and those who have lived in their ward the least identify it as the least age friendly, or vice versa.

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

In many instances, minority characteristics had too small sample sizes to say with any certainty whether or not there were notable variances. For example, if fewer than 5 or 10 people share a minority characteristic, the sample size is too small to say if variances from the averages are likely to constitute a pattern. This is particularly the case with Sexual Orientation, Religion and Ethnicity.

Table 5.4 is an example demonstrating little variation in answers based on marital status, except for where smaller numbers are experiencing fluctuations (in this case, co-habitation).

Table 5.4: To what extent do you live in an age friendly neighbourhood? (N=307)				
Marital Status	Not at all age friendly	Not really age friendly	Somewhat age friendly	Very age friendly
<b>Co-habiting</b> (n=9)	0%	33%	56%	11%
<b>Divorced</b> (n=43)	2%	12%	53%	33%
<b>Married or Civil Partnered</b> (n=126)	3%	13%	54%	30%
<b>Single</b> (n=52)	6%	19%	52%	23%
<b>Widow or Widower</b> (n=77)	5%	14%	44%	36%

One interesting variation (see table 5.5) shows that slightly more, 23% compared to 14%, of respondents with a disability identified their neighbourhood as not at all or not really age friendly. 51% of respondents identified that they had a long-term illness or disability.

Table 5.5: To what extent do you live in an age friendly neighbourhood? (N=314)				
Do you have a long-standing mental or physical illness or disability?	Not at all age friendly	Not really age friendly	Somewhat age friendly	Very age friendly
<b>Yes</b> (n=160)	6%	17%	52%	25%
<b>No</b> (n=154)	3%	11%	55%	32%

There are also slight variations in gender. However, the sample is dominated by women (72%).<sup>19</sup>

Table 5.6: To what extent do you live in an age friendly neighbourhood? (N=329)				
Gender	Not at all age friendly	Not really age friendly	Somewhat age friendly	Very age friendly
<b>Female</b> (n=237)	6%	13%	49%	32%
<b>Male</b> (n=92)	2%	17%	59%	22%

It should be noted that all individuals will have different perceptions of what an age-friendly neighbourhood actually is, so their answers are also not necessarily directly comparable (as individuals may have different aspects in mind). In addition, variations may be affected by any number of factors. We cannot be sure that any variations are due to any one particular characteristic. The next section analyses qualitative data to explore this concept.

<sup>19</sup> Note that no individual identified their gender in another way (an option on the question).

## What makes an age friendly neighbourhood?

A large amount of qualitative data is collected in relation to age friendly neighbourhoods. The question *‘What do you think makes an age friendly neighbourhood?’* is asked in the Volunteer and Participant questionnaires, and respondents to *‘To what extent do you live in an age friendly neighbourhood?’* on event feedback forms are asked to elaborate on their answer.

This data has been analysed using a Coding process. Coding is a method for analysing large volumes of qualitative research. Each response is given a number of ‘codes’ based on the topics or factors mentioned within.

Once each response has been allocated codes, the codes are then reviewed to determine whether any ‘Master Codes’ can be created by combining these codes by theme or topic. Using this process, 8 master codes were generated, with an additional 2 for ‘other comments’<sup>20</sup> and ‘unrelated comments’<sup>21</sup>. Each response may have been allocated more than one code or master code.

Each master code is presented here, with bullet points summarising the key features of each. Quotes are from individual responses to this question.

### Access to Services

- Access to community services, such as libraries and leisure centres;
- Access to statutory services, such as GP Surgeries;
- Flexible opening times, including evenings and weekends; and
- Proximity to local shops, banks, cafes and other amenities.

*“For me an age friendly neighbourhood would look like one where I can age happily. It would have the necessary support systems and infrastructure facilities to allow me the opportunities to live an active, independent life with dignity. I would have easily accessible services/spaces for my physical and emotional wellbeing e.g. community centres offering various activities/services for older people, open parks to undertake activities being close to nature, a transport system convenient for the aged/isolated to easily get by. Safer roads and neighbourhoods for the elderly to live in peace and harmony, easy access to hospitals/surgeries when needed. Readily available support for dealing with statutory bodies and other agencies.”*

### Activities and Meeting Opportunities

- Activities for people to come together;
- Opportunities to meet new people;
- Accessible spaces for people to meet with friends;

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<sup>20</sup> Where a comment or comments were not repeated by others so were not turned into master codes. Often these were comments that related very specifically to a particular area.

<sup>21</sup> Where an answer was unrelated to the question, or an individual did not understand the question

- Opportunities to learn English, IT lessons, exercise classes, lunch clubs and other various groups (mostly run by the community and voluntary sectors).

***“I think having a community centre, mosque, shops, nursery, school and health centre nearby can help make somewhere age friendly. I also think having friends and family and good neighbours from different backgrounds helps make somewhere more age friendly.”***

## **Community Integration**

- Interaction with people from different backgrounds;
- Getting to know people who are new into the area (regardless of age);
- Practical steps, e.g. learning English; and
- Respect and tolerance for all ages and backgrounds.

***“Respect and tolerance for all age and ethnic groups. People treating others as they would wish to be treated. Understanding the needs of others and helping where possible/advisable without causing offence. Clearly advertising functions giving people the opportunity to attend.”***

## **Feelings of Safety**

- Feeling safe outside e.g. in the dark;
- Feeling safe in public spaces, e.g. parks, buses and community buildings; and
- Low levels of crime and vandalism.

***“I think an age friendly neighbourhood would look like:***

- 1. A welcoming place***
- 2. An accessible place, within other local amenities e.g. mosque, shops, medical centre, leisure facilities.***
- 3. A nice and clean surroundings inside the neighbourhood (age friendly)***
- 4. Access to digital communication, e.g. TV, computers***
- 5. A safe and secure neighbourhood***
- 6. Easy access to main transport system - bus, tram etc.”***

## **Friendly Neighbours & People**

- Looking out for one another;
- Knowing your neighbours;
- Saying hello to people in the street and in local places;
- Having friends in the area; and
- Helping each other out with practical things.

***“People always giving time to have a smile and a friendly chat with neighbours, mostly when people are lonely and on their own. It does not take a lot to give a friendly hand and try and help people who are on their own.”***

## Good Transport

- Access to safe and clean public transport;
- Transport that is accessible to those with disabilities; and
- Reliable public transport, particularly buses.

*“A place where older people feel safe, have good transport systems, equitable access to services and are given the opportunities to participate in the community.”*

## Intergenerational Engagement & Harmony

- Activities and opportunities to engage with younger people;
- Sharing skills between generations;
- Understanding between generations; and
- Places to spend time with family, including grandchildren.

*“A mix of young, old, families and ethnic origin living in an areas. All learn different skills from each other, e.g. young teaching old how to use technology and old teaching young to knit, cook, crochet, read, garden etc.”*

## Spaces & Buildings

- Infrastructure such as smooth pavements and roads;
- Facilities such as public benches and toilets;
- Accessible and clean green spaces; and
- Able to walk around the neighbourhood.

*“Where common space is designed in such a way for us to enable people to meet and spend time with others and people are involved in the design and improvement of their own communities.”*

## Other<sup>22</sup>

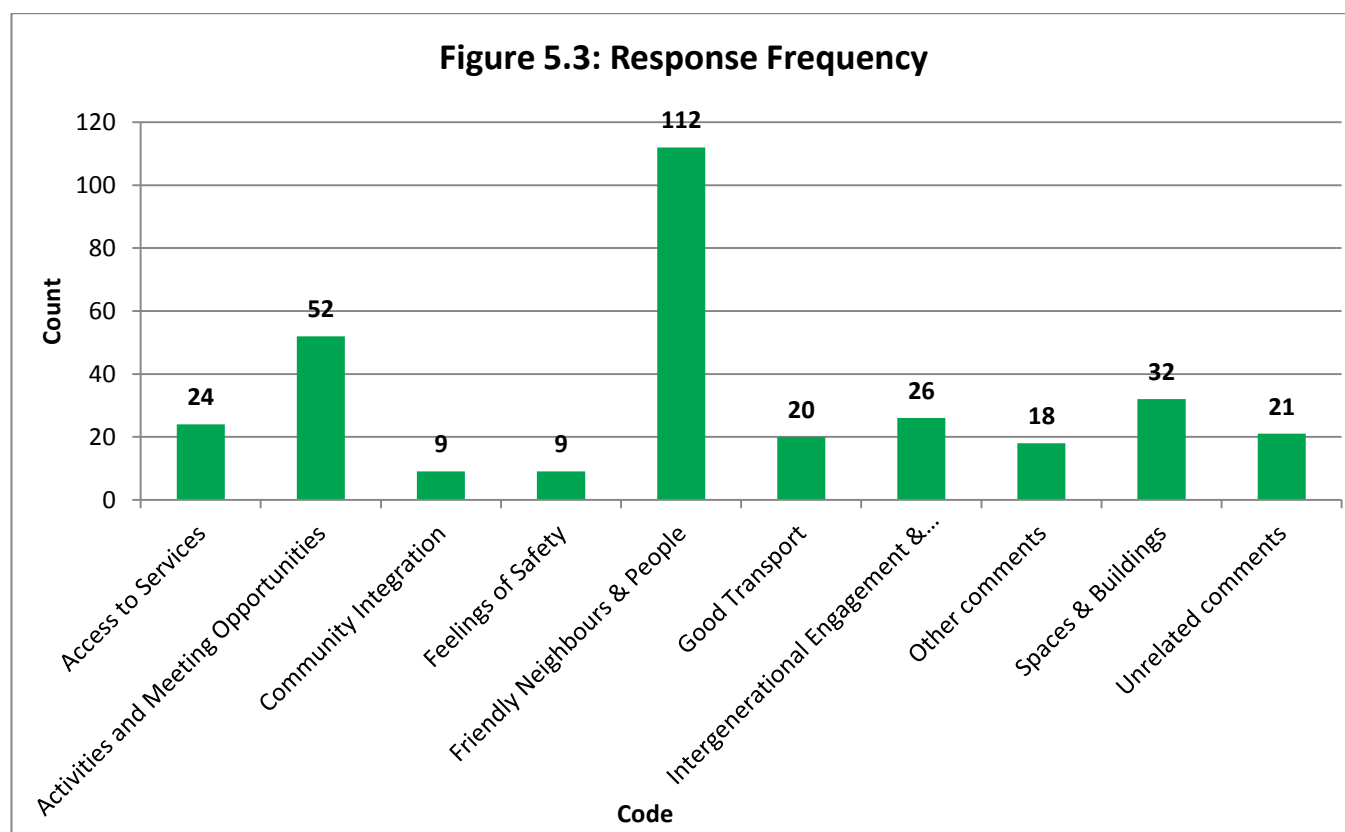
- Having a Neighbourhood Watch;
- Leaflets to advertise what's on;
- Getting involved in the community;
- Employment; and
- A high number of older people in the area.

*“Community spirit, looking out for neighbours, particularly those who live alone, or are ill, or helping those who are caring for someone at home. Getting involved in the community in a wider sense, i.e. keeping the neighbourhood clean and tidy (together) - adopting a small piece of local land and developing it into a garden. Perhaps organising social events too.”*

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<sup>22</sup> Various other comments were mentioned, but not enough times to warrant a 'master code' i.e. no more than twice. Several of these related to a particular community place or space, so are not generalizable.

Figure 5.3 shows how many times each master code was allocated to an individual response. There were 259 responses to the question ‘What do you think makes an age friendly neighbourhood?’, and there may have been more than one master code per response.



The most commonly allocated master code is ‘Friendly Neighbours & People’, followed by Activities & Meeting Opportunities, Spaces & Buildings, Intergenerational Engagement, Good transport and Access to Services.

There are, of course, several crossovers in these categories. For example, access to English lessons falls under both Community Integration and Access to Services. Feelings of Safety apply when travelling on public Transport and in outdoor Spaces and Buildings.

Perhaps not unsurprisingly, these themes are strongly correlated to the WHO’s 8 domains of age friendliness. These are:

1. Built environment
2. Transport
3. Housing
4. Social participation
5. Respect and social inclusion
6. Participation and employment
7. Communication
8. Community support and health services

The next section will look at this outcome from the perspective of ‘Community Attachment’. Community attachment is about how involved we feel with the places in which we live. It’s also



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

## **Project Highlight: Knit and Natter & Walk and Talk, Alexandra Park, Oldham**

This is an existing group that started in August 2014, and meets every Thursday at the café in Alexandra Park in Oldham. They approached Ambition for Ageing for further funding to keep the group operational, recognising the long-term benefits of social walking.

There are around 16 regular members who meet every week. The group is diverse, with many suffering from long-term health problems and wanting to get more exercise to help alleviate these. The group encourages older people with long-term health conditions to lead more active lives, and acknowledges the improved mental and physical health that comes from taking part in group exercise.

## **Community Attachment**

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

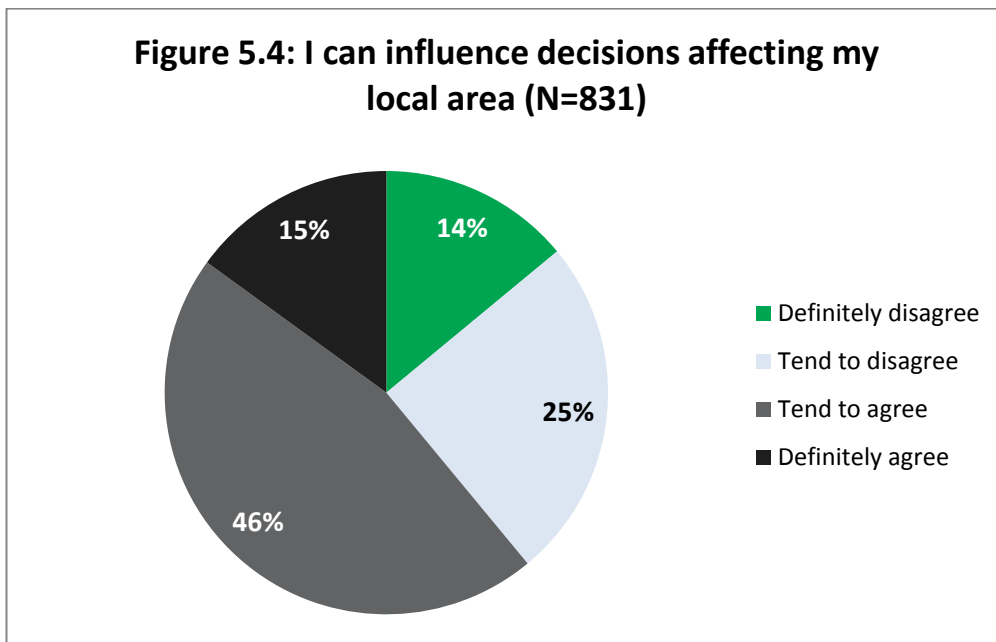
Civic participation is a key factor in an individual's feelings of attachment to where they live, and fundamental to an age-friendly neighbourhood. The question is as follows:

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

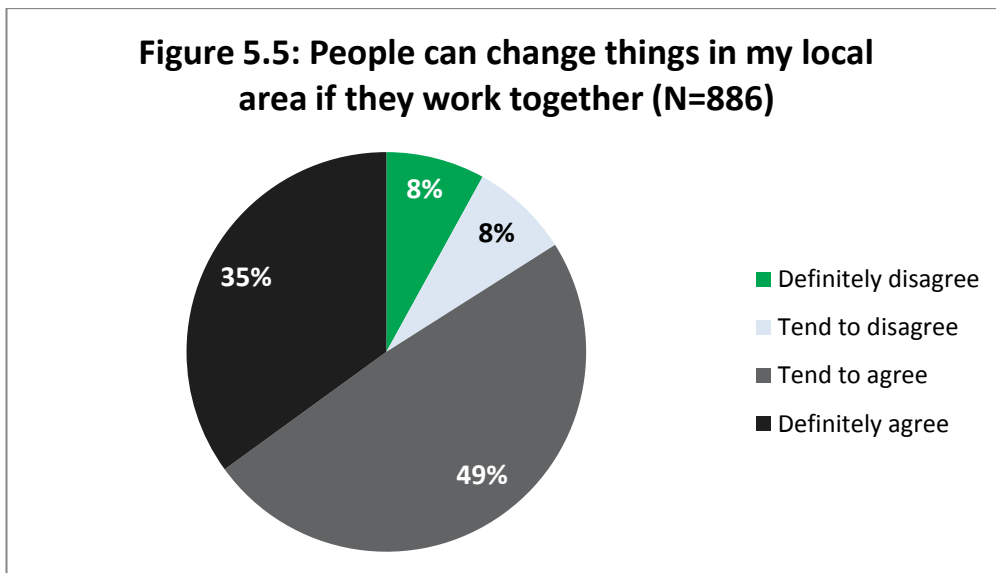
The latter statement in particular is a key principle in the Ambition for Ageing programme; the idea that older people can come together and, with investment facilitating this action, make sustainable and positive changes in their local areas. Older people's engagement is fundamental to the success of Ambition for Ageing.

Including the question, in particular, on event feedback forms, provides an indication of community level perceptions about an area.

Responses to the first statement appear to be less positive than other questions (although still majority positive). 61% of respondents tended to or definitely agreed that they could influence decisions affecting their local area. Figure 5.4 visualises the results:



A large majority of respondents, 84%, tended to or definitely agreed that people could change things in their local area if they worked together.

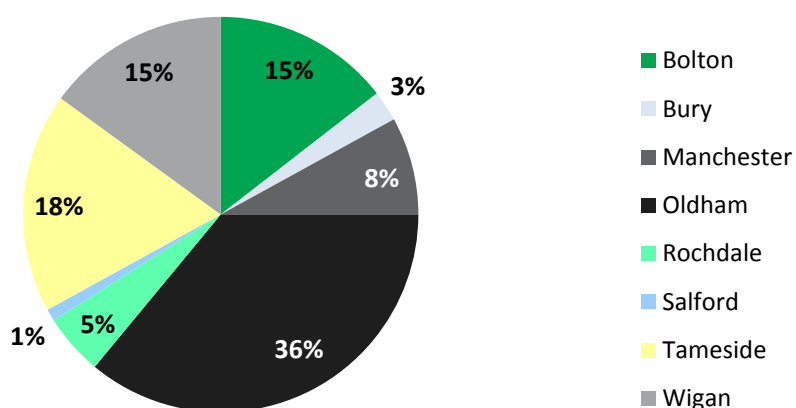


This is promising for the AfA programme as it relies on individuals working together to make changes. However, it does not appear to be an area on which AfA will have much impact (i.e. potential for change) given its very high starting point.

As before, the majority of the data for these statements is provided by Bolton, Oldham, Tameside and Wigan. Figure 5.6 is an average sample size between the two statements.<sup>23</sup>

<sup>23</sup> There is no more than 2% difference for each.

**Figure 5.6: Sample Size by LA Area**



When answers to the question are broken down by local authority area, some geographical variations emerge (tables 5.7 and 5.8). However, those with smaller sample sizes should not be used to draw conclusions (particularly Bury, Rochdale and Salford).

**Table 5.7: I can influence decisions affecting my local area (all data sets)**

Area	Definitely disagree	Tend to disagree	Tend to agree	Definitely agree
<b>Total (N=831)</b>	<b>14%</b>	<b>25%</b>	<b>46%</b>	<b>15%</b>
<b>Bolton (N=118)</b>	12%	25%	47%	16%
<b>Bury (N=21)</b>	19%	14%	62%	5%
<b>Manchester (N=67)</b>	9%	37%	40%	13%
<b>Oldham (N=310)</b>	13%	22%	48%	17%
<b>Rochdale (N=42)</b>	17%	33%	33%	17%
<b>Salford (N=7)</b>	29%	0%	71%	0%
<b>Tameside (N=147)</b>	14%	22%	48%	16%
<b>Wigan (N=119)</b>	18%	30%	39%	12%

Most notably, a higher percentage of respondents in Wigan, 48% (compared to 39%), tended to or definitely disagreed that they could influence decisions affecting their local area. 50% of respondents in Rochdale also tended to or definitely disagreed with the same statement, but they do have a much smaller sample size.

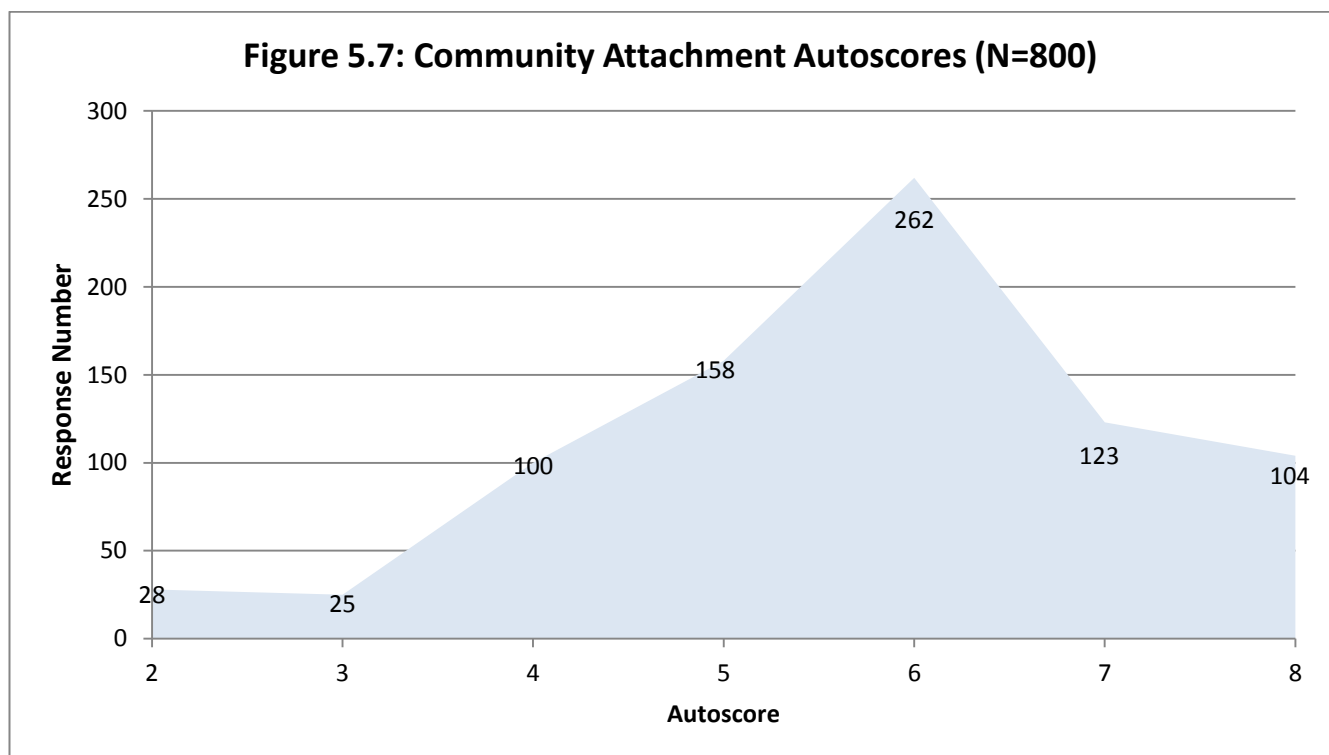
**Table 5.8: People can change things in my local area if they work together (all data sets)**

Area	Definitely disagree	Tend to disagree	Tend to agree	Definitely agree
<b>Total (N=886)</b>	<b>8%</b>	<b>8%</b>	<b>49%</b>	<b>35%</b>
<b>Bolton (N=132)</b>	8%	11%	42%	39%
<b>Bury (N=19)</b>	11%	0%	84%	5%
<b>Manchester (N=68)</b>	0%	6%	57%	37%
<b>Oldham (N=314)</b>	8%	9%	49%	34%
<b>Rochdale (N=42)</b>	5%	14%	45%	36%
<b>Salford (N=7)</b>	0%	0%	100%	0%
<b>Tameside (N=161)</b>	6%	9%	47%	37%
<b>Wigan (N=143)</b>	9%	8%	50%	34%

There are some differences in the second statement, particularly in Manchester where 0% definitely disagreed that they could change things in their local area if they worked together. However, sample sizes are likely affecting other variations (e.g. in Bury, Salford and Rochdale), and may be doing so in Manchester as well.

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

The average score across all answers is 5.7. In time, we would hope that the highest point on the graph below would gradually move to the right (indicating higher confidence).



It is also possible to match the demographic data from the previous section with this question, where the data source is Participant Questionnaires. This provides a sample size of 235.<sup>24</sup>

All demographic data was analysed alongside this question to determine whether there were any notable variances based on shared characteristics. In many instances, minority characteristics had too small sample sizes to say with any certainty whether or not there were notable variances. For example, if fewer than 5 or even 10 people share a minority characteristic the sample size is too small to say if variances from the averages are likely to constitute a pattern. This is particularly the case with Sexual Orientation, Religion and Ethnicity.

<sup>24</sup> For those who answered both statements. Responses to individual statements vary. Sample sizes presented alongside demographic information will be smaller as this is dependent on individuals a) answering the community attachment question and b) the demographic question being analysed.

There are significant variations in answers to the question when split by Gender. However, the sample size is dominated by women (71%) so can not necessarily be directly compared. Tables 5.9 and 5.10 provide a breakdown:

<b>Table 5.9: I can influence decisions affecting my local area (N=188)</b>				
<b>Gender</b>	<b>Definitely disagree</b>	<b>Tend to disagree</b>	<b>Tend to agree</b>	<b>Definitely agree</b>
<b>Female</b> (n=134)	16%	19%	49%	16%
<b>Male</b> (n=54)	9%	44%	39%	7%
<b>Overall</b> (participants only)	12%	28%	46%	14%

35% of women tended to or definitely disagreed that they could influence decisions, whereas 53% of men answered in the same way. In other words, 50% more men than women tended to or definitely disagreed. Similarly, double the amount of women than men definitely agreed that they could influence decisions. Whilst the sample size for men is much smaller, this is a potentially interesting trend for further research.

However, table 5.10 indicates that there are only small variations by gender for the second statement. There does not appear to be a clear trend as above:

<b>Table 5.10: People can change things in my local area if they work together (N=200)</b>				
<b>Gender</b>	<b>Definitely disagree</b>	<b>Tend to disagree</b>	<b>Tend to agree</b>	<b>Definitely agree</b>
<b>Female</b> (n=145)	10%	10%	53%	27%
<b>Male</b> (n=55)	5%	15%	60%	20%
<b>Overall</b> (participants only)	8%	11%	55%	26%

Table 5.11 shows that a slightly higher percentage of people, 25% compared to 14%, with a long-standing illness or disability definitely or tended to disagree that they could change things in their local area. There are also variations in the number that 'definitely agree'.

<b>Table 5.11: People can change things in my local area if they work together (N=196)</b>				
<b>Do you have a long-standing mental or physical illness or disability?</b>	<b>Definitely disagree</b>	<b>Tend to disagree</b>	<b>Tend to agree</b>	<b>Definitely agree</b>
<b>Yes</b> (n=104)	12%	13%	60%	16%
<b>No</b> (n=92)	5%	9%	53%	33%

However, these variations do not appear alongside the influencing statement – with figures roughly the same for both. This is interesting and may indicate that people with a long-standing condition or disability feel less able to work with others to make changes to their area.

Table 5.12: I can influence decisions affecting my local area (N=184)				
Do you have a long-standing mental or physical illness or disability?	Definitely disagree	Tend to disagree	Tend to agree	Definitely agree
Yes (n=93)	15%	24%	49%	12%
No (n=91)	14%	26%	45%	14%

Data analysis on age-friendly neighbourhoods and community attachment appears to indicate that:

- Respondents are generally positive about the age-friendliness of their neighbourhoods
- Respondents are generally optimistic about their ability to work with others to make positive changes in their neighbourhoods
- However, there are notable minorities who identify their neighbourhood as not at all age friendly, and are not optimistic about their neighbourhoods.
- When broken down by characteristics, most sample sizes are currently too small to highlight variations.
- However, some variations appear by gender and disability.

The next section will look at the second outcome: social contact.

### **Project Highlight: Learning English in Bolton**

English as a Second Language (ESOL) classes are being delivered across Crompton and Halliwell in Bolton to women over 50 from South Asian backgrounds. The need was identified by the community for women who migrated to England upon marrying, many of whom became full time mothers and wives and did not learn English.

As they have grown older, many of their husbands have passed away and children have moved out. As a result, these women have become very isolated as they are not able to communicate with many people.

The group will focus on learning English with practical uses, such as phoning for doctors' appointments. The group will run for 6 months, and the group will be encouraged to carry on meeting informally in other venues so that they can practice their new language skills and make lasting friendships.



## Section 6: Social Contact

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

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

As a result, the outcome is measured through a series of proxies. The statements below assess subjective feelings of social connectedness, including neighbourhood attachment and involvement. Questions about frequency and type of social contact form the basis of objective measurements. These are analysed later on in the report.

### Subjective Measures

Participants and Volunteers answer a matrices question that assesses relationships and social contact in their neighbourhoods. This is as follows:

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

This matrix is designed to provide a comprehensive picture of:

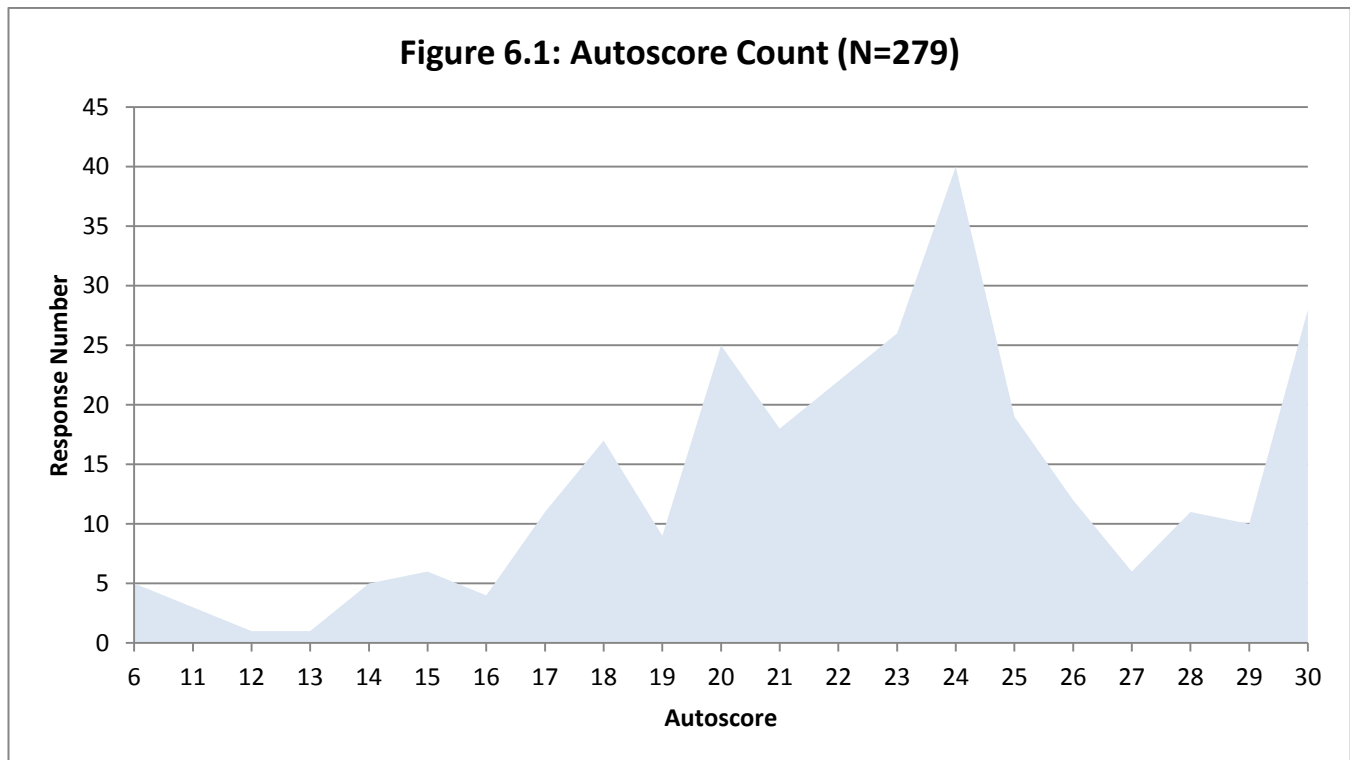
- Neighbourhood belonging (linked closely to community attachment);
- Quality and quantity of relationships within neighbourhoods; and

- Active expression of these relationships (e.g. putting the relationships into action through exchanging favours and providing advice).

Complete answers (where an individual has answered each statement, N=279) are then given an autoscore. The minimum score, where an individual has answered ‘Strongly Disagree’ to all statements, is 6. The maximum score, where an individual has answered ‘Strongly Agree’ to all statements, is 30. A low score (close to 6) indicates dissatisfaction with a neighbourhood and poor relationships within it. A high score (close to 30) indicates the opposite.

The average score for complete responses was 22.5, indicating an overall positive response to the question.

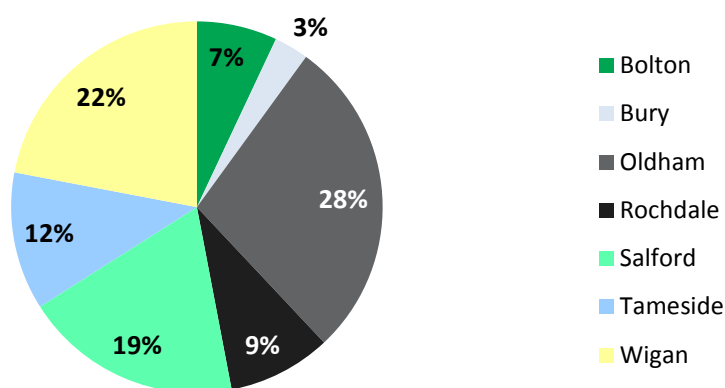
Figure 6.1 shows the numbers of times each possible score was calculated. In time, we would hope that the highest point on the graph would gradually move to the right, indicating higher levels of social participation in neighbourhoods (both quantity and quality).



This data excludes Manchester.<sup>25</sup> It is mostly representative of Oldham, Salford and Wigan. Figure 6.2 (on the following page) provides the sample sizes for the above autoscore calculations:

<sup>25</sup> Full matrix data is not available for Manchester as the last statement was excluded, so the data is incomplete and this means that an autoscore cannot be calculated for this data.

**Figure 6.2: Sample Size by LA Area (N=279)**

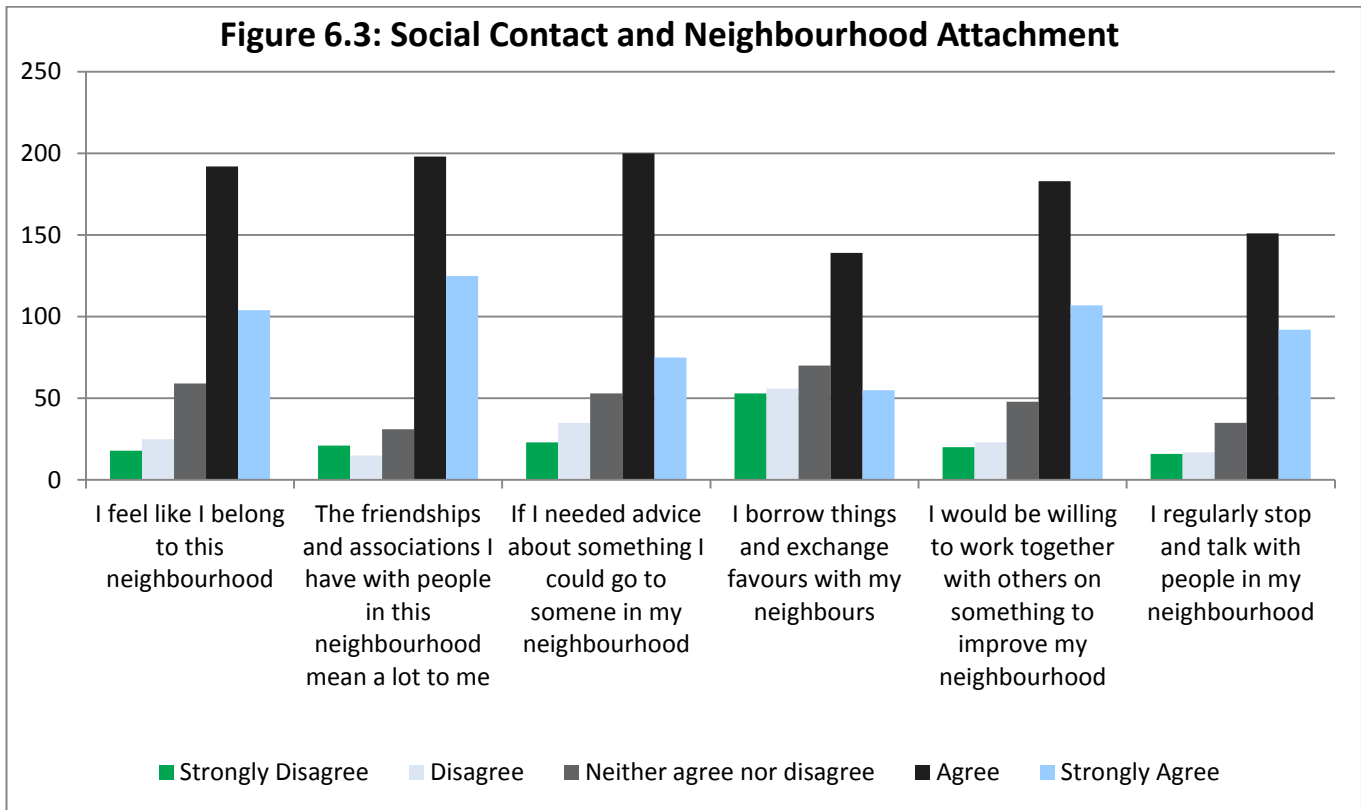


However, the autoscores alone do not provide a nuanced picture, and there are some variations within the statement answers. Table 6.1 includes answers where the full matrices was not answered (i.e. an individual only answered 5 or less statements) and includes Manchester.<sup>26</sup>

**Table 6.1: To what extent do you agree or disagree that...**

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
<b>I feel like I belong to this neighbourhood (N=398)</b>	5%	6%	15%	48%	26%
<b>The friendships and associations I have with other people in my neighbourhood mean a lot to me (N=390)</b>	5%	4%	8%	51%	32%
<b>If I needed advice about something I could go to someone in my neighbourhood (N=386)</b>	6%	9%	14%	52%	19%
<b>I borrow things and exchange favours with my neighbours (N=373)</b>	14%	15%	19%	37%	15%
<b>I would be willing to work together with others on something to improve my neighbourhood (N=381)</b>	5%	6%	13%	48%	28%
<b>I regularly stop and talk with people in my neighbourhood (N=311)</b>	5%	5%	11%	49%	30%

<sup>26</sup> Except for the last statement 'I regularly stop and talk with people in my neighbourhood'



Responses are least positive to the statement ‘I borrow things and exchange favours with my neighbours’ and ‘If I needed advice about something I could go to someone in my neighbourhood’.

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

**Project Highlight: Red Bank – Young in Mind in Radcliffe North, Bury**

Redbank is a supported housing scheme for older people in Radcliffe North, Bury. Spring Lane is a nearby Pupil Referral Unit.

This project brings residents and pupils together in weekly sessions, where they can share experiences and skills. 10-15 residents and pupils will take part in activities, such as making items that will be offered for sale at a local market.

This intergenerational project helps to break down stigma and barriers to engaging with different ages at each end of the spectrum

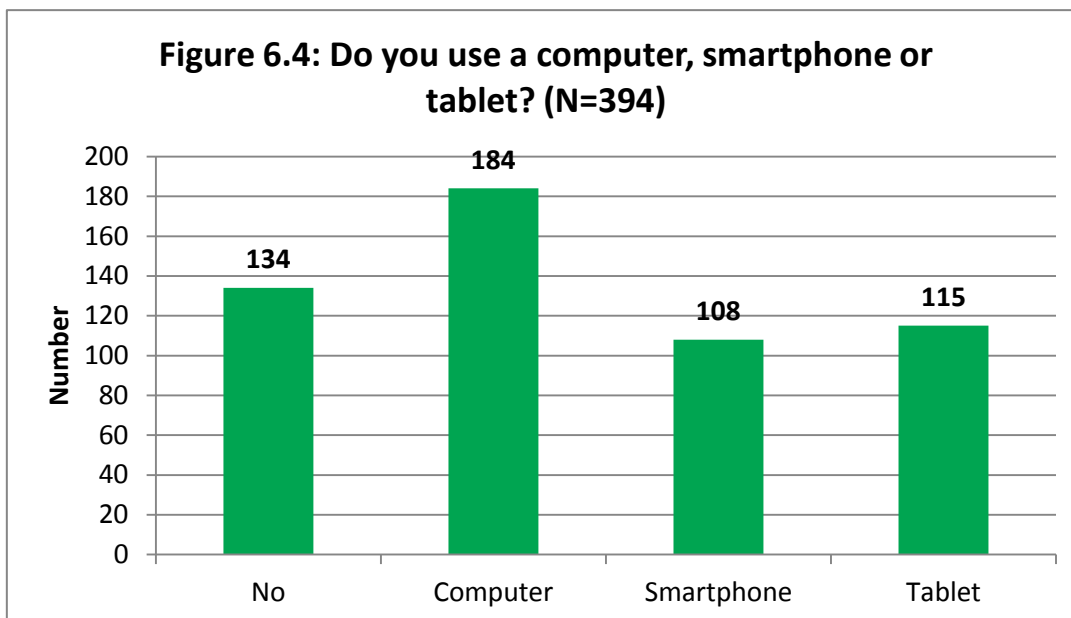
## Objective Measures

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

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

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

Just a third of respondents, 33%, do not use a computer, smartphone and/or tablet.<sup>27</sup> Of those who do use any form of this technology, the most commonly used is a computer:



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

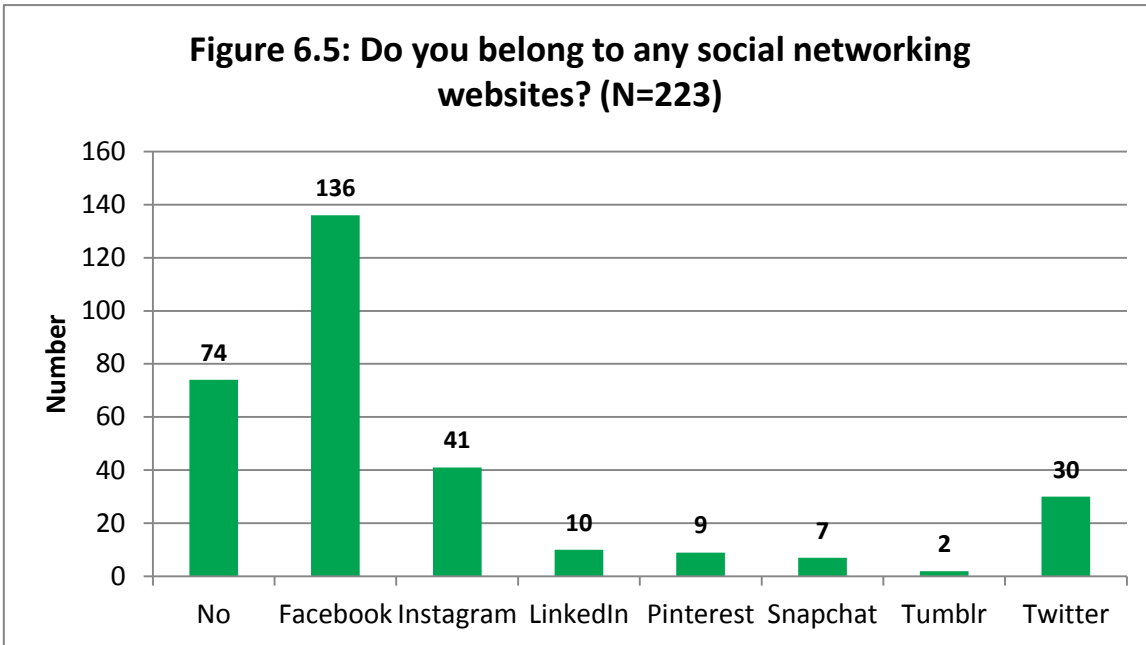
Those who do use a computer, smartphone or tablet are then asked if they use some form of social media. Again, just a third (33%) of those who use a smartphone, tablet or computer do not use some form of social media. This means that 67% of people who have access to a device use at least one social media platform. This is a higher percentage than perhaps some would expect for an older cohort.

By far the most commonly used social media platform is Facebook. Indeed, almost double the amount of people use Facebook as don't.<sup>28</sup> Again, people can provide more than one answer, so totals add up to higher than the overall sample size.

<sup>27</sup> N=394

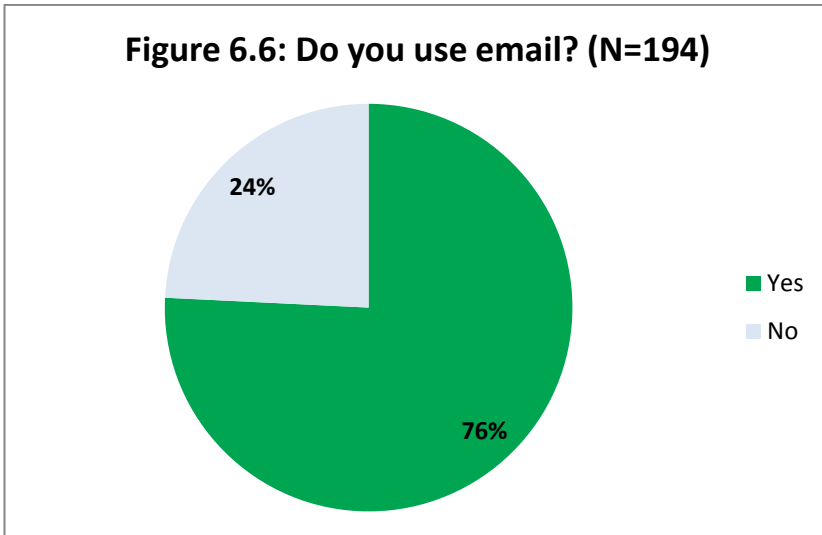
<sup>28</sup> Out of those who have access to a device).

**Figure 6.5: Do you belong to any social networking websites? (N=223)**



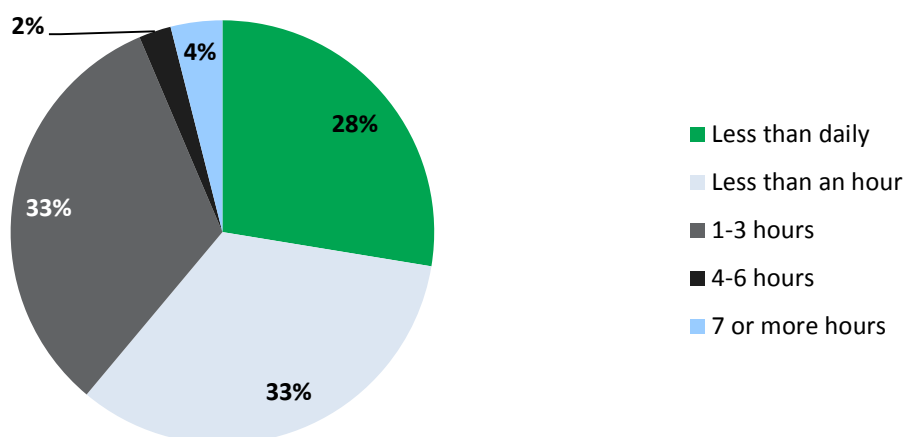
76% of people who use a smartphone, computer or tablet use email. The following data excludes Manchester.

**Figure 6.6: Do you use email? (N=194)**



The majority of people who use their devices to interact with friends or family online (i.e. emails or social media), do so at least daily (72%), most commonly for up to three hours. The following data excludes Manchester.

**Figure 6.7: How many hours do you spend interacting or chatting with people through social media or email on a typical day? (N=200)**



This suggests quite high levels of interaction with others via social media or email, amongst those who do have access to devices.

Of course, we need to bear in mind that 33% of respondents likely do not interact with others via social media or email, as they do not have a computer, smartphone or tablet with which to do so.

The second data set is about contact with others both face-to-face and over the phone is gathered from participants. This is provided in table 6.2. The data excludes Manchester.

**Table 6.2: On average, how often do you do each of the following with friends, colleagues, family or neighbours, not counting any who live with you?<sup>29</sup>**

	Three or more times a week	Once or twice a week	Once or twice a month	Every few months	Less than once a year or never
<b>Meet up</b> (N=253)	48%	32%	8%	4%	8%
<b>Speak on the phone</b> (N=240)	58%	24%	8%	3%	7%
<b>Send or receive text messages</b> (N=216)	52%	15%	3%	4%	25%

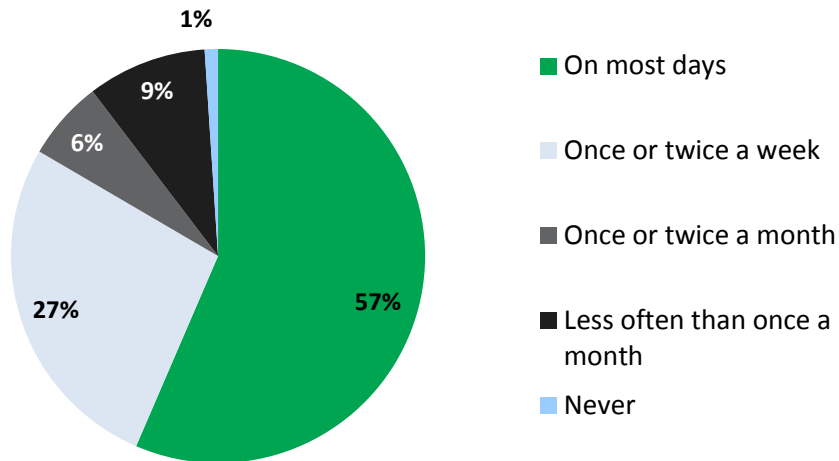
A fairly high percentage of respondents never send text messages (compared, at least, to the other two mediums). However, the most common response across all communication mediums is 'Three or more times a week'. This suggests fairly regular interaction with other individuals via these mediums.

Most people said that they talked to their neighbours on most days. The following data excludes Manchester.

<sup>29</sup> Note that an option is also provided for 'Once or twice a year'. However, this value returned 0 in each instance, so it is not included in the results table.



**Figure 6.8: How often do you talk to your neighbours?(N=193)**



When considering these objective measures, the majority of people seem to be in fairly regular contact with neighbours, friends, colleagues and family members. This is fairly consistent across different formats, e.g. face-to-face, via phone or other technology.

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

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

43% of participants currently volunteer. Of the 57% who do not volunteer, 32% want to. In addition, 50% of AfA volunteers also volunteer with other organisations, groups or projects. This indicates quite high levels of volunteering (whether through AfA or not), a positive safeguard against social isolation and source of social contact for many people.

### **Project Highlight: Dementia Friendliness in Moss Side & Hulme**

The Together Dementia Support group provides support and activities for people with dementia and their relatives/carers in Moss Side and Hulme. The group approached Ambition for Ageing in Manchester to provide a service that will assess and audit how accessible & helpful places, services and organisations are for people with dementia.

The group (volunteers and people living with dementia) will attend activities for older people in Hulme and Moss Side, and provide feedback as to how they could better serve the needs to people living with dementia. The group will also seek to investigate why and how people with dementia in Hulme and Moss Side become socially isolated.

# Conclusion

AfA is engaging a fairly large number of varied and diverse older people, though some groups are currently under-represented. These under-represented groups may be at risk of social isolation, so it is important that these people are included in the programme. Sample sizes are currently dominated mostly by white women aged over 70.

Evidence collected to date from these older people provides important insights into their local area, and have done so particularly in relation to research on what makes an age-friendly neighbourhood.

The majority of people who have responded to the questionnaires analysed in this report appear to be fairly positive about the places in which they live, and neither feel nor appear to be socially isolated.

However, there are significant minorities that could, in theory, be chronically isolated. These are those individuals who:

- Do not have any contact with neighbours, family or friends
- Do not think that their neighbourhood is age-friendly
- Do not feel strong levels of community attachment
- Possess risk factors or are at risk of experiencing discrimination

There is a danger that AfA continues to engage only with a certain type of individual. This is reflected both through the demographic characteristics of respondents, but also responses to outcome-related questions. Renewed efforts should be made to engage with those individuals who are at risk of experiencing marginalisation and social isolation.

In addition, projects seem to be heavily focused on 'Group Interventions'. This is promising as these are generally effective at increasing social participation. However, the sustainability of group interventions provided with a limited amount of funding is questionable. Focusing on providing more wider community development/neighbourhood interventions may increase the likelihood of long-term sustainability.

However, the currently very low levels of follow up data mean that any conclusions about impact of the programme cannot be made. As sample sizes for these increase, we would hope to see positive changes in the data.