The place to be

Guiding the activation of a community to facilitate ageing in place

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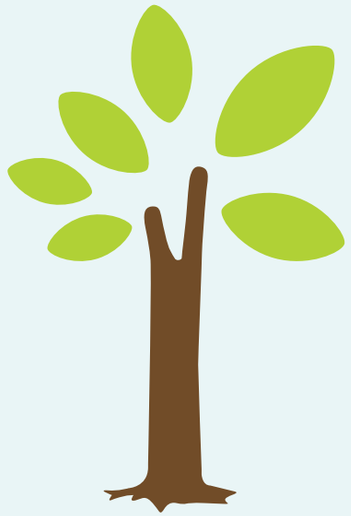
Dedicated to the older people, ageing in place,
in my own neighbourhood,
who inspired me to carry out this research.

Content

Chapter 1



General introduction

Background

Ageing is an important policy issue for governments and healthcare organisations. The worldwide increase of older people has consequences that are relevant in this context (World Health Organization, 2021). In Europe, people aged above 65 are expected to account for over 30% of the population by 2060 (World Health Organization, 2021). Within the countries of the European Union, almost all (approximately nine out of ten) older people remain living independently in their own homes. The Dutch government encourages older people to 'age in place' (Dobner et al., 2016; Gobbens & van Assen, 2018). In the Netherlands, the percentage of older people living at home is even higher (95%) (Strandell & Wolf, 2019). Some factors behind this high percentage of ageing in place in the Netherlands include the decreasing role of the welfare state, a growing redirection of care into the private sector, alongside the personal desire to stay in one's own home (Gobbens & van Assen, 2018). Facilitating older people's ageing at home, also referred to as 'ageing in place', is beneficial to the quality of life and might provide a solution to the increasing costs due to institutionalization of care or care at home (Carnemolla, 2018; Coleman et al., 2016; Peace et al., 2011; Sixsmith & Sixsmith, 2008). However, negative consequences can also occur for the older person. Ageing in place may result in experiencing isolation and loneliness due to a lack of social contact (Sixsmith & Sixsmith, 2008). This is often caused by a senior-unfriendly physical living environment, which hinders older people's mobility, which in turn affects their social contacts with others in the immediate vicinity (Sixsmith & Sixsmith, 2008). Besides isolation and loneliness, many older people at a certain point will face declining health, limitations in their functioning, and/or other complex issues that affect their ability to live independently. As a result of these limitations, the demand for care and support for older people will increase (De Klerk et al., 2019), yet there is also a shortage of healthcare professionals and care partners in the Netherlands. This may increase the burden on informal caregivers, which is known to be one of the main predictors of nursing home admission (van Beusekom et al., 2015). This in turn increases the challenge of providing appropriate support to older people (Haufe et al., 2019). Hence, aspects such as a senior-friendly

living environment, participation in society, a sense of purposefulness, social contacts, income, and a safe living environment are essential for older people to maintain a good quality of life as their need for care and support increases (van Bilsen, 2007).

To adequately respond to the challenges mentioned above, it is necessary to develop solutions to support older people (Iecovich, 2014). A possible solution could be the facilitation of ageing in place by (vitalised) communities in the social environment of older people living at home. Vital communities seem to contribute to ageing in place and the quality of life of older people living at home. According to a number of studies, it seems possible to identify positive relationships between ageing in place and the quality of life through the support of vital communities (Bigonnesse & Chaudhury, 2021; Fung, 2020; Spain, 2007; Trivedi et al., 2013). However, vital communities that provide support for older people do not vitalise automatically. Vitalising the community implies a complex intervention built up from a number of components, for example, the number and difficulty of behaviours required by those delivering or receiving the intervention—in this case, community members and older people ageing in place (Craig et al., 2008). The greater the difficulty of defining precisely what exactly the active ingredients of an intervention are and how they relate to each other, the greater the likelihood that you are dealing with a complex intervention. Components could effectively involve people in the whole activation process (Campbell et al., 2007; Harris et al., 2016). In addition, there is limited evidence on how to activate communities and what aspects to take into account. The literature does describe the activation of communities of practice and the corresponding development phases (Webber & Dunbar, 2020; Wenger et al., 2002). However, scarce literature has been found about activating communities to support ageing in place. This dissertation focuses on the activation of vital communities in order to facilitate ageing in place. This chapter provides a general introduction to the subjects of this dissertation. First, the concept of ageing in place and the theoretical underpinning are explained. Second, the concept of vital communities will be described in more detail. Third, the activation of vital communities by co-creation will be explained. Fourth, the general aim as well as the research question will be presented. This chapter will then end with an outline of the dissertation.

Theoretical underpinning

Ageing in place

Following the structure of this dissertation, first, the concept of ageing in place and the theory of social ecology are explained. The reason is that social ecology theory could be seen as the theoretical basis of ageing in place, based on the view that older people receive support from the social network in the home environment where they

live (Bookchin, 2007). As stated before, the common concern of society, professionals, and policymakers is to design new concepts in such a way as to allow the fulfilment of older people's needs in their own place. Horner and Boldy (2008) defined ageing in place as a 'positive approach to meeting the needs of the older person, supporting them to live independently, or with some assistance, for as long as possible'. Grimmer et al. (2015) stated that 'Ageing in place is mostly about the opportunity for older people to remain in their own home for as long as possible, without having to move to a long-term care facility'. The Centres for Disease Control and Prevention (2019) defined ageing in place as 'the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level'. A quick look at the three definitions shows that the focus of the definition of ageing in place is developed in time, from support to the place and the community. The first definition focuses on support for older people to live independently (Horner & Boldy, 2008). The second definition points to the home as a place where support will be provided (Grimmer et al., 2015). Meanwhile, the last definition describes the support for older people at home from the community. In this dissertation, we use the definition of Horner and Boldy (2008) because these authors defined ageing in place more positively as 'the extent to which the needs of older persons are met, supporting them to live independently, or with some assistance, for as long as possible'. The core of this definition is that support has to meet the needs of older people. Moreover, this definition also ties into demand-oriented care, which is now very central in care for older people.

Social ecology and ageing in place

Social ecology is a philosophical theory about the relationship between the environment and social issues (Bookchin, 2007; Davis, 2002). Although ageing in place mostly appeals to support through older people's social networks, place in terms of the home and living environment is an important theme of research, as well. Both themes of ageing in place, support through the social network and place, originate from social ecology theory. Place has several dimensions that are interrelated (Iecovich, 2014; McLeroy et al., 1988). First, place is a physical dimension that can be seen and touched, like home. Second, place is a social dimension involving relationships with people and the ways in which individuals remain connected to others. Third, place is an emotional and psychological dimension, which has to do with a sense of belonging and attachment. Fourth, place is a cultural dimension, which has to do with older people's values, beliefs, ethnicity, and symbolic meanings. According to Lawton (1985), the social sciences have developed emphases on the person-versus-environment aspects of ageing, named social ecology of ageing. This theory's point of view is to integrate the knowledge of what goes on within older people with what goes on outside of them (Lawton, 1977). The four dimensions of Iecovich (2014) (place as physical, social, psychological, and cultural dimensions) are comparable to the four ecological levels

of another theory, the so-called social-ecological model of Bronfenbrenner (1975). This ecological approach requires that the person, the environment, and the relations between them be conceptualised in terms of systems, and subsystems within systems. The first level relates to the individual living environment (home); the second level, to the direct social environment (social networks); the third level, to the community; and the fourth, to the (sub) culture (Bronfenbrenner, 1975). Following the dimensions and levels of the social ecology of ageing theory, this dissertation focuses on the third level, the community as a source of support for older people. The reason for this choice lies in the fact that despite emerging bodies of research that have described singular initiatives of ageing in place, there has been very little knowledge that forges conceptual linkages across this increasingly vast domain of research, practice, and policy. Integrative theory development is critical to ensure that ageing in place initiatives do not become fragmented from each other (Greenfield, 2012). The focus of this dissertation is in particular on the third dimension (the community) and all three levels of the social ecology theory: namely, the support of older people ageing in place through and in the community. Furthermore, according to the social ecology theory of ageing, the conditions that are necessary to enable older people to age in place go further than care and support at home. Indeed, many sociologists and environmental gerontologists have argued that advanced age brings increased attachment to place and to the social and physical environment (Lawton, 1985). This highlights the importance of communities as people age, particularly in terms of quality of life, participation in society, sense of purposefulness, social contacts, a safe living environment, and support (Huber et al., 2016; van Bilsen, 2007).

Vital communities

Origination of vital communities

The concept of vital communities has its roots in the early community psychology literature as well as in the development of community ecology. Community ecology is the study of the interactions between members within a community on spatial scales, including the distribution, structure, demography, and interactions between coexisting populations (Sahney & Benton, 2008). At the time of the development of community vitality, this theory was defined as the ability of communities to collectively solve problems (Scott, 2010a). These can also be social and care-related problems, such as supporting older people living independently in their own living environment.

Variations in communities

Although one may assume that vital communities share the general characteristics of social networks, in reality, they may be made up of numerous members and explicit

common goals, or shared interests (Scott, 2010b). Webber (2016) distinguished four different variations of vital communities: (a) communities of interest, (b) communities of place, (c) communities of action, and (d) communities of practice. In the case of this dissertation, communities of place appear to be most relevant because these vital communities consist of people who have a connection through the physical environment in which they live (Wenger et al., 2002).

Definitions of vital communities

The concept of vital communities is popular and broad, with various applications. According to Dale et al. (2010), definitions of vital communities are found in reports published by a variety of organisations, yet few scientific publications exist on their characteristics and the use of the concept. In a primarily theoretical paper, Scott (2010a) asserted that vital communities are characterised by strong, active, and inclusive relationships between residents, the private sector, the public sector, and social organisations. Together, these stakeholders promote individual and collective well-being. Vital communities are depicted here as communities that are able to cultivate relationships and thereby create an environment where citizens can adapt and thrive, enjoying improved well-being in a changing world (Scott, 2010a). The vitality of a community can be derived from community resilience (Abramson et al., 2015). According to Norris et al. (2007), community resilience could be seen as the outcome of four sets of networked resources or capacities: economic development, social capital, information and communication, and community competence. The extent to which a vital community can achieve individual and collective goals depends on the development phase the vital community is in (Wenger et al., 2002). Vital communities have various development phases (Webber & Dunbar, 2020; Wenger et al., 2002): the initiative phase, the formation phase, the growth phase, and the flowering phase. These development phases are distinguished by the degree of support and leadership from the initiator(s) and the bond between the members. In the initial phase, for example, there is little bonding between the members, and a high degree of support is required from the initiators(s). In the growth phase, there is more bonding between the members, and less support is needed from the initiator(s) (Wenger et al., 2002). Besides these development phases, there are also other indicators that reflect the vitality of the community, such as the social cohesion, commitment, social participation, empowerment, involvement, and ownership of members (Altpeter et al., 2014; Berman et al., 2008; Dale et al., 2010; Foster-Fishman et al., 2009; Letcher & Perlow, 2009). The vitality of a community refers also to the extent to which residents have a sense of mutual commitment, belongingness, and interdependence with their neighbours (Chavis & Wandersman, 1990). To summarise, many indicators determine how vital a community is.

Related concepts for vital communities

The context of the neighbourhood environment and the extent to which vital communities are supportive could enable older people to age in place successfully (Bigonnesse & Chaudhury, 2021; Van Dijk et al., 2015). However, besides vital communities, other initiatives could also support older people to age in place, such as age-friendly communities and community partnerships. A vital community focuses more on mutual relations and support, while age-friendly communities focus more on tangible aspects like accessibility, visibility, and avoiding thresholds. Age-friendly communities develop and apply frameworks to make communities more liveable for older people through community needs assessments, strategic planning, community education campaigns, and community interventions (Hanson & Emlet, 2006). Age-friendly communities explicitly focus on transforming the physical environment and are often led by municipal governments, local partners, and community-based organisations. Older people are involved as informants and partners in community decision-making (Greenfield, 2012). Community partnerships for older people are initiatives to facilitate partnerships amongst diverse community stakeholders to develop innovative ways to meet the long-term care needs of older adults within a particular community (Bailey, 2009). The main focus of this initiative is on the social environment, e.g., convening stakeholders' meetings. Community partnerships could be organised at the municipal, county, or regional levels and largely led by community-based organisations. Older people are typically considered as primary partners and leaders (Greenfield, 2012).

Design-oriented research

Complexity

As mentioned before, the activation of communities implies a complex intervention and, on most occasions, does not happen automatically. The question is which components a community consists of and which interventions can take the community's vitality to a higher level. When developing a new method to activate communities, it is essential to thoroughly understand the users, their contexts, and their practices (Henry et al., 2001). Empathizing with the end users is key. This is especially important for older people. Their experiences might be very different from those of the researchers and providers of support, making them difficult to empathize with and, more specifically, to understand the issues they face (Henry et al., 2001). In addition to the end users, many stakeholders are involved in a vital community: e.g., family, friends, neighbours, volunteers, and professionals from the housing, healthcare, and welfare sectors, the municipality, and local associations. Therefore, the aim of this dissertation is to develop a method to activate a vital community using a design-oriented research design. This research design emphasizes the participation of all stakeholders in the development of a method (Feuerstein et al., 2008). We choose a living lab to be able to make optimal use of the knowledge available from practice and an environment that is as concrete and natural as possible. The living lab was situated in a social meeting hub in the city centre. Participants were older people ageing in place and other stakeholders involved in practice from the housing, healthcare, and welfare sectors, municipalities, and local associations who were living and working in the community setting of the living lab. The living lab concept has been successful in fostering inclusive local development amongst all stakeholders through collective learning, innovation co-creation, and knowledge exchange (Habiyaremye, 2020). Living labs are user-focused experimental environments in which users and producers co-create innovative solutions in real-life settings. Living labs are commonly used to investigate healthcare or support problems in older populations (Kim et al., 2020).

General aim and research question

The general aim of this dissertation is to develop a method that can assist community members (professionals, volunteers, care partners, and older people) in selecting helpful strategies and interventions to activate a community in order to facilitate ageing in place. Consequently, an overview of the extent, range, and nature of existing definitions of the concepts of ageing in place and vital communities will be given. Providing such overviews may be helpful for policymakers, researchers, communities, and service providers to make sense of the versatility and use of the concepts and allow the improvement and increase the success of efforts to contribute to the quality of life of older people. Furthermore, the conceptual relation between vital communities and ageing in place will be evaluated. The question is whether vital communities can add value for the key themes of ageing in place. Finally, a method will be developed which can be of assistance to community members to select helpful strategies and interventions to activate a community in order to facilitate ageing in place.

Outline of the dissertation

This dissertation comprises seven chapters in which five studies will be described (see Table 1). The first three studies are mainly exploratory, resulting in an overview of the concepts of ageing in place, vital communities, and the relation between these two concepts. The fourth and last studies concern community-based participatory research aiming for the development of a method to activate a community and the validation of a developed quick-scan. After this general introduction, which provides background information and the outline of the dissertation (**Chapter 1**), **Chapter 2** will describe the concept of ageing in place. **Chapter 3** describes the second study,

a literature study on the conceptualisation of vital communities. **Chapter 4** describes the conceptual relation between vital communities and ageing in place according to experts in these fields. **Chapter 5** presents the results of a study that aimed to develop a method to activate a community. **Chapter 6** presents the study and results of content and usability validity of a developed quick-scan to map the vitality of a community. The dissertation concludes in **Chapter 7** with a general discussion and **Chapter 8** an impact section.

Table 1.
Overview of the research project and outline of the dissertation

Studies	Aim/methods
Chapter 2 Definitions, key themes, and aspects of ageing in place	The aim of this study was to draw on existing empirical research into ageing in place to build knowledge about the different definitions and the key themes of ageing in place. A scoping review was conducted, adopting Arksey and O'Malley's scoping review methodology. The search yielded 3,692 articles, of which 34 were included in the scoping review.
Chapter 3 The conceptualisation of vital communities related to age-ing in place	The purpose of this study was to draw on existing empirical research into vital communities to build knowledge about the different descriptions and dimensions of the concept to contribute to the formulation of better policies and the development of better practices in serving older people. A scoping review was conducted, adopting Arksey and O'Malley's scoping review methodology. The search yielded 4,433 articles, of which six were included in the scoping review.
Chapter 4 Towards consensus according to experts on the theorised contribution of vital communities to successful ageing in place	The objective of this study was to explore the theorised contribution of vital communities with regard to successful ageing in place. A modified Delphi study was conducted, consisting of two stages. In the first stage, we carried out two panel discussions in order to develop statements representing the theorised contribution of the features of vital communities to the key themes of ageing in place. This was followed by the second stage, which had three online Delphi rounds, and which aimed to reach a consensus among 126 international experts concerning the theorised contribution.
Chapter 5 The development of a guideline to activate vital communities facilitating older people ageing in place	The aim of this study was to give a more comprehensive understanding of the development phases, helpful strategies, and interventions for activating communities and the customisation of their support for older people. A co-creation design-oriented research methodology was applied to involve parties in an iterative and interactive approach in order to develop the guideline. The research was conducted in a living lab especially set up for this study in the south of the Netherlands. During the meetings in the living lab and online stakeholder sessions, we used co-creative methods in order to develop a set of guidelines that would help to activate a community in order to facilitate ageing in place. The systematic development process included five phases: (1) needs assessment, (2) design, (3) selection, (4) finalizing for further evaluation, and (5) testing and improvement.
Chapter 6 The validation of a quick-scan to map the vitality of a community	This study aimed to validate a developed quick-scan concerning the content and usability. Content and usability validation was conducted. Twenty-one experts in the fields of housing, (informal) care, community care, social innovation, citizen participation, and liveable neighbourhoods were asked to complete an online questionnaire. The open answers were analysed by means of deductive coding.

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Chapter 2

Definitions, key themes and aspects of ageing in place: a scoping review

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Abstract

The purpose is to give an overview of the extent, range, and nature of existing definitions of the concept 'ageing in place'. Providing such an overview may be helpful, for policy makers, researchers, communities, and service providers, to make sense of the versatility and uses of the concept, and allow the improvement and increase the success of efforts to contribute to the quality of life of older people. The overview was created using the Arksey and O'Malley's scoping review methodology. Out of 3,692 retrieved articles, 34 met the inclusion criteria. These studies concentrate on the following five key themes concerning 'ageing in place': 'Ageing in place' in relation to place, to social networks, to support, to technology, and in relation to personal characteristics. Each of these key themes consists of other aspects. Like physical place and attachment to place for the keyword place. This study concludes that the concept 'ageing in place' is broad and can be viewed from different (i.e. five) key themes. A more thorough understanding of 'ageing in place' provides knowledge about the existing key themes and aspects. These findings might provide practical support for professionals and governments when they develop their policies about 'ageing in place' integrally and to develop fit policies.

Introduction

Ageing is emerging as a key policy issue. One reason for this is that both the absolute number as well as the proportion of older people in populations around the world are increasing World Health Organisation (WHO) (2015). In Europe, the percentage of people aged 65 and over is increasing at an unprecedented rate and is expected to account for over 30 percent of the population by 2060 (European Commission (2015). Within the 28 countries of the European Union, approximately nine out of ten people aged 65 and over in Germany, France, Finland and the United Kingdom, live independently in their own home. In the Netherlands, the percentage is even higher (95 percent). By contrast, Southern and Eastern European countries such as Cyprus, Spain, Portugal and Estonia show particularly low percentages. In these countries, older people more often live in common households together with their children. In Romania, Poland and the Baltic States more than 10 percent of older people are in this type of living arrangement, which is only practiced by 4.6 percent of senior citizens Europe-wide. It is particularly rare in the Scandinavian countries and the United Kingdom (Eurostat, 2011). These trends affect national policy in all countries and have major implications for the allocation of national resources and budgets (International federation of ageing (IFA), 2011). Ageing is also strongly associated with the unpredictability of retirement costs and the costs of care (Van Nimwegen & Ekamper, 2018). Taken together with the fact that a further increase in life expectancy is inevitable,

this massive demographic change calls for a major effort to ensure quality of life of the older population (Giacalone et al., 2014). However, the increase in life expectancy may be viewed as a public health achievement, and older people are heterogeneous and many are continuing to help their families and friends even in their later years (International federation of ageing (IFA), 2011), which is beneficial for older people 'ageing in place'. Additionally, western countries have been experiencing similar patterns of change in their population due to cultural changes. Not only life expectancy has increased, but also marriage, fertility and birth rates have changed. Most couples get their first child at a higher age than before, there are more divorces, common-law unions and out of wedlock births. These developments are also called the 'Second Demographic Transition' (Lesthaeghe, 2010) and have led not only to challenges concerning how older people can be supported, in remaining independent and active, but also how the quality of life in general can be improved.

As mentioned earlier, also western societies are currently dealing with the rapid ageing of their population. Therefore it is necessary to develop new concepts, programmes and services to fulfil the expectations of their older population, but also for the service providers and policy makers (Iecovich, 2014). Askham, Cameron and Heywood have studied the wishes and demands of older people concerning their living environment (Means, 2007). They found that older people's choice to stay in their home for as long as possible is especially influenced by policies, but also by their own individual needs. It appears that most older people are attached to their independence and that they prefer to live in the environment they are familiar with (Machielse, 2016; Vermij, 2016). The main reason for this is that independent living contributes to maintaining a sense of self-reliance, self-management and self-esteem (Milligan, 2009). Machielse (2016) endorses that older people should be able to live independently, provided that their health situation allows them to do so and that there is adequate housing and social support available in their own living environment.

In many countries, the question of whether or not older people continue living in their own house is strongly related to their financial situation, and how it fits with the costs of residential and nursing home provision (Chen et al., 2015). According to Horner and Boldy 'ageing in place' has the potential to provide more appropriate care at a lower cost than a move to a more specialised and sheltered facility' (Horner & Boldy, 2008). 'Ageing in place' is mentioned as one possible solution to these financial issues. It may save financial expenditures and improve the quality of life of older people (International federation of ageing (IFA), 2011). The idea behind the policy of 'ageing in place' is that living in a familiar environment has a positive impact on the well-being of older people and contributes to positive experiences in later life (Van Dijk, 2015). Although a field of study about ageing, the needs of older people, and the issues brought about by the fact that a large(r) part of society is 65 or over has taken shape over the

past the last 10 years, the concept 'ageing in place' is used very broadly and has not been defined very clearly so far.

The aim of this study is to identify conventions and patterns in the scholarly treatment of the concept of 'ageing in place'. A more thorough understanding of 'ageing in place' might provide knowledge about the existing key themes and aspects of 'ageing in place' to gain professionals, governments, researchers and communities to better attune their policies. We therefore conducted a scoping review and formulated the following research question: 'How is 'ageing in place' defined in the literature and which key themes and aspects are described?'.

Methods

The overview was created using the Arksey and O'Malley's scoping review. A scoping review is particularly useful for examining a broadly covered topic to comprehensively and systematically map the literature and identify key concepts, theories, evidence or research gaps (Arksey & O'Malley, 2005). It also allows the inclusion of many different study designs, which suits the aim to give an overview of the way researchers define 'ageing in place'. Arksey and O'Malley's scoping review methodology outlines an approach consisting of six stages: (1) identifying the research question, (2) identifying relevant studies, (3) selecting studies, (4) charting the data, (5) collating, summarising and reporting the results, and (6) consultation.

Stage 1: Identifying the research question

The starting point of this scoping review is the identification of the research question. Arksey and O'Malley (2005) suggest using an iterative process for developing one or more guiding research questions. An exploratory literature study was conducted to increase the authors' familiarity with the literature, so that a research question could be formulated. 'Ageing in place', 'key themes' and 'aspects' were identified as key words for the research question. 'Ageing in place' was operationalised in synonyms (independent living, healthy ageing, housing for elderly and ageing at home) and search terms by the findings of an initial search to become better acquainted with the literature. Key themes was defined as a collection of somewhat related values and aspects. 'Aspects' means the side from which something is considered.

Stage 2: Identifying relevant studies

The eligibility criteria form the limitations to this research and the base of including or excluding resources. These limitations are strict guidelines and offer a framework

in order to prevent the research from becoming too broad or even invalid. They also help the researchers (authors KEPH and IZ) to stay on the same track, while analysing different resources. To set up the inclusion criteria we applied the Population, Concept and Context (PCC) mnemonic method (Joanna Briggs Institute (JBI)), 2015). Based on the research objective and research question, we further defined and elaborated the inclusion criteria for the research population, the concept, the context and types of sources. The used inclusion criteria are presented in Table 1.

Table 1.
In- and exclusion criteria of studies on definitions, key themes and aspects of 'ageing in place'

Inclusion criteria	Exclusion criteria
Population: Older People: People who are currently in the third and fourth age of life according to the theory by Peter Laslett. (Laslett, 1987)	**Population:**
Concept: Ageing in place Ageing at home	**Concept:** Articles which cover topics clearly different from goals such as: • illnesses (diabetics, HIV, alcohol abuse e.g.); • long-term care; • design and architecture/construction.
Context: All geographic locations Older people living independently at home	**Context:** People living in nursing homes, long term care facilities or other institutional care facilities.
Types of Sources: Empirical studies, quantitative and qualitative studies systematic reviews, meta-analyses, meta-syntheses, and scoping reviews. Published in the English, German and Dutch language.	**Types of Sources:** Books, narrative reviews, rapid reviews, critical reviews, PhD thesis's, opinion literature, grey literature, abstracts conferences and integrative reviews.

Five electronic databases (PubMed, PsychInfo, EMBASE, CINAHL, and SAGE) were used to find the studies to be analysed for this scoping review. Additionally, three search engines (Google Scholar, the catalogue of Maastricht University, and the catalogue of Zuyd University of Applied Sciences – both in The Netherlands) were used to optimise the search results of the electronic databases searches and to improve the reliability of the search strategy (Bramer et al., 2017). We conducted a search on the 3rd of July 2019, with no restrictions on the date of publication. In addition, reference lists of relevant articles were screened to identify key studies that had been missed.

Research strategy

The research strategy comprises the choice of resources and the way to find those resources. The authors that reviewed the literature (authors KEPH and IZ) first agreed on search terms. The selected search terms were combined and tested on the five electronic databases and three search engines. Bramer (2017) argues that to reach a maximum recall, searches in systematic reviews ought to include a combination of databases and search terms. Combining the search terms led to a unique search strategy for each of the five electronic databases and each of the three search engines. For example, during our empirical testing, we decided to apply the search term 'ageing at home' to optimise the search results in the search engine Google Scholar. The results of the search terms that we ended up settling on for each database and search engine of the whole search strategy are available on request from the corresponding author. The search terms that the authors settled upon as well as the search strategy are shown in Table 2.

Table 2.
Search terms and search strategy of studies on definitions, key themes and aspects of 'ageing in place'

Search terms	Synonyms	Linked search terms
Ageing in Place	Independent living Healthy ageing Housing for the elderly Ageing at home	Independent living Healthy ageing Housing for the elderly Staying home Ageing Gerontology Well-being
Elderly People	Aged	Aged Later life Third age Fourth age

Summery search strategy

Database	Search strategy	N
PubMed	'Ageing in place'	87
PsychInfo	Concept 'Ageing at home' OR 'Ageing in place'	82
CINAHL	Aging in place and seniors	79
EMBASE	Ageing in place	75
SAGE	Ageing in place	56
Search engines		
Catalogue of Zuyd University of Applied Science	Concept 'Ageing at home' OR 'Ageing in place' 'Communities'	1,424
Catalogue of Maastricht University	Concept 'Ageing at home' OR 'Ageing in place' 'Communities'	321
Google Scholar	Concept 'Ageing at home'	372
Other resources		
German resources	Konzept 'Zuhause' 'alt werden	988
Dutch resources	Zelfstandig wonen leven ouderen	121
Experts	Ageing in place	60
Key journals	Ageing in place	27
Total		**3,692**

Stage 3: Study selection

Once the searches (using the indicated search criteria) had been conducted, a selection had to be made from the results, so that actual analysis could take place. This study selection process was conducted on the basis of the inclusion criteria (Table 1), and consisted of three stages, each with a focus on a particular part of the studies (title, abstract, and full text). During each of these three stages, the authors divided the studies into relevant, irrelevant and doubtful. Relevant studies are defined here as studies that fit the scope and objective of this scoping review. In order to validate the selection procedure, the inclusion and exclusion criteria were checked for consistency by the two reviewers (authors KEPH and IZ) independently. This assessment was made first by looking at the title of the articles, and then by looking at the abstract of each article. After screening the titles and abstracts, articles that were deemed eligible were obtained as full texts, further scanned for eligibility and finally discussed with the members of the Research Centre of Facility Management, Zuyd University of Applied Science for validation. The Research Centre of Facility Management consisted of experts in healthcare, facility management and research. For all studies that were excluded on the basis of their full text articles the reasons for exclusion were recorded in a logbook. The studies that were left after the third stage of selection were considered relevant for this scoping review. All articles that resulted from conducting the searches in the electronic databases and search engines were exported into Endnote X8, registered in a logbook and making the part about comparing on the basis of consensus in each stage. If the researchers did not agree on the relevance of a study a third reviewer (author GJJWB) was asked to decide on the suitability.

Stage 4: Charting the data

To facilitate the data selection, the researchers agreed to use a chart on which they noted all information that was considered useful. More specifically, they kept track of the following points: author(s), year of publication, country of origin, research aim, research question, study population, sample size, research methodology, definition the authors gave of 'ageing in place', key findings and conclusions.

Stage 5: Summarise and report

Focusing on definitions, key themes and aspects of 'ageing in place', we conducted a qualitative content analysis (Levac et al., 2010). An open axial coding method was used. The data from the articles were inductively coded in Excel. With open coding, labels were linked to the fragments from stage 4 (charting the data). These labels summarised the core of the fragment. The labels were then analysed and the axial coding method was used to add overarching labels or themes. The analysis resulted in an

overview of study characteristics, and an overview of main findings and definitions of 'ageing in place'. Again, two reviewers (authors KEPH and IZ) independently summarised and reported all results in tables. The content of the tables was then compared and adapted to consensus if necessary.

Stage 6: Consultation

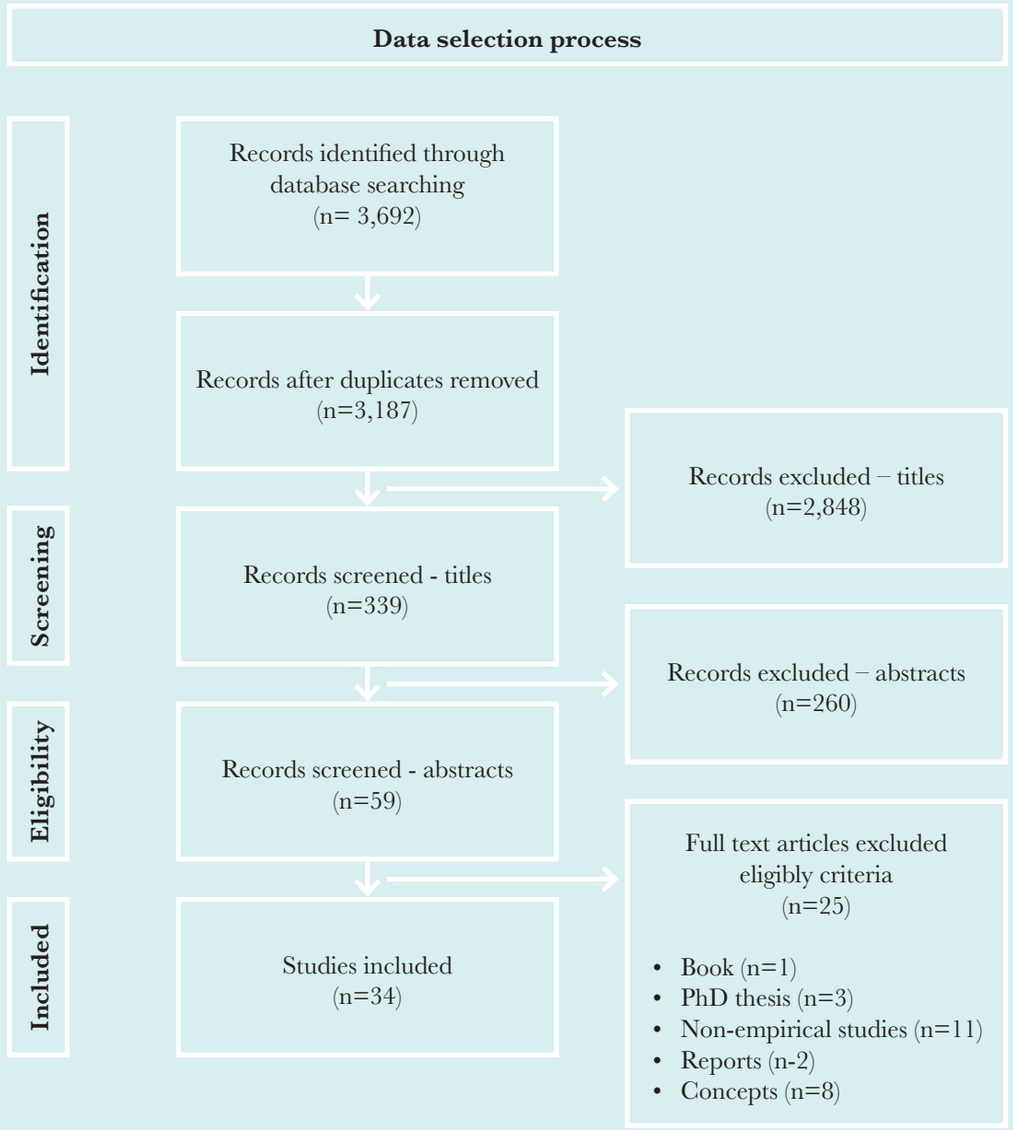
The consultation stage consisted of two meetings with a focus group. In the first meeting, the validity of the research strategy was discussed. During the second meeting, the results of the research were presented and discussed. The focus group consisted of professionals (a housing corporation representative, a general practitioner, a community nurse, policy staff of healthcare- and welfare organisations, a local government employee), an older person, and a member of a neighbourhood association. All of them, except the older person, assist older people while they 'age in place'. The older person that is part of the focus group, was asked to join to represent older people in this scoping review. This consultation phase provided opportunities for stakeholder involvement and provided insights beyond those in the literature.

Results

Study characteristics

Five electronic databases and three search engines were searched on the 3rd of July 2019 with no restriction on the date of publication. Based on the first search, 3,692 articles concerning 'ageing in place' were identified. Next, 505 duplicate articles were removed. The titles of the remaining 3,187 articles were then reviewed, on the basis of which 339 articles were deemed suitable for the current study. Independent screenings were then conducted looking at the abstracts of these 339 articles, after which 59 articles were still considered relevant. A final assessment of these articles, this time taking the full text of each of them into account, left a final number of thirty-four relevant studies for the scoping review. An overview of the data selection process is shown in Figure 1.

Figure 1.
Flowchart of data selection process of scoping review on 'ageing in place'



The reviewed articles focus on different geographical locations. Most of the studies concern European countries (n=17), with the Netherlands (n=8) and Spain (n=3) being addressed most often, while seven studies each focus on Oceania (n=7) and North America (i.e., the United States (n=6) and Canada (n=1)). Several different methodologies are used in the thirty-four selected studies, with the most common being qualitative research methodologies (n=21), quantitative research methodologies (n=8) and mixed methods (n=5). The characteristics and research aims of the articles included in the current scoping review about 'ageing in place' are provided in Table 3.

Table 3.
Descriptions of included research papers of scoping review on 'ageing in place'

Author(s) (year)/country	Study population	Perspective	Research method	Research aim/question
Bradby, H. et al. (2010) / United States	n = 10 (≥ 90 ≤ 96)	Older people	Mixed method (in-depth interviews and participant observation)	To explore how older women take responsibility for their own health and care through adapting everyday technologies – from slow cookers to gardening tools to televisions – to fit their needs and to age comfortably.
Magnusson, L. et al. (Magnusson et al., 2004) / Sweden	n = 1,527 (articles)	Research	Qualitative research (systematic literature review)	To provide an overview of the current 'state of the art' with regard to information and communication technology as a support for frail older people living at home and their family carers.
Peek, S. T. M. et al. (2017) / The Netherlands	n = 33 (seniors)	Older people	Qualitative research (explorative longitudinal qualitative field study with semi-structured interviews)	To better understand origins and consequences of technology acquirement by independent-living seniors.
Peek, S. T. M. et al. (2014) / The Netherlands	n = 16 out of 2,841 (articles)	Research	Qualitative research (systematic literature review)	To provide an overview of factors influencing the acceptance of electronic technologies that support 'ageing in place' by community-dwelling older adults.
Van Hoof, J. et al. (2011) / The Netherlands	n = 18 (older adults)	Older people	Qualitative research (comprised of interviews and observations of technology and environmental interventions in the home environment)	To investigate the needs and motives, related to 'ageing in place', of the respondents receiving ambient intelligence technologies, and to investigate whether, and how, these technologies contributed to aspects of 'ageing in place'.

Author(s) (year)/country	Study population	Perspective	Research method	Research aim/question
Ahn, M. Kang, J. Kwon, H. (2019) / United States	n = 650 (≥60)	Older people	Quantitative research (by an online survey)	To frame the 'ageing in place' concept within an extended theory of planned behaviour model incorporating environmental domains.
Boldy, D. et al. (2011) / Australia	n= 6,859, survey n = 39, interviews (≥55 ≤ 75)	Older people	Mixed method (survey followed by structured interviews with a subsample of respondents)	To investigate 'ageing in Place' in terms of house, locality and support, related to the western Australia members of National Seniors Australia.
Butcher, E. Breheny, M. (2016) / New Zealand	n = 8 (older Māori)	Older people Policy makers	Qualitative research (qualitative interviews)	To examine the ways that place influences experiences of ageing for older Maori in New Zealand.
Costa-Font, J. et al. (2009) / Spain	n = 729 (≥ 55)		Quantitative research (survey)	To examine, in vigorous, moderately vigorous and less vigorous elderly people ex-ante and current preferences for housing (in older age) and its suitability, given current or future needs and characteristics.
FernÁNdez-Carro, C. (2016) / Spain	n = 2,535 (≥ 65)	Older people	Quantitative research (data)	To shed light on the preferred residential and care arrangements in later life of the older Spanish population exploring the willingness for each one of the alternatives considered: one's own home, the relative's home and institutions.
Cramm, J. M. et al. (2018) / The Netherlands	n = 945, questionnaire n = 32,interviews (70-93)	Older people	Mixed-methods (questionnaire and interviews)	To characterise the relationship between frailty and ageing in place, and to identify differences in neighbourhood characteristics supporting 'ageing in place' missed by frail and non-frail older people.
Han, J. Kim, J. (2017) / Australia	n = 12,252 (≥ 55)	Older people Policy makers	Quantitative research (data)	To investigate the preferences of older people for staying or moving from their current home and neighbourhood. It also elucidates the factors associated with the decision to age in home and the decision to age in neighbourhood.
Hillcoat-NallÉTamby, S. Ogg, J. I. M. (2014) / United Kingdom	n = 4,079 (≥ 50)	Older people	Quantitative research (data)	To examine the likelihood that a desire to move will be shaped by dislikes about home and neighbourhood environments, amongst older Welsh people.

Author(s) (year)/country	Study population	Perspective	Research method	Research aim/question
Horner, B. Boldy, D. P. (2008) / Australia	n = Not reported	Older people	Qualitative research (action research study)	To investigate the complexities and challenges of change in an aged care community in Western Australia.
John, D. H. Gunter, K. (John & Gunter) / United States	n = 387, survey n = 237, participatory processes (elderly people/)	Older people	Mixed method study (survey and participatory processes)	To gain a better understanding of the urban and rural contexts for place-based aging to inform programs and policy.
Kerbler, B. et al. (2017) / Slovenia	n = 930 (≥ 50)	Older people	Quantitative research (survey)	Analysing how attached the elderly in Slovenia are to their homes and wider living environment and how satisfied they are with living there.
Martens, C. (2017) / Norway	n = 27 (articles) n = 89 (municipalities)	Government	Mixed method study (structured literature review and qualitative/ quantitative document study)	Which housing alternatives are compatible with the 'ageing in place' concept? Who are responsible for providing housing in old age?
Mesthrige, J. Cheung, S. (2019) / Hong Kong	n =224 (seniors)	Older people	Quantitative research (questionnaire survey)	To Investigate whether the introduced design elements and facilities satisfy the numerous special needs of the seniors in line with the concept of 'ageing in place'.
Norazizan, S.A.R. et al (2006) / Malaysia	n = 386 (≥ 60)	Older people	Qualitative research (interviews)	To describe the difficulties faced by older Malaysians in their present home environment.
Peace, S. et al. (2011) / United Kingdom	n = 54 (≥61 ≤93)	Older people	Qualitative research (focus groups)	To reflect the diversity of people and places in three areas. Metropolitan/urban (London Borough of Haringey); small town/urban/suburban (the town of Bedford), and small town/village/semi-rural (the county of Northamptonshire).
Renaut, S. et.al (2015) / France	n = 11 (≥79 ≤89) n= 17 (carers)	Older people Carers	Qualitative research (interviews)	To understand how individuals construct the space both within their own home and their immediate surroundings and how this construction is linked to their own perception of ageing and growing old.
Roy, N. et al. (2018) / Canada	n = 86 out of 660 articles	Research	Qualitative research (systematic literature review)	To identify the sets of factors influencing the housing decision-making of older adults.

Author(s) (year)/country	Study population	Perspective	Research method	Research aim/question
Sixsmith, A. Sixsmith, J. (2008) / United Kingdom	n = 40 (≥ 80≤ 89)	Older people	Qualitative research (interviews)	To illustrate the problems and challenges that exists in relation to 'ageing in place' in the United Kingdom.
Van Dijk, H. M. (2015) / The Netherlands	n = 32 (IRELAND)	Older people	Qualitative research (discussion groups)	To examine frail and non-frail older peoples' perceptions of the relative importance of ideal neighbourhood characteristics for 'ageing in place'.
Van Hees, S. et al. (2017) / The Netherlands	n = 18 (≥70≤ 85) n = 14 professionals (social workers, housing consultants, neighbourhood managers and community workers)	Professionals	Qualitative research (photo voicing)	To advance the investigation of 'ageing in place' by not only focusing on which constraints and regulators older adults recognise in their environment, but by also exploring how their constructions of ageing-in-place connect or interact with those of local professionals (social workers, housing consultants, neighbourhood managers and community workers) who translate 'ageing in place' policies into daily practices.
Van Hees, S. et al. (2018) / The Netherlands	n = 28 older people n = 48 (policy makers, directors, partners of older people)	Older people Policy makers	Qualitative research (interviews and focus groups)	To explore what the development of life cycle robust neighbourhoods means in relation to notions of 'ageing in place' and age friendly communities.
Vasunilashorn, S. et al. (2012) / United States	Articles published from 1980-2010	Research	Qualitative research (systematic review)	To examine how the literature on 'ageing in place' has changed over time in highly visible gerontology journals, with a focus on analysing trends related to the amount, location, and variety of research topics.
Wiles, J. L. et al. (2011) / New Zealand	n = 121 (≥ 56≤ 92)	Older people	Qualitative research (focus groups and interviews)	To illuminate the concept of 'ageing in place' in terms of functional, symbolic, and emotional attachments and meanings of homes, neighbourhoods, and communities.
Dobner, S. et al. (2016) / The Netherlands United States	n = 40 (older adults)	Older people	Qualitative research (in-depth interviews and multiple (within-case) observations)	What are the experiences of formal and informal social support and neighbourhood ties of older adults 'ageing in place' in Amsterdam and Portland? And how can differences between Amsterdam and Portland be understood in relation to differences in welfare state arrangements?
Wilkinson-Meyers, L. et al. (2014) / New Zealand	n = 3,753 (≥ 75, New Zealanders) (≥ 65, Māori)	Older people	Quantitative research (questionnaire)	To describe the met and unmet need for personal assistance reported New Zealanders living in the community.

Author(s) (year)/country	Study population	Perspective	Research method	Research aim/question
Grimmer, K. et al. (2015) / Australia	n = 42 (≥ 65)	Older people	Qualitative research (interviews and focus groups)	To explore and synthesize the experience and perspectives of older people planning for and experiencing 'ageing in place'.
Doblas, J. (2018) / Spain	n = 68 (≥63 ≤ 92)	Older people	Qualitative research (discussion groups and theoretical framework)	To examine why living arrangements among the elderly are changing in Spain.
Roberts, E. et al. (2017) / United States	n = 23 (≥ 65) n = 20 (≥ 8 ≤ 25)	Older people	Qualitative research (interviews)	To highlight Active Aging for L.I.F.E., an intergenerational pilot health initiative developed and implemented in the state of Oklahoma.
Versey, H. S. (2018) / United States	n = 98 (≥ 55)	Older people	Qualitative research (interviews and focus groups)	To explore how neighbourhood changes are viewed by lower-income, long-term residents 'ageing in place' in a neighbourhood that has undergone, and is still undergoing, waves of gentrification.

Definitions of 'ageing in place'

Turning to the actual content of the selected studies, only two studies developed an explicit definition of 'ageing in place' as a result of empirical research. Most studies cited definitions from other sources, mostly in the introduction of their work. Although all these 34 included studies examined aspects related to 'ageing in place', none of them were directly focussed on the development of a definition of this concept. Only two studies mentioned their own definition of 'ageing in place'. Grimmer et al. (2015) stated that 'ageing in place' is mostly about the opportunity for older people to remain in their own home for as long as possible, without having to move to a long-term care facility. Horner and Boldy (2008) defined 'ageing in place' as a 'positive approach to meeting the needs of the older person, supporting them to live independently, or with some assistance, for as long as possible'.

Key themes and aspects of 'ageing in place'

By structuring the data the following key themes of 'ageing in place' were identified: place (n=23), social networks (n=2), support (n=3), technology (n=5), and personal characteristics of older people (n=1). See Table 4 for the main findings of the included research papers.

Table 4.
Main findings of included studies of scoping review on 'ageing in place'

Author(s)/country	Key themes	Aspects	Key findings
Bradby, H. et al. (2010) / United States	Technology	Mobility Communications Technologies Biotechnologies	The spectrum of technologies enables the mobility for elderly. These tools help them stay connected and in control, to foster intellectual growth and by association, the health benefits that scientists now associate with brain stimulation. Technologies are key instruments for self-care, tools that can elicit creativity, connection, expression, health and even exciting new challenges.
Magnusson, L. et al. (2004) / Sweden	Technology	Information & Communication technology (ICT)	The use of a variety of search terms for ICT, family carers, older people and home care in the main brought up the health telematics literature and to a lesser extent the nursing and gerontology literature. The key theme was telehealth and telecare models in home care for older people and their family carers.
Peek, S. T. M. et al. (2017) / The Netherlands	Technology	Acquirements	A new conceptual model which provides an integrative perspective on why and how technologies are acquired, and why these may or may not prove to be appropriate and effective, considering an independent-living senior's needs. Externally driven and purely desire-driven acquirements led to a higher risk of suboptimal use and low levels of need satisfaction.
Peek, S. T. M. et al. (2014) / The Netherlands	Technology	Support 'ageing in place' Acceptance	Most articles investigated acceptance of technology that enhances safety or provides social interaction. Acceptance in the pre-implementation is influenced by 27 factors, divided into six themes: concerns regarding technology (e.g., high cost, privacy implications and usability factors); expected benefits of technology (e.g., increased safety and perceived usefulness); need for technology (e.g., perceived need and subjective health status); alternatives to technology (e.g., help by family or spouse), social influence (e.g., influence of family, friends and professional caregivers); and characteristics of older adults (e.g., desire to age in place).
Van Hoof, J. et al. (2011) / The Netherlands	Technology	Ambient intelligence technology (Safety & security)	The most prominent reason was to improve the sense of safety and security, in particular, in case of fall incidents, when people were afraid not to be able to use their existing emergency response systems. The ambient intelligence technologies were initially seen as a welcome addition to strategies already adopted by the respondents, including a variety of home modifications and assistive devices. The systems tested increased the sense of safety and security and helped to postpone institutionalisation.
Ahn, M. Kang, J. Kwon, H. (2019) / United States	Place	Environmental domains	The results confirmed the significant mediating role of the TPB (Theory of Planned Behaviour) components between the path from personal, built, and interpersonal environments to 'ageing in place' intention. Except for one built environmental construct (housing satisfaction), personal and interpersonal environmental constructs were found to indirectly affect 'ageing in place' intention. One of the interpersonal environmental constructs, social connectedness, was revealed as the strongest factor in this relationship.

Author(s)/country	Key themes	Aspects	Key findings
Boldy, D. et al. (2011) / Australia	Place	Holistic view of place Housing Locality Support	Overall, 44% of respondents had carried out building modifications to make it easier for them to continue living in their home; this proportion steadily increased with age. Remaining 'independent' is a key aim as people age. The study has shown the importance, both for older people and policy-makers, of each of three key themes related to place: 'housing', 'locality' and 'support'. These three key themes, and associated push–pull factors, have different influences on people's moving or staying decisions at different life stages.
Butcher, E. Breheny, M. / New Zealand	Place	Physical and social environment Place attachment Cultural Identity	Through their connection to place, the participants drew on a comforting and comfortable dependence on land and family to enable autonomy in later life. Rather than seeking to maintain independence in terms of avoiding reliance on others, older Māori conceptualized older age through autonomy and freedom to live in accordance with Māori values.
Costa-Font, J. et al. (2009) / Spain	Place	Suitability of housing Mobility Accessibility	Adequate housing conditions (mobility/accessibility) are essential for individual quality of life and certain aspects of individual well-being. "ageing in place" seems to be preferred by the vast majority of the population, although the suitability of housing for old age is not guaranteed by encouraging the elderly to stay in their dwellings. 'ageing in place' may still be the preferred option because the psychosocial benefits of remaining in the same, less uncertain, environment could outweigh the disadvantages.
FernÁNdez-Carro, C. (FernÁNdez-Carro) / Spain	Place	Ideal living environment Own home Children Family-oriented values	About 90 per cent of the respondents declared that they would prefer to live in their own home as long as they retain good physical and cognitive functioning, even if during this time they live alone. They prefer ageing in their own home if such a situation would imply a sufficient level of autonomy. On the other hand, when Spanish older people were asked about their preferences should they suffer from some physical or cognitive limitation, more than half – 56 per cent – identified co-residence with a relative, principally the adult children's home, as the ideal living environment.
Cramm, J. M. et al. (2018) / The Netherlands	Place	Neighbourhood characteristics Supporting 'ageing in place' Age friendly environment	Results showed that gender, age and especially frailty were related to miss neighbourhood characteristics. People displayed awareness of their increasing frailty and often acknowledged that it increased the need for neighbourhood characteristics enabling them to age in place. Conclusion is that dependence on neighbourhood varies with frailty status. This relationship is dynamic; with frailty, older people become more dependent on their neighbourhood.
Han, J. Kim, J. (2017) / Australia	Place	Home Neighbourhood Community Social ties	People aged 55 and over prefer to stay in their current neighbourhood. They were more likely to intend to move from their current house but not to change their current local community. Older people with a higher income are more likely to intend to move house but want to stay in the same community to maintain their strong social ties. Also is found that retirement entails the adjustment of housing consumption; the number of bedrooms in one's current dwelling is an important predictor of downsizing.

Author(s)/country	Key themes	Aspects	Key findings
Hillcoat-NallÉTamby, S. Ogg, J. I. M. (2014) / United Kingdom	Place	Home environment Attachment to place Design Location Maintenance	Wishing to move is more pronounced for dislikes about the home than the neighbourhood, and along with our descriptive analysis of the actual nature of dislikes, indicates that older people's concerns about the structural design features, location and maintenance aspects of their home environment can lead to serious consideration of residential mobility. This suggests that the design constraints of the home environment can potentially impede a sense of personal competence about being able to age in place, to the extent that feelings of attachment to place are progressively overridden, giving way to thoughts about the desirability of moving.
Horner, B. Boldy, D. P. (2008) / Australia	Place	Wellbeing Empowerment Social connection	Older people prefer to live in their own home, rather than in an institution or care centre. The literature reveals the importance of wellbeing, expressed as quality of life, empowerment, 'ageing-in-place' and social connection.
John, D. H. Gunter, K. / United States	Place	Community Environment	For the 'engAGE in Community Age-Friendly Model,' the World Health Organization's 'age-friendly' topic areas were categorized into three separate (but not isolated) environmental categories: physical (i.e., outdoor spaces and buildings, transportation, housing), social (i.e., social participation, respect and social inclusion, civic participation, and employment), and service (i.e., communications and information, community support and health services).
Kerbler, B. et al. (2017) / Slovenia	Place	Attachment to home Wider living environment	The respondents reported that they were very satisfied with their immediate and wider living environment and that they were very attached to it.
Martens, C. (2017) / Norway	Place	Home adaptions Long term family home Familiar surroundings Housing alternatives Living in the community	There is no agreement on place in 'ageing in place'. 'Ageing in place' policies entails joint individual and public responsibility for housing. Different policy expressions of 'ageing in place' at national and local government levels are demonstrated.
Mesthrige, J. Cheung, S. / Hong Kong	Place	Micro, meso, macro scale	Senior tenants were generally satisfied with the present living environments in the estates. At the micro-scale, seniors were satisfied with the level of privacy and sense of autonomy derived from the present design features in their homes. For the meso-scale, the study revealed that the seniors were particularly satisfied with the design elements such as convenient transportation and accessibility, including convenient walkways. At the macro-scale, the community care service is deemed important for seniors' wellbeing.
Norazizan, S. A. R. et al / Malaysia	Place	Difficulties Present home environment Ergonomic Safety	This paper identified environmental problems and associated factors among older Malaysians. It was found that most environmental difficulties reflected both the permanent and variable environmental conditions. However, research findings also show that the majority of the respondents are satisfied with their living area, as although observations showed there are obvious obstacles and hazards present in all these areas.

Author(s)/country	Key themes	Aspects	Key findings
Peace, S. et al. (2011) / United Kingdom	Place	Micro environment Macro environment Person environment system related to the quality of later life.	The concept of 'option recognition' sets out to capture the extent of environmental impact that can affect decision-making in later life, and points up the importance of continuity and change in both macro- and micro-environments. It recognises that individual experience of place is layered and that knowledge of personal biography and experience in time and space leads to greater clarification of the complexity of person–environment interaction. In reconsidering theoretical developments to date in environmental gerontology, the authors have demonstrated the importance of ethnographic research across settings and locations that enable comparability within and between place for older people living in both ordinary and supportive environments.
Renaut, S. et.al (2015) / France	Place	Home Home surroundings Home environment	Individual life course histories combined with socio-economic and socio-psychological factors to shape each individual's perception of the home environment and the adaptions that were made to it in the context of growing old. Four behavioural types are identified that categories the participants according to of and how they modify and adapt their home environment: 1).act when the time is right, 2). anticipation and prevention, 3). situational compromise or resignation, 4). recourse to the domestic economy and cohabitation.
Roy, et al. (2018) / Canada	Place	Housing decision factors	Overall, a total of 88 factors were identified, of which 71 seem to have an influence on the housing decision-making of older adults, although the influence of 19 of them remains uncertain due to discrepancies between research methodologies.
Sixsmith, A. Sixsmith, J. / United Kingdom	Place	Home Negative aspects	Negative aspects of remaining at home are: barriers in the home, the symbolic home, hiding increasing frailty, fearfulness, barriers outside the home, loneliness, challenges to services.
Van Dijk, H. M. (2015) / The Netherlands	Place	Neighbourhood characteristics	Although both frail and non-frail older people strongly desired a neighbourhood enabling them to age in place, they have divergent views on such a neighbourhood. Frail older people's viewpoint: secure neighbourhood with facilities nearby, a neighbourhood with adequate housing and a supportive network, an accessible neighbourhood. Non-frail older people's viewpoint: a well-kept neighbourhood with people to whom you can relate, a calm neighbourhood with good facilities, lively and engaged neighbourhood.
Van Hees, S. et al. (2017) / The Netherlands	Place	Attachment to place Amenities Mobility Meeting places	Professionals primarily consider objective characteristics of neighbourhoods such as access to amenities, mobility and meeting places as important enablers for older adults to remain living independently. Analysis of older adults' photographs and stories show that they associate 'ageing in place' with specific lived experiences and attachments to specific, intangible and memory-laden public places.

Author(s)/country	Key themes	Aspects	Key findings
Van Hees, S. et al. (2018) / The Netherlands	Place	Attachment to place Life cycle robust neighbourhoods	'Ageing in place' has a different meaning in policy discourses the in practice. While developers mainly considered place as something construable, older people emotionally attached to place through lived experiences.
Vasunilashorn, et al. (2012)/ United States	Place	Services Environment Not one-size-fits-all Technology	The more specific papers on 'ageing in place' focus on services (e.g., nursing homes and assisted living facilities, health monitoring, housing and social support, and palliative care). Second, with respect to the environment, 'ageing in place' has two prongs: 'ageing in place' in the home and in other structured settings in the community. Third, 'ageing in place' is not a one-size-fits-all concept. There are multiple issues surrounding differences in 'ageing in place' among diverse populations. Fourth, technology has become an increasingly important component to the literature on 'ageing in place'.
Wiles, J. L. et al. (2011)/ New Zealand	Place	Functional, symbolic, and emotional attachments and meanings of homes, neighbourhoods, and communities.	'Ageing in Place' is linked to sense of attachment and social connection, security and familiarity and to sense of identity, linked to independence and autonomy. The overarching message around 'ageing in place' was that older people wanted to have choices about their living arrangements and access to services and amenities.
Dobner, S. et al. / The Netherlands United States	Support	Community support Available infrastructure, amenities or services	Some factors, including the decreasing role of the welfare state, a growing redirection of care into the private sector, alongside the personal desire to stay in one's own home, are becoming increasingly relevant for an unprecedented number of older adults in urban settings. Community support and informal networks among neighbours may become even more vital for older adults living far away from family members. The experiences of older adults of 'ageing in place' in Portland and Amsterdam were found to be surprisingly similar, in spite of the different national, institutional, and local settings. Fewer available amenities (grocery stores, pharmacies) and few public transport options present crucial hurdles to 'ageing in place', especially in the disadvantaged neighbourhood in Portland. Strengthened and fostered community support and social cohesion in both Portland neighbourhoods may mitigate infrastructural lacks. However, this places increasing demands on older adults with limited local support networks and/or declining health. In contrast, older adults in both neighbourhoods in Amsterdam raised fewer demands regarding changing or enhancing the available infrastructure, amenities, or services.
Wilkinson-Meyers, L. et al. (2014) / New Zealand	Support	Personal assistance Instrumental support Formal support Informal support	Eighty-one per cent of participants required support with at least one instrumental activity of daily living. Sixty-six per cent were meeting their needs with the support they were currently receiving. Unmet need was most frequently reported for heavy housework (65%) and light housework (53%). While spouses, family members and friends were the main providers of support for light housework, meal preparation, shopping, finances and transportation, paid staff most frequently provided personal care and heavy housework assistance.

Author(s)/country	Key themes	Aspects	Key findings
Grimmer, K. et al. (2015) / Australia	Personal characteristics successful ageing	Health, information, practical assistance, finance, activity (physical and mental), company (family, friends, neighbours, pets), transport, and safety	Identifying personal characteristics (resilience, adaptability, and independence) and key elements of successful aging-in-place, summarized in the acronym HIPFACTS: health, information, practical assistance, finance, activity (physical and mental), company (family, friends, neighbours, pets), transport, and safety.
Doblas, J. (2018) / Spain	Social networks	Living Arrangements Residential -independence Intergenerational -households Live alone	Residential independence does not lead to disconnection, but instead, offers a new framework for intergenerational family relations. Although adapting to living alone is difficult, many elderly assume the challenge of doing so because they feel that no other way of life will guarantee them as much freedom, privacy and autonomy.
Roberts, E. et al. (2017) / United States	Social networks	Active ageing Community engagement Participation	Demographic indicators reveal that the overall world population of adults older than 65 years will continue to grow moving forward, underlining the need to communicate to people of all ages that the lifestyle choices made at every point across the life course influence health and wellness. Advances in technology and medicine, as well as improved community and housing options, also highlight the need for programs to increase awareness of these complex and interconnected issues in an aging society. The Active Aging for L.I.F.E. program may be promoted through county extension offices, community centres, and in public schools to provide education for improved health and wellness outcomes across the generations.
Versey, H. S. (2018) / United States	Social networks	Community Neighbourhood	Given separation from family, rent increases, and paying more for goods and services, the question of whether these changes affected desires to live in Harlem was posed to residents. Overwhelmingly, participants emphasised not wanting to leave their homes or the neighbourhood. Participants preferred to live independently in an urban setting rather than move south with family, relying primarily on neighbours and friends to support everyday activities, such as going to doctors' appointments or grocery shopping.

Place

Twenty-three out of the thirty-four studies focussed on the key theme place. During the analysis of these twenty-three studies a distinction between physical place and attachment to place was recognised. Some studies mentioned physical place, while others mentioned attachment to place. Three levels of physical place are described, namely home, home environment and the neighbourhood. Studies that were focussed on the physical home concern the choice between moving and making building modifications to make it easier for older people to continue living in their home (Boldy et al., 2011). Costa-Font *et al.* (2009) argue that adequate housing conditions such as mobility and accessibility are essential for an individual's quality of life and certain aspects of individual well-being. Hillcoat *et al.* (2014) argue that wishing to move is more caused by dislikes about the home than by the neighbourhood (Hillcoat-NallÉTamby & Ogg, 2014). The built environment has to be changed completely or adapted and improved for people to be physically able to age there (Martens, 2017). The built environment is an important aspect among physical abilities. According to Sixsmith and Sixsmith (2008), increasing frailty and 'barriers in and outside the home' as examples of 'physical health state' and 'the current state of the built environment have a huge impact on people's independence and thereby on their ability to age in place.

'Ageing in place' is also discussed in the sense of an attachment to place, as a place brings with it certain social connections, security, familiarity, and a sense of identity (Wiles et al., 2011). Three levels of attachment to place are described, namely home, home environment and the neighbourhood. As stated before, people normally wish to stay at home for as long as possible, they are quite attached to their home environment. Several theoretical approaches were analysed by Butcher and Breheny (2016) in order to find out what 'attachment to place' really means to older people. According to these authors attachment to place combines social, environmental, functional, emotional, and psychological meanings of place, and this attachment tends to increase over time (Butcher & Breheny, 2016). Therefore, 'ageing in place' includes not only staying in one's own home, but also includes remaining in a stable and known environment where people feel that they belong. Responding to a description of attachment to place by Butcher and Breheny (2016), Van Hees and colleagues recently used an approach where place is divided into socially related aspects and physical aspects (Van Hees et al., 2017). The social aspects refer to the place where people live with respect to emotions, memories, experiences and people whereas the physical aspects are more related to the function and physical or hard elements of the place (Van Hees et al., 2017). Even though 'ageing in place' is mostly related to people ageing in their home, the place and environment they have been living in for a long time, there are several recent theories that redefine the term home in this context. In such theories, home does not only relate to places that people know but also to places that people are attached to emotionally and that allow them to live an individual and self-determined life outside of an institutionalised environment (Bartlett & Carroll, 2011). This indicates that 'ageing in place' should not only be understood as people ageing in their own, known houses, but also as having the ability to move within their living environment (Han & Kim, 2017). This can either refer to the social environment, such as when people wish to live geographically closer to their social network, or to the built environment, such as when people move to a place where they can live a more self-determined and independent life. Butcher & Breheny argue that social environment and family are important (Butcher & Breheny, 2016). Older people with a higher income are more likely to intend to move from their house but want to stay in their current community to maintain their strong social ties (Han & Kim, 2017). Boldy et al. (2011) argue that the place is a holistic concept consisting of three key themes: housing, locality and support. 'Ageing in place' is not a one-size-fits-all concept. There are multiple issues surrounding differences in 'ageing in place' among diverse populations (Vasunilashorn et al., 2012).

Summarising these findings, two interpretations of place can be derived from the literature. While the key theme place is used to refer to physical and functional aspects in some cases, it is used to describe much less tangible, rather emotional and experience-based aspects in other cases.

Social networks

Another way in which 'ageing in place' is viewed in the literature, relates more to social networks. Only three out of the thirty-four studies focussed especially on social networks. Doblas (2018) focussed on social networks in relation to living arrangements, residential independence and intergenerational households. More specifically, residential independence does not lead to disconnection with the social network, but instead, offers a new framework for intergenerational family relations. Although adapting to living alone is difficult, many older people assume the challenge of doing so because they feel that no other way of life will guarantee them as much freedom, privacy and autonomy. However, whatever the circumstances, the social actors (such as having strong emotional ties to their homes and environment) coincide in stating that they have regular family contact, practically daily with the children and/or other family members they are closest to. The relationship is face-to-face when relatives live nearby and, if they don't, the relationship takes place by telephone and in the form of occasional visits (Doblas, 2018). In her study concerning 'ageing in place' in Harlem (New York) Versey (2018) argues that there are also aspects to be careful about, when thinking of the consequences of 'ageing in place'. Adjusting neighbourhoods and bringing diversity to communities may lead to separation from families, rent increases,

and paying more for goods and services for the existing current residents of the neighbourhood. The participants of the Versey study stated that they were not willing to leave their current homes, even if it meant being separated from their families. They preferred living in their known urban setting and neighbourhood, being a member of the community and taking part in daily activities, relying on their neighbours and friends. The current residents and their wishes, also concerning their community, can be seen as an important aspect (Versey, 2018). A study by Roberts *et al.* (2017) concerns the importance of active ageing, community engagement and participation. They confirms that active ageing, community engagement, participation, and social cohesion are important elements to engage older people to stay in contact with their social network. The next studies focused on social networks in combination with place or other key themes. As mentioned before, older people prefer to live in an environment (and surrounded by people) to which they feel attached based on memories and experiences. The environment should be familiar, older people feel attached based on memories and experiences, as a familiar environment gives them a feeling of safety and security (Dobner et al., 2016). This familiar environment can also be related to the social environment and to the people in the social network or community of older people. Older people mostly wish to be engaged and needed within their social network (John & Gunter, 2016). They want to be a part of the community and live a self-determined life. Joining the everyday life of the community, leads to a maximisation of their self-fulfilment and enables older people to enjoy their lifestyle (Boldy et al., 2011). Joining the everyday life of the community also includes to use the people's own individual talents to support the community. Engagement in the community is also important for people's mental health. Being a part of a community may help to prevent loneliness (Sixsmith & Sixsmith, 2008). Overall then, although the theme 'social networks' is mentioned far less than the theme 'place' within the literature in the field, social networks are without doubt acknowledged as playing a part when it comes to 'ageing in place'.

Support

Two studies focussed on support as a key success factor for 'ageing in place'. We found that two different kinds of support were brought up in the literature; formal support and informal support. Formal support is provided by professionals and service providers, while informal support is provided by informal networks consisting of anyone from family members, neighbours, and friends, to the community in general. Formal support mainly consists of the infrastructure, facilities, and services that are available to the older people in question. Such as public transportation, grocery stores, pharmacies, meal services and personal care (Dobner et al., 2016). Paid staff most frequently provides personal care and (heavy) housework assistance(Wilkinson-Meyers et al., 2014).

Fewer available amenities (grocery stores, pharmacies) and few public transport options present crucial hurdles to 'ageing in place', especially in the disadvantaged neighbourhoods. Strengthened and fostered community support and social cohesion may mitigate infrastructural lacks. According to a study by Wilkinson (2014) eighty-one per cent of the participants required support with at least one instrumental activity of daily living. Sixty-six per cent were meeting their needs with the support they were currently receiving. Unmet need was most frequently reported for heavy housework (65 per cent) and light housework. The providers of informal support are family members, neighbours, friends, and the community in general. They are the main providers of informal support, being light housework, meal preparation, shopping, finances and transportation(Wilkinson-Meyers et al., 2014). According to Dobner, Musterd and Droogleever Fortuijn (2016), who focussed on informal community support and informal networks among neighbours in their study, informal networks (friends, neighbours, community) may become even more vital for older adults who live far away from family members (Dobner, Musterd & Droogleever Fortuijn 2016). Dobner, Musterd, and Droogleever Fortuijn (2016) focused on informal community support and informal networks among neighbours.

Summarising these findings, support concerns personal assistance, the living environment, the daily needs and facilities, and is divided into formal support and informal support. Formal support is provided by professionals and service providers, while informal support is provided by informal networks made up of family members, neighbours, the community, and friends.

Technology

Five out of the thirty-four studies defined 'ageing in place' in terms of technology. These five studies define technology as one or more of the following: support of mobility, information and communication technology (ICT), biotechnology and ambient intelligence. This spectrum of technology may enable older people to be more mobile. Bradby, Joyce and Loe (2010) stated that the spectrum of mobility technology is much broader than walking sticks, walkers, wheelchairs and stair lifts, and can include everything from automobiles to public transport, security systems, special shoes, clothing, medication, and heaters. Older people incorporate a range of information and communication technologies, including telephones, computers, televisions, and radios, into self-care routines and meaningful activities. These tools not only help them stay connected and in control, but also help to foster intellectual growth and, as such, the health benefits that scientists now associate with brain stimulation (Bradby et al., 2010). Biotechnology, such as pharmaceuticals and over-the-counter medications are generally associated with health and wellbeing. However, paying attention

to the meaning older people attach to medical use and non-use can illuminate how these biotechnologies are positioned as an array of techniques older people use to practice self-care (Bradby et al., 2010). The ambient intelligence technologies were seen as a welcome addition to strategies already adopted by older people, including a variety of home modifications and assistive devices (Van Hoof et al., 2011). Older people have various motives to use ambient intelligence technologies to support 'ageing in place'. The most prominent reason was that using these technologies improved the sense of safety and security that they experience, in particular when it comes to fall incidents. The fear of not being able to use existing emergency response systems in case of such incidents, was mitigated by several of such ambient technologies and helped postpone institutionalisation (Van Hoof et al., 2011). Peek and colleagues investigated the extent to which older people accept technology and which factors influence this acceptance rate. They found 27 factors, which they divided into six themes: concerns regarding technology; expected benefits of technology; need for technology (e.g., perceived need and subjective health status); alternatives to technology; social influence (e.g., influence of family, friends and professional caregivers); and characteristics of older adults (e.g., desire to age in place) (Peek et al., 2017). Peek *et al.* also conducted a study about why and how technologies are acquired by older people and found that externally driven and purely desire-driven acquirements led to a higher risk of suboptimal use and to low levels of need satisfaction (Peek et al., 2017).

In summary, it can be said that technology is a theme of significance when it comes to 'ageing in place', and that it covers a wide range of attributes and tools. Using technology may enable older people to live independently at home and may give them a feeling of safety and security.

Personal characteristics

Only one study focussed on 'ageing in place' in relation to personal characteristics of older people. This study presented older people's views about how they and their peers perceive, characterise, and address changes in their capacity to live independently and safely in the community. The authors identified personal characteristics (resilience, adaptability, and independence) and key elements of successful 'ageing in place', summarised in the acronym HIPFACTS: health, information, practical assistance, finance, activity (physical and mental), company (family, friends, neighbours, pets), transport, and safety. Supporting older people's choices to live safely and independently in the community ('ageing in place') can maximise their quality of life. Little is known of the views of older people about the 'ageing in place' process, and how they deal with the fact that they require support to live in the community accommodation of their choice, as well as how they deal with prioritising their (Grimmer et al., 2015). This provided a range of insights about, and strategies for 'ageing in place'. Participants identified relatively simple, low-cost, and effective supports to enable them to adapt to change, while retaining independence and resilience. The findings highlighted that successful 'ageing in place' requires integrated, responsive, and accessible services. Key personal characteristics of successful 'ageing in place' are being resilient, having adaptability, being independent, physically and mentally active and being healthy (Grimmer et al., 2015).

Consultation

After consulting the focus group (stage six in the Methods chapter) the experts agreed with the overview of how 'ageing in place' is framed in existing literature. During the focus group meeting, the study characteristics, definitions, key themes and aspects were presented to the members of the focus group, after which a discussion took place about the results. The members of the focus group recognised and indicated the results found. Additionally, they indicated that one important aspect was not brought forward by the current study, namely the idea that 'ageing in place' should be primarily a long-term solution. According to the members of the focus group, definitions of the concept 'ageing in place' should make mention of long-lasting, durable solutions that allow and support older people to continue living at home, instead of temporary ad-hoc solutions. The inclusion of durable solutions should be taken into account in the development of sustainable policies by both government(s), as well as healthcare and service providers, where the quality of life and the well-being of older people are paramount.

Discussion

The aim of this scoping review was to identify conventions and patterns in the scholarly treatment of 'ageing in place'. The findings of this study, resulting from an analysis of a total of thirty-four studies highlight some key themes (place, social networks, support, technology, and personal characteristics) that are largely congruent with the concepts and meanings of 'ageing in place' found in prior research. The majority of the studies that were analysed in the current review focussed on aspects related to the key theme *place*. Two interpretations of place can be distinguished within these twenty-three studies: while some studies concentrate purely on the physical, functional aspects of place, others describe place in a more psychological way. The latter also has implications for the concept of 'ageing in place', because it does not bind people to one specific geographical place anymore but is more flexible and related to social ties. Another key theme of 'ageing in place' is *social networks*. Although the theme 'social networks' is mentioned far less than the theme 'place' within the literature in

the field, social networks are without doubt acknowledged as playing a part when it comes to 'ageing in place'.

The third key theme is *support*. Two different aspects of this theme were noticed, namely receiving *support* and offering *support*. Two studies relate to the *support* and assistance that older people *receive* from policy makers, service providers and the social network. Without this support many people would not be able to 'age in place'. The fourth key theme is related to *technology*. The five studies that address this theme define the term technology as encompassing one or more of the following: support of mobility, information and communication technology, biotechnology and ambient intelligence. Technology is a broad concept. Using technology may enable older people to live independently at home. Only one article (out of the 34) looked into *personal characteristics* of 'ageing in place'. This article brought forward five key personal characteristics of 'ageing in place', namely resilience, adaptability, independence, physical and mental activity, and health.

To gain an insight into the interrelations among the key themes and aspects we may look at geographical differences, the development of the concept 'ageing in place' over time and the relation between different socio-economic, cultural backgrounds and different abilities of older people. We noticed some differences between studies from different continents in terms of the key themes that were mentioned. European studies pay most attention to the two key themes *technology* and *place*. Research into the key theme place is also being done in Oceania. The other key themes (*social networks, support and personal characteristics*) are highlighted across European countries, North America and Oceania. Not all regions cover all the five key themes. This brings a potential risk of lacking attention to one or more themes in those regions which might imply a threat for successful 'ageing in place'. Our recommendation is to make sure that research on 'ageing in place' is conducted in such a way that the focus of conducted studies is distributed in a more balanced way, with each of the five key themes (and the coherence between them) being studied in all geographical regions. The evaluation of an experiment in Rotterdam in The Netherlands shows that this recommendation for an integrated approach of all key themes is valid. The experiment, 'Even Buurten', was part of the National Programme for Elderly Care in the Netherlands (2008-2016) and aimed to support the formal and informal networks around older people so that they can continue to live independently at home for as long as possible (Van Dijk, 2015). The focus of this experiment was on social networks, support, self-reliance (personal characteristics) and the physical environment (place). Technology, supporting 'ageing in place', and attachment to place were not included in this integrated approach, although they are found to be related with 'ageing in place'.

In addition to geographical differences in how research themes are addressed, we also noted differences over time. Vasunilashorn (2012) reported that topics related to the environment and services were the most commonly examined between 2000 and 2010, while the number of studies pertaining to technology and health/functioning was on the rise. According to Vasunilashorn (2012) this underscores the increase in diversity of topics that surround the literature on 'ageing in place' in gerontological research. Our study also shows a development over time with regard to the key themes. The studies related to *technology* were conducted between 2004 and 2017, those on *place* between 2006 and 2019, those on *support* between 2014 and 2016, those on *personal characteristics* in 2015 and those on *social networks* in 2017 and 2018. The key theme *place* is dominant in the evolution of the concept and has appeared more frequently as of late. In other words, a shift is noticeable: from 'hard' aspects of 'ageing in place' (place and technology) to 'soft' aspects (social networks and support).

The context of 'ageing in place' is diverse for older people, depending on their different socio-economic and cultural background and different abilities. Differences in socio-economic status have been operationalised by Grimmer (2015) in a so called HIPFACTS score. HIPFACTS is an acronym and stands for: Health, Information, Practical assistance, Finance, Activity (physical and mental), Company (family, friends, neighbours, pets), Transport, and Safety (Grimmer et al., 2015). Lower HIPFACTS scores indicate a modest self-reliance. Modest self-reliance is not found to be beneficial for successful 'ageing in place'.

Due to the scope of our study, we cannot do without a discussion about definitions of 'ageing in place' that the literature provides. Only two definitions of 'ageing in place' were found in the studies we analysed. We compared these definitions to the definition of Centers for Disease Control and Prevention (CDC) and came to the conclusion that all the three definitions have been drawn-up from another perspective. CDC (2019) defined 'ageing in place' as 'the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level'. This definition is particularly based on the ability older persons have or not. Horner and Boldy (2008) defined 'ageing in place' more positively as the extent to which the needs of older persons are met, supporting them to live independently, or with some assistance, for as long as possible. The core of this definition is that support has to meet the needs of older people. Grimmer et al. (2015) stated that 'ageing in place' is mostly about the opportunity for older people to remain in their own home for as long as possible, without having to move to a long-term care facility. This somewhat more narrow definition describes the situation as such. The three perspectives emphasise different components that may complementary to each other.

Strengths and limitations

Our review has several strengths. First, we used a comprehensive search strategy across multiple databases and search engines with no date restrictions, minimising the risk of having missed scientific studies about 'ageing in place'. Second, to enhance trustworthiness, the process of selecting studies and extracting charting data was done independently, by two reviewers (Levac et al., 2010). However, the search that was conducted for this study may have also been subject to certain limitations. First, in our search we used a combination of keywords, but 'ageing in place' is a broad concept encompassing a varied terminology. It is possible that we have missed studies that used other terms with similar meanings. In an attempt to limit the effect of this issue, we checked reference lists and asked experts for literature. Second, we limited our search to databases of peer-reviewed, scientific articles. Books, grey literature, discussion papers for instance are not included. As a result, we may have missed some definitions of 'ageing in place'. However, we were especially interested in the way 'ageing in place' is defined in the scientific literature, and we did not expect to find this within books and grey literature. Another problem we faced was that scientific publications frequently focus on just one key theme of 'ageing in place' such as place, social networks, support, technology or personal characteristics. It is therefore possible that our overview of key themes and aspects is incomplete and also that more authors than we found used their definition of 'ageing in place'. We attempted to minimise this risk by checking the references for other sources providing more detailed descriptions. In future studies, it might be worthwhile to actively approach the authors of the included studies for additional information. A final remark is that we did not assess the quality of the selected studies. However, according to Levac (Levac et al.), the strength of the scoping review methodology is that it focusses on the state of research activity rather than evaluate the quality of existing literature.

Conclusion and implications

The research question of this study was 'How is 'ageing in place' defined in the literature and which key themes and aspects are described?'. 'Ageing in place' as a result based on empirical research is defined just in a very few studies. Grimmer et al. (2015) stated that 'ageing in place' is mostly about the opportunity for older people to remain in their own home for as long as possible, without having to move to a long-term care facility. Horner and Boldy (2008) defined 'ageing in place' as a 'positive approach to meeting the needs of the older person, supporting them to live independently, or with some assistance, for as long as possible'. From our scoping review, we noticed that the concept 'ageing in place' is broad. We were able to identify five key themes: place, social networks, support, technology and personal characteristics. Professionals and governments should consider to include all of these key themes in the development

of policies concerning 'ageing in place'. Only then they can handle 'ageing in place' in an integrated way and develop policies that suit older people. Only five out of the thirty-four included studies focussed on social networks (3) and support for older people (2). However, it is assumed that particularly social networks and support have a large impact on 'ageing in place'. Further research into the relationship between 'ageing in place' and communities providing informal support is recommended. Future research on 'ageing in place' will face some serious challenges, such as longitudinal effects, changing populations and shifting healthcare policies. There is only one way to deal with these challenges: keep focussing on the quality of life as it is perceived by older people who are ageing in place, because that aim will probably survive some generations.

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Chapter 3

The conceptualisation of vital communities related to ageing in place: a scoping review

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Abstract

Older people today are more likely to age in their own private living environment. However, many face declining health and/or other issues that affect their ability to live independently and necessitate additional support. Such support can be provided by formal networks, but a considerable part can also be offered by informal networks of older people themselves. Going beyond these networks, older people can additionally and perhaps even more substantially benefit from *vital communities*. Nevertheless, even though this term is increasingly common in the literature, its meaning remains indistinct. A more thorough understanding of this concept might provide valuable knowledge that health care professionals, researchers and community workers can use to offer meaningful and effective support. The purpose of this paper is to draw on existing empirical research on vital communities to build knowledge of the different descriptions and dimensions of the concept. Arksey and O'Malley's scoping review methodology was adopted. Our search, conducted on 23 March 2020 and updated on 06 January 2021, yielded 4,433 articles, of which six articles were included in the scoping review. We deduced that the conceptualisation of a vital community is based on three dimensions: the aim of a vital community, the processes behind a vital community, and the typical characteristics of a vital community. None of the selected studies have mapped all three dimensions. Nevertheless, we assume that understanding all three matters when vital communities aim to contribute to the quality of life of people ageing in place.

Introduction

The world's population is ageing rapidly. This is apparent both in terms of apparent numbers and growing proportions of older people within different countries' populations across the world (World Health Organization (WHO), 2015). In Europe, the percentage of people aged 65 and older is increasing at an unprecedented rate and is expected to account on average for over 30% of the continent's population by 2060 (European commission (EU), 2015). Today, older people age in their own private living environment (ageing in place) and for longer compared to in past decades. On the one hand, this development is influenced by changes in policy and regulations and, on the other, by older people's wish to keep their independence (Machielse, 2016; Thomas & Blanchard, 2009; Vermij, 2016). Grimmer et al. (2015) stated that 'ageing in place' is mostly about the opportunity for older people to remain in their own home for as long as possible, without having to move to a long-term care facility. Horner and Boldy (2008) defined 'ageing in place' as a 'positive approach to meeting the needs of the older person, supporting them to live independently, or with some assistance, for as long as possible'. Such a desire for continued independence probably owes to the fact that independent living helps older people to maintain a sense of self-reliance, self-management and self-esteem (Milligan, 2012). However, many older people face declining health, limitations in their functioning and/or other issues that affect their ability to live independently. Thus, older people who face such challenges but wish to continue living at home may require additional support (Machielse, 2016). Golant (2015) describes the problems that ageing in place can cause when people reach the last stages of old age. They often need caregivers, and in many cases, the people who give the care are family members. Formal networks can partly provide this support, but the (informal) social networks of older people themselves may also make an important contribution. Formal support, provided by professionals, mainly consists of the infrastructure, facilities and services available to the older people in question. These services include public transportation, grocery stores, pharmacies, meal services and personal care (Dobner et al., 2016). However, a lack of amenities (e.g. grocery stores, pharmacies) and public transport options present significant hurdles to 'ageing in place', especially in disadvantaged neighbourhoods. Strengthened and fostered community support and social cohesion may mitigate infrastructural deficiencies. The providers of informal support for older people in need include family members, neighbours, friends and the community in general. Such informal support consists of tasks such as light housework, meal preparation, shopping, finances and transportation (Wilkinson -Meyers et al., 2014). Focusing on informal community support and informal networks among neighbours, Dobner et al. (2016) have highlighted how informal networks (friends, neighbours, community) may become even more vital for older adults living far away from family members. However, for successful day-to-day support, the majority of one's social network should be in relatively close proximity, and neighbours should be willing to interact and check up on each other. Moreover, even if both of these aspects are present, a social network will not function well if there is limited engagement or willingness and ability to work together among the members of the social network (Nocon & Pearson, 2000).

Going beyond (informal) social networks, older people may also—and perhaps even more substantially—benefit from *vital communities*. This concept has its roots in the early community psychology literature from the 1960s and 1970s. At that time, community vitality was defined as the ability of communities to collectively solve problems (Scott, 2010). Although one may assume that such communities share the characteristics of social networks, in reality they may be made up of numerous people and explicit common goals or shared interests. Apart from these general characteristics, different notions seem to exist about how vital communities are described and what kinds of vital communities exist. According to Dale et al. (2010), definitions of vital communities are mainly found in reports published by a variety of organisations, yet few scientific publications exist on their characteristics and the use of the concept. In a primarily theoretical paper Scott (2010) asserts that vital communities are charac-

terised by strong, active and inclusive relationships between residents, the private sector, the public sector and social organisations. Together, these stakeholders promote individual and collective well-being. Vital communities are depicted here as communities that are able to cultivate relationships and thereby create an environment where citizens can adapt and thrive, enjoying improved well-being in a changing world (Scott, 2010).

A more thorough understanding of vital communities might help create valuable insights for health care professionals, researchers and community workers to offer meaningful and effective support of complementary interest for older people's quality of life. The purpose of this paper is to draw on existing empirical research into vital communities to build knowledge about the different descriptions and dimensions of the concept to contribute to the formulation of better policies and the development of better practice in serving older adults.

Methods

A scoping review is particularly useful for comprehensively and systematically mapping the literature and identifying the key concepts, theories, evidence and/or research gaps that exist in a broadly covered topic (Arksey & O'Malley, 2005). It also allows for an analysis of papers that describe studies with diverse designs. Given that both of these features of scoping reviews fit the purpose of our study, which aimed to provide an overview of the different descriptions and dimensions of the concept of vital communities, we adopted this method to answer our research question. More specifically, we applied the scoping review methodology outlined by Arksey and O'Malley, which details an approach consisting of five stages: (a) identifying the research question, (b) identifying relevant studies, (c) selecting studies (d) charting the data and (e) collating, summarising and reporting the results.

Identifying the research question

In order to provide an overview of the different descriptions and dimensions of the concept of vital communities, we defined the following research question: 'What descriptions, dimensions and characteristics of the concept of vital communities have been distinguished in the scientific literature?'

Identifying relevant studies

The main goal of the second stage was to create an overview of sources discussing vital communities (in this case) to an extent that is relevant for analysis. Prior to this study, the authors conducted a scoping review of the concept of ageing in place. During that study, they were particularly looking for definitions, key themes and aspects of the concept of ageing in place (Pani-Harreman et al., 2020). For the current study, we were particularly focusing on the concept of vital communities. To achieve this goal, we conducted an exploratory literature study in books and articles(Dale A. et al., 2014; Deindl & Brandt, 2017; Grigsby, 2001; Hwang et al., 2008; Moulaert & Garon, 2016). The literature study increased the authors' familiarity with the literature and allowed them to operationalise the term *vital communities* into synonyms (e.g. 'community participation', 'social environment', 'social participation', 'social marginalisation', 'social responsibility') and linked search terms (e.g. 'society', 'social welfare', 'social cohesion', 'neighbourhood', 'social networks', 'community', 'vitality'). The authors used these synonyms and linked search terms to develop a number of terms (e.g. 'community networks', 'community network', 'vital community', 'vital communities', 'community health network', 'community health networks', 'community care network', 'community care networks') that could be utilised to conduct searches within relevant databases and search engines: (a) PubMed, (b) PsychInfo, (c) CINAHL and (d) Scopus. The next step in this stage was to identify the most useful combination of search terms for each database. Table 1 presents the full electronic search strategy for the PubMed database, such that it could be repeated (Tricco et al., 2018). This task was carried out by two scientific reviewers (author KEPH and researcher SdG) independently. The two reviewers subsequently discussed their findings until they reached a consensus on one combination of search terms for each database. In this way, a different combination of search terms was identified for each database.

Table 1.
Steps and detailed search terms used in the PubMed search

Step 1 Search term	Step 2 MESH term PubMed	Step 3 Entry terms PubMed	Step 4 Free text words	Step 5 Search strategy
Vital community	Community network	Community network Community health networks Community care networks	Community network(s) Community health network(s) Community care network(s) Vital community Community participation	Vital community[tiab] OR Vital communities[tiab] Community Networks'[Mesh] OR vital community[tiab] 'vital community' OR 'vital communities' OR 'community participation' Community Network[Mesh] OR vital community[tiab] OR community networks[tiab] OR community network[tiab] OR community health network[tiab] OR community health networks [tiab] Community Network[Mesh] OR vital community[tiab] OR vital communities[tiab] OR community networks[tiab] OR community network[tiab] OR community care network[tiab] OR community care networks[tiab] Community Network[Mesh] OR vital community[tiab] OR vital communities[tiab] OR community networks[tiab] OR community network[tiab] OR community health network[tiab] OR community health networks[tiab] OR community care network[tiab] OR community care networks[tiab]

Table 2 shows the combination of search terms used for each database as well as the number of hits that resulted from the search. Additionally, the search engine Google Scholar was used to optimise the results of the electronic database searches and to improve the reliability of the search strategy (Bramer et al., 2017). We conducted a search in March 2020 and updated this search in January 2021, with no restrictions on the date of publication. Reference lists of the included articles were also screened to identify additional key studies.

Table 2.
Search terms and search strategy scoping review vital communities

Database	Search strategy	Hits
PubMed	'community networks' [mesh] OR 'vital community' OR 'vital communities' OR 'community networks' OR 'community network' OR 'community health network' OR 'community health networks' OR 'community care network' OR 'community care networks'	2,510
CINAHL	(MH 'community networks') OR 'vital community' OR 'vital communities' OR 'community health network' OR 'community health networks' OR 'community care network' OR 'community care networks'	370
PsychInfo	'community networks' OR 'community network' OR 'vital community' OR 'vital communities' OR 'community health network' OR 'community health networks' OR 'community care network' OR 'community care networks'	536
Scopus	'community networks' OR 'community network' OR 'vital community' OR 'vital communities' OR 'community health network' OR 'community health networks' OR 'community care network' OR 'community care networks'	485
Google Scholar	('vital community' OR 'vital communities') AND ('older people')	532
Total		4,433

Selecting studies

The third stage was aimed at facilitating the extraction and analysis of data from relevant papers by selecting from the articles retrieved in the identification stage. Studies were eligible if they: 1) described the concept, 2) described a definition, 3) and/or described the characterisation of a vital community, 4) were original research articles (quantitative and/or qualitative empirical studies, systematic reviews, meta-analyses, meta-syntheses and scoping reviews) and (5) were written in English, German or Dutch.

This study selection process consisted of assessing the articles in three steps, first by focusing on the title, then the abstract and then the full text of each article. The reviewers divided the studies into one of three categories (relevant, irrelevant or doubtful) for each step of the process. To validate the selection procedure, the eligibility criteria were independently checked by two reviewers (author KEPH and researcher SdG) for consistency. This assessment was first made by checking the title of each article and then by reading it's abstract. After screening the titles and abstracts, the articles that were deemed eligible were obtained as full texts and then further scanned for eligibility. A logbook was used to record the reasons for excluding studies based on their full texts. The studies that remained after the third stage of selection were considered relevant for this scoping review. If the two reviewers did not agree on the relevance of a particular study, a third reviewer (author GJJWB) was asked to determine its suitability. To facilitate the selection process, Endnote X9 was used to import the title, author(s), date of publication, journal of publication, abstract and full text (if available) of each article resulting from the searches. This information was used to keep track of the selection process by sorting articles along the lines of inclusion and exclusion. A logbook was used to record the number of articles resulting from each phase of the selection process and Endnote X9.

Charting the data

The fourth stage of the scoping review involved charting key items of information obtained from the papers being reviewed. Charting is a technique by which qualitative data are synthesised and interpreted via sifting and sorting material according to key issues and themes (Arksey & O'Malley, 2005). To facilitate the data selection, the authors agreed to use a chart on which they noted all information that was considered useful. Two reviewers (authors KEPH and GJJWB) independently charted the data from each article, discussed the results and continuously updated the data chart in an iterative process. This data chart contained the following descriptive variables: author(s), year of publication, country of origin, research aim, research question, study population, sample size, research methodology, descriptions given by the author(s) of vital communities and key findings.

Collating, summarising and reporting the results

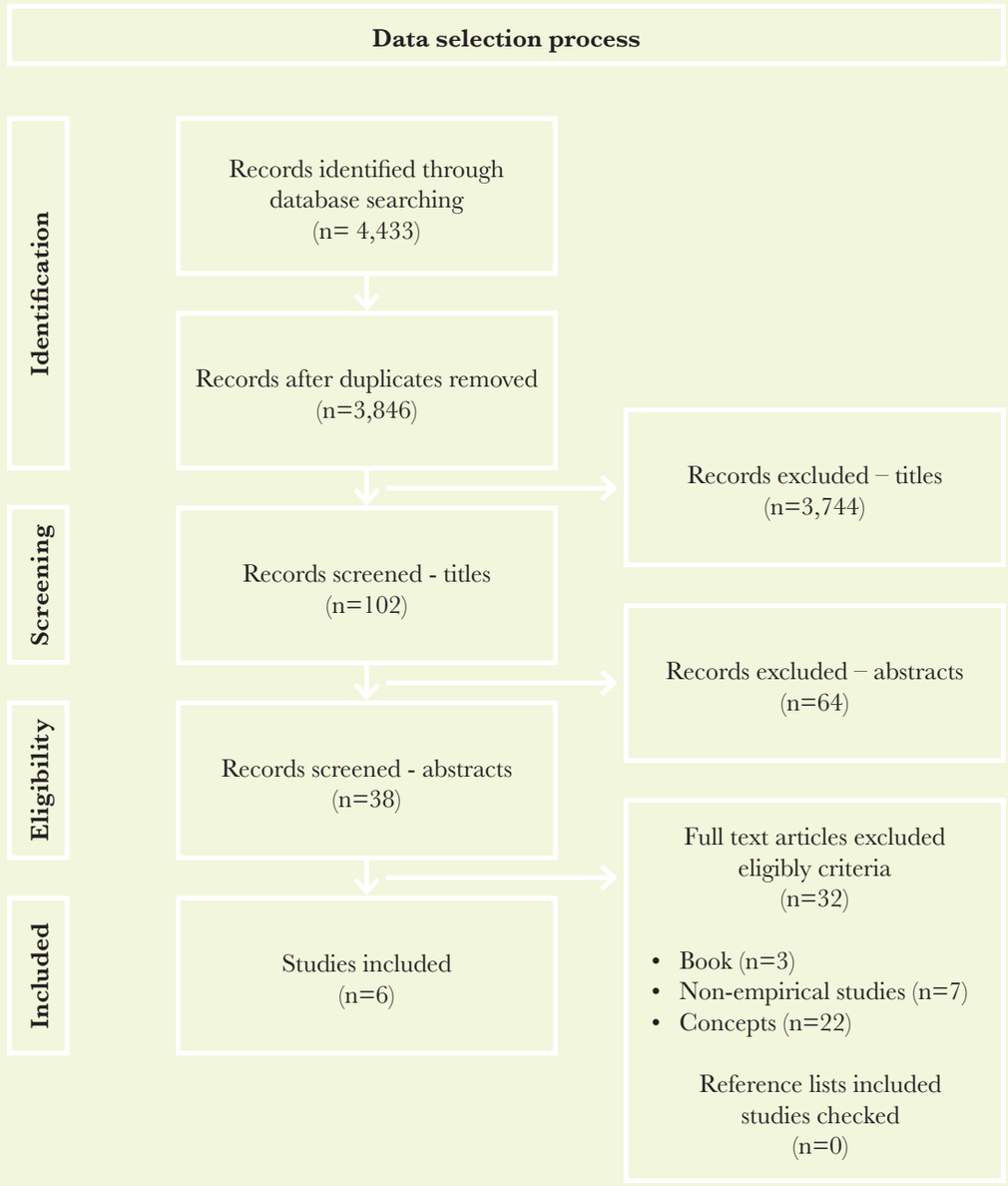
The fifth stage of a scoping review involves collating, summarising and reporting the results (Arksey & O'Malley, 2005). Focusing on the descriptions and the characteristics of vital communities, we applied a qualitative content analysis in which we used an open, axial and selective coding method (Levac et al., 2010). The data from the articles were inductively coded in Excel. With open coding, labels are linked to the fragments from stage four (e.g. charting the data). These labels summarise the core of the fragments. The coding scheme is refined by clustering codes together to make categories (axial coding) during the conceptualisation of similarities and differences in the codes. Conceptual saturation is reached when no new categories are generated from the open codes. The categories are then examined for their relationships to each other (selective coding) to add overarching categories.

Findings

Study characteristics

The four electronic databases and the search engine Google Scholar were searched on 23 March 2020 and updated on 6 January 2021 with no restrictions on publication dates. Based on the search, 4,433 articles concerning vital communities were identified.Next, 587 duplicate articles were removed. The titles of the remaining articles were then independently reviewed and 3,744 articles were excluded from the study based on their titles. Out of the remaining 102 articles, independent screenings of the abstracts led to 38 articles still being considered relevant. A final assessment of these articles, this time taking their full texts into account, left a final number of six relevant studies for the scoping review. An overview of the data selection process is shown in Figure. 1.

Figure 1.
Data selection scoping review vital communities



The selected articles were published between 2008 and 2020 and focused on the following different geographical locations: the United States (n = 4), Canada (n = 1) and Europe (n = 1). The studies centred on a research population of communities, key informants (e.g. federal and state government, philanthropy, national associations, regional/local health and ageing services organisations), outreach workers, residents and members of a service exchange programme. Different methodologies were used in the six selected studies: interviews (n = 2); survey (n = 1); secondary data analysis (n = 1); and meta-case study (n = 2). The study characteristics of the selected articles are shown in Table 3.

Table 3.
Study characteristics included research papers

Author(s) (Country, Year)	Study population (sample size)	Research method	Research aim and/or question	Key findings
Berman, J. J., Murphy-Berman, V., & Melton, G. B (2008, United States)	Outreach workers Community members Age: 20 or older Gender (male): 36% Gender (female): 64% (n=676)	Data analyses of the biweekly reports	To describe the work of the outreach staff in strong communities and to evaluate whether it conformed to the principles on which the initiative was based, as described in the introduction to this issue of *Family & Community Health*. Second, to provide future innovators with concrete ideas concerning whom they might approach and what kinds of activities they might suggest when they attempt the difficult task of transforming a community.	The results showed that strong communities have indeed penetrated into the target communities in diverse ways, engaging people of disparate backgrounds. The first years of the initiative showed the feasibility of engaging primary community institutions in a broad-based effort to enhance children's safety in their homes and the community at large. They indicated the importance of community gatekeepers and of seemingly 'natural' but actually constructed events and groups in facilitat-ing such efforts. 64% of the individuals named in the biweeklies were women. The 'typical' person who is central in an activity in Strong Communities is a woman, white, and be-tween the ages of 30 and 49.

Author(s) (Country, Year)	Study population (sample size)	Research method	Research aim and/or question	Key findings
Foster-Fishman, P. G., Pierce, S. J., & Van Egeren, L. A. (2009, United States)	Residents living in the seven poor neighbourhoods involved in YWC Age: 18 or older Gender (male): 23% Gender (female): 77% (n=205)	Survey	To examine the factors associated with citizen participation levels in resident leaders and followers in seven low-income neighbourhoods in one community.	Overall, the findings suggested that different factors facilitate participation in leaders and followers. Leaders are more likely to actively participate in neighbourhood and community affairs if they perceive themselves as having the skills needed to organise others and make change happen. Whereas perceived skill levels also matter for followers, these residents are strongly influenced by the norms for activism within their neighbourhood. These norms mediate the impact of neighbourhood readiness and the capacity for change on citizen participation levels.
Letcher, A. S., & Perlow, K. M. (2009, United States)	Members of a service exchange programme in an urban community Age: 23-84 Gender (male): 28% Gender (female): 72% (n=211)	In-depth interviews	To explore how diverse participants engage in a supportive network and proposes a theoretic model of community building for health promotion.	Four primary themes related to participation in the service exchange programme were identified: (1) motivation for participation; (2) service exchange, or reciprocity, as vital to the programme, with distinct benefits in a heterogeneous group; (3) occurrence of personal and community growth; and (4) health promotion and improved well-being. A model of how participation in the service exchange leads to community building is presented.
Altpeter, M. Schneider, E. C. Whitelaw, N. (2014, United States)	Key informants (e.g. federal and state government, philanthropy, national associations, regional/ local health and ageing services organisations) Age: not mentioned Gender: not mentioned (n=11)	Interviews	To learn how ageing and health collaborations created strategic partnerships to foster multi-sector systems change and pursue long-term goals and near-term activities to sustain and expand evidence-based health programming.	Four creative strategies emerged across sites as contributing to the growth and sustainability of evidence-based health programming including engagement of non-traditional partners, development of new relationships with health care, building of innovative systems of structures and tools, and systematically working with vulnerable populations.

Author(s) (Country, Year)	Study population (sample size)	Research method	Research aim and/or question	Key findings
Dale, A. Ling, C. Newman, L. (2010, Canada)	Canadian communities Age: not mentioned Gender: not mentioned (n=35)	Mixed-methods Meta-case analysis	To outline how community vitality acts as a cornerstone of sustainable development and suggests some courses for future research.	The analysis of the thirty-five case study communities revealed common features that can be deemed characteristic of community vitality: Community openness and trust Connection with people and place Continuity and stability of funding and leadership Perturbation Diversity
Machielse, A. Vaart, van der, W. (2020, The Netherlands)	Residents of 10 selected complexes in the Netherlands Age: 55 or older Gender (female): 76% Gender (male) not mentioned (n=405)	Mixed-methods Meta-case analysis	To explore the possibilities of residents in low-income housing complexes to improve the social quality in their complexes and to get insight into the need for professional support.	Results showed that the self-organising capacity of the residents is limited due to a lack of knowledge and organisational skills, and health problems. Improving social quality requires permanent attention from facilitating professionals, who guide the process and ensure continuity.

The results of the data analysis yielded only one definition of vital communities. We deduced that the conceptualisation of a vital community is based on three dimensions: the aim of a vital community, the processes behind a vital community and the typical characteristics of a vital community.

Definitions of vital communities

The results of the data analysis yielded only one definition of vital communities, by Dale et al. (2010), as follows:

A vital community is one that can thrive in the face of change. It is a place that can remain at its core a functional community without loss to ecological, social and economic capitals in the long run, whatever occurs as a result of exogenous changes beyond its control. And perhaps more importantly, it is a place where human systems work with rather than against natural systems and processes (p. 217, introduction).

Dimensions of vital communities

Three main dimensions of vital communities were identified: (a) the aim of a vital community (the 'why'), (b) the mechanisms behind a vital community (the 'how') and (c) the typical characteristics of a vital community (the 'what'). The first dimension describes the reasons for existence. The second dimension represents the processes behind a vital community. Finally, the third dimension represents the key characteristics of vital communities, in other words, the characteristics that make a community a vital community. The structure of the dimensions resulting from the data analysis is shown in Table 3.

Table 4.
Coding tree, dimensions of vital communities

Selective coding Dimensions of vital communities	**Axial coding**	**Open coding**
The aims of vital communities	To create beneficial partnerships	Creating mutually beneficial partnerships (Altpeter et al., 2014)
	To support programme expansion and cultural change	Building system of structure and tools, supporting programme expansion and cultural change (Altpeter et al. (2014)
	To reinforce the sense of belonging	Improving quality of life and sense of belonging (Letcher & Perlow, 2009)
	To reinforce the quality of life	Improving quality of life and sense of belonging (Letcher & Perlow, 2009)
Mechanisms behind a vital community	Strategies	Implementing creative strategies for growth and sustainability (Altpeter et al., 2014)
	Creativity and innovation	Stimulating community vitality through innovation and creativity (Dale et al., 2010)
	Community- and service exchange	Creating vital communities through community and service exchange, leading to relationships that in turn create community (Letcher & Perlow, 2009)
	Partnership	Pursuing innovation and creativity (thus vital communities) by secure and stable leadership and particularly private/public partnerships (Dale et al., 2010)
	Active participation	Stimulating active participants and volunteers (Berman et al., 2008)

Selective coding Dimensions of vital communities	Axial coding	Open coding
	Community capacity	Stimulating a sense of community by improving community capacity (relationship between neighbourhood readiness, capacity and citizen participa-tion) (Foster-Fishman et al., 2009) The self-organising capacity of the residents is limited due to a lack of knowledge and organisational skills (Machielse, Van der Vaart 2020)
	Community skills	Stimulating (citizen) participation by leadership, neighbourhood conditions and community skills (Foster-Fishman et al., 2009)
	Leadership and funding	Continuity and stability of leadership and funding (Dale et al., 2010)
	Perturbation	Maintaining the vitality of communities by perturbation. Perturbation stimulates innovation and creativity, leading to community action and vitality (Dale et al., 2010)
	External change	Enhancing vitality by external change (Dale et al., 2010)
Typical characteristics of a vital community	Personal and collective growth	Vital communities create environments of both personal and collective growth, fuelled by member engagement (Letcher & Perlow, 2009)
	Openness and trust	Vital communities are characterised by community openness, community trust and communication (Dale et al., 2010)
	Cohesion	Community vitality is related to the degree of community cohesion (Dale et al., 2010)
	Shared vision	Vital communities are characterised by a shared vision (Dale et al., 2010)
	Connection to people and place	Vital communities are characterised by connection to place (generally not the built environment, but the people and the social capital in the specific location) (Dale et al., 2010)
	Engagement, involvement and empowerment	Vital communities are characterised by the engagement of members (Berman et al., 2008), the involvement of various demographic groups (Berman et al., 2008), the involvement of community sectors (Berman et al., 2008) and by the engagement and empowerment of vulnerable populations (Altpeter et al. 2014)
	Resilience	The heuristics of community vitality are resilience, innovation and adaption (Dale et al., 2010)
	Sustainment, growth and advocacy	Vital communities are characterised by the needs and opportunities for sus-tainment, growth and advocacy (Altpeter et al., 2014)
	Diversity	Diversity is a basic component of community vitality (Dale et al., 2010)
	New collaborations	Vital communities are promoting new collaborations with broader missions (Altpeter et al., 2014)
	Adaption	The heuristics of community vitality are resilience, innovation and adaption (Dale et al., 2010) Vital communities support organic development and adaption (Altpeter et al., 2014)
	Benefits from participation	The benefits of participation in community exchange range from access to affordable services, to meaningful relationships, to community mobilisation (Letcher & Perlow, 2009)

The aim of a vital community

Two of the six studies included described the aim of a vital community: Altpeter et al. (2014) discussed vital communities as aiming to create beneficial partnerships in order to support programme expansion and cultural change, while Letcher and Perlow (2009) described these communities as aiming to reinforce their members' sense of belonging and quality of life. According to Altpeter et al. (2014), vital communities seek to create mutually beneficial partnerships with health care organisations by building strong partnerships with community care partners. The purpose of vital communities is to build systems of structures and tools to support programme expansion to make permanent impacts. Letcher and Perlow (2009) found that vital communities reinforce the improved well-being of their members. They also identified members' sense of belonging to a community and improved perceived quality of life. Moreover, as members developed a supportive network, they enhanced their resilience in times of stress.

Mechanisms behind a vital community

Five of the six studies included described the mechanisms behind a vital community that influence its vitality. The mechanisms found were the following: (a) creative strategies, creativity and innovation, (b) partnership, community and service exchange and active participation, (c) community capacity, community skills, stable leadership and funding and (d) perturbation and external change.

Creative strategies, creativity and innovation

Developing and implementing creative strategies ensures the growth and sustainability of a vital community. According to Altpeter et al. (2014), creative strategies facilitate the development of mutually beneficial partnerships and service exchange, empowering vulnerable people and building systems of structures and tools to support programme expansion and cultural change in order to make permanent impacts. Dale et al. (2010) identified creativity and innovation as two other mechanisms that stimulate the vitality of a community. For example, they highlighted evidence that minority opinions stimulate creativity and divergent thoughts, which can result in innovation during participation.

Partnership, community and service exchange and active participation

Dale et al. (2010) found that (particularly private and public) partnerships expand the public sphere to pursue innovation and creativity, leading to community vitality. Letcher and Perlow (2009) noted that community and service exchange lead to relationships with mutual benefits that in turn create a sense of community. The benefits of service exchange include inclusion, individuals taking on new roles, respect and appreciation for others and a network of friends. Exchange allows those who have been socially isolated or stigmatised to build relationships. Community members like having a network of partners who are willing to build such relationships. Indeed, they like having a team and working together to offer reciprocal instrumental and social support, without distinguishing those who give from those who need services. Exchange also encourages people to take on new roles. As members stretch themselves to honour the community's expectation of reciprocity, they learn to respect others. Relationships emerge out of a network where everyone has opportunities to give and receive and to be recognised for their contributions. Service exchange allows members to get to know each other based on sharing. Members joining community exchange may be motivated instrumentally. Furthermore, some members perceive their current participation in a community as an investment in social capital or as an 'insurance' policy that gives them the confidence that help will be available to them in the future. Vital communities need highly active participants and a body of exceptional volunteers as kick-starters and endurance power (Berman et al., 2008). In Berman et al.'s study, the most active participants were not elected officials, corporate leaders or the individuals named to relevant citizen boards but rather those who could easily leverage the resources of a particular community institution and who were committed community servants.

Community capacity, community skills, stable leadership and funding

Vital communities create strong relations that promote community readiness and capacity. For example, Foster-Fishman et al (2009) found strong support for their hypothesis that activism norms would mediate the relationship between community readiness and capacity and citizen participation. Their study also showed that the organising skills of a vital community represent a strong direct predictor of citizen participation. According to a study of Machielse and van der Vaart (2020), the self-organising capacity of community members is limited due to a lack of knowledge and organisational skills, and health problems. Other research indicated that vital communities need community leaders and gatekeepers to work in a complementary manner. For example, Dale et al. (2010) showed that vital communities require substantial organisational skills, these being crucial to participation. This study also showed that men in vital communities often provide long-term direction while women take care of day-to-day leadership. Stable and secure leadership is important and expands the public sphere to pursue innovation and creativity. In addition, Dale et al. (2010) demonstrated that stable and secure leadership is directly linked to community vitality. The continuity of funding was identified as a key element in protecting the leadership from the constant stress of fundraising and related burnout. This in turn

allowed for the stability of leadership, as the core group was maintained. Such stability is often severely lacking in civil society organisations, especially in grassroots and smaller groups.

Perturbation and external change

Dale et al. (2010) found that perturbation and stability are also important, as change inhibits vitality. They identified a possible link between the degree to which a community is stable and can respond to change on the one hand and its functional social diversity on the other. If perturbation occurs in such a way, that it maintains core stability, then it actually stimulates vitality. In other words, perturbation may promote the resilience of a community: the community is stable and able to respond adequately to perturbation. It seems clear that perturbation is needed to stimulate action and, in some cases, vitality. Changes are necessary, with the key element being to build redundancy at the local level alongside resilience as a buffer, especially for coping with exogenous shocks so that change does not prove catastrophic. This reinforces the importance of both variables for sustainable community development, as change helps enhance vitality, assuming that vitality and sustainable development are linked (Dale et al., 2010).

Typical characteristics of a vital community

The third dimension of a vital community is its typical characteristics, defined as typical or noteworthy qualities. According to the outcomes of the previous studies, such characteristics make a community a vital community. We have arranged these characteristics on three levels: (a) individual, (b) collective, that is, all members together and (c) the vital community as an entity.

Individual characteristics

We can note the following individual characteristics of community members: attachment to place, engagement, involvement and empowerment. Vital communities are based upon connections between people and attachment to place. A sense of the meaning of the place within the community stimulates community attitudes and values. Attachment to place is manifested less in terms of the built environment and more with the people and the social capital that exist in the specific location, developed through networks of empowerment (Dale et al., 2010). Engaging, involving and empowering individuals provides the essence of a vital community. According to Berman et al. (2008) participant involvement is a key characteristic. In a project that seeks to facilitate community change, it is important to understand the quantity and the type of people involved. Moreover, Altpeter et al. (2014) argued that through community

initiatives, a vital community systematically engages and empowers vulnerable people to address older adult health and well-being.

Collective characteristics

The identified collective characteristics of a vital community are community cohesion, resilience and diversity. A vital community is characterised by cohesion. According to Dale et al. (2010), it is plausible that community vitality is related to the degree of community cohesion and that there may be an integral relationship between adaptive governance, stability and community vitality. The results of Dale et al.'s study additionally distinguish three heuristics of community vitality: resilience, innovation and adaption. Resilience is a function of the social networks that form part of a community and can be measured by indicators such as variability of income, stability of livelihoods, wealth distribution, demographic change and agency. Vital communities require sustainment, growth and advocacy (Altpeter et al. 2014). Diversity is one of the basic characteristics of community vitality and ensures the sustainable development of a vital community (Dale et al., 2010). It is a basic characteristic because of complementarity in the group: relationships within the network create an environment of both personal and collective growth that is fuelled by member engagement. In Letcher and Perlow's (2009) study, several respondents described the emerging leaders who were engaged in activities that would strengthen the group as a whole (e.g. recruiting new members, developing programmes, offering classes, organising events). The entire network can become stronger as more members begin to engage in complex tasks together, ranging from organising meals and leisure activities to gathering a community of help when required by people. Community exchange thus establishes a powerful mechanism for social engagement or, as one member explained, a way of 'having a stake in the community' (Letcher 2009, p. 296).

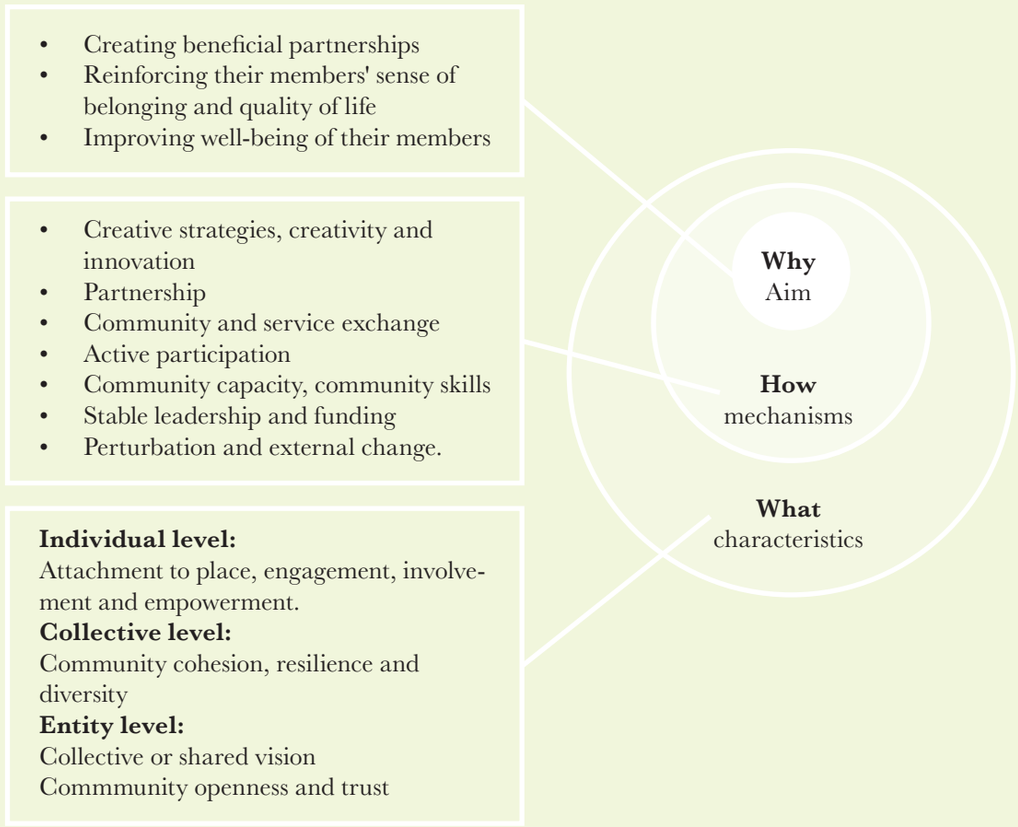
Vital communities as an entity

We can also note the characteristics of a vital community as an entity. These include having a collective or shared vision and community openness and trust (Dale et al., 2010). Having a collective vision brings newcomers and the core community together, resulting in increased community vitality. The second typical characteristic of a vital community as an entity is community openness and trust. In terms of vitality, Dale et al. (2010) showed that communities are stronger and more sustainable when there is community openness and trust. Community openness also enables and facilitates transdisciplinary cooperation between community members. According to Altpeter et al. (2014), vital communities create new collaborations between broader target groups and broader missions. In their study, sites developed new collaborations extending beyond their established ageing service partners. Furthermore, in Letcher and Perlow's

(2009) study, the community members described the benefits of participating in community exchange, ranging from having access to affordable services to meaningful relationships and, finally, to community mobilisation. Indeed, members can help reduce the barriers to care by providing services such as transportation to medical appointments and respite care for families.

Given the complex and multidimensional nature of the concept of vital communities, a visual representation of the narrative is given in Figure. 2.

Figure 2.
Visual representation of the narrative of vital communities



Discussion

This scoping review was performed to gain greater insights into the different descriptions, dimensions and characteristics of the concept of vital communities, based on previous empirical research. The study demonstrates one definition and three dimensions that are largely congruent with the concepts and meanings of vital communities. Specifically, we have identified three dimensions of vital communities: (a) the aim of a vital community, (b) the mechanisms behind a vital community and (c) the typical characteristics of a vital community.

Altpeter et al. (2014) discussed vital communities as aiming to create beneficial partnerships in order to support programme expansion and cultural change by creating mutually beneficial partnerships with health care organisations, by building strong partnerships with community care partners. This aim differs from the aim of a Senior Friendly Community (SFC), framed by Schichel (2020) as focussing on older people's public health, well-being and quality of life. In addition, the author's opinion is that in a vital community the mutual exchange of giving and receiving support is key, while in a SFC one-way traffic (the community and environment being senior friendly) is dominantly present. However, the mechanisms we found within communities that influence the vitality of these communities in order to achieve their shared goals, are remarkably comparable. The essence of these mechanisms exists in both variants of: (a) increased use of local skills and knowledge; (b) strong (mutual) relationships and communication; (c) taking the initiative and showing responsibility and adaptability; (d) the existence of sustainable, healthy ecosystems; and (e) varied and healthy economies (Flora, 1998). The findings of these reviews and the findings of Flora (1998) contradict to the more practical and critical factors, stated by the MetLife Mature Market Institute (2014). According to this institute, most important critical factors are accessible and affordable housing, safe neighbourhoods, the presence of healthcare (programs), home and community-based caregiving support services, retail outlets, programs and organisations that promote social activities and intergenerational contact, senior transportation programs, and walkable neighbourhoods. In summary, a vital community focuses more on mutual relations and support, while SFC focuses more on the tangible aspects. It would be interesting for future research to find out if, how and to what extent these two concepts can reinforce each other. Additionally, the structure of a vital community seems to be of minor importance, because our results have demonstrated, no typical characteristics of a vital community were found, with regard to the structure. Although one may assume that vital communities share the characteristics of social networks, in reality they may be made up of numerous people and explicit common goals or shared interests. It would be of interest to investigate the similarities and differences between vital communities and social networks in future research.

We may highlight Dale et al.'s (2010) definition of a vital community as a community that can thrive in the face of change. Dale et al. (2010) assume that a vital community is a physical place. However, today one can also question whether a vital community might exist virtually. The current Covid-19 pandemic could be an interesting external threat of a vital community. Perturbation is listed as a mechanism influencing the vitality of vital communities and it would be of interest at some point in the future to assess what impact the pandemic has on the sustainability and resilience of vital communities.

Strengths and limitations

This scoping review has several strengths. First, we used a comprehensive search strategy across multiple databases and a search engine with no date restrictions. This minimised the risk of missing scientific studies about vital communities. Second, to enhance trustworthiness, the process of selecting studies and extracting charting data was done independently by two reviewers (Levac et al., 2010). Nevertheless, the search conducted for this study may have also been subject to certain limitations. First, in our search strategy, we used a combination of keywords, but a vital community is a broad concept encompassing varied terminology. It is possible that we missed studies using other terms with similar meanings. In an effort to limit the negative implications of this issue, we checked reference lists. Second, we limited our search to quantitative and qualitative empirical studies, systematic reviews, meta-analyses, meta-syntheses and scoping reviews. As a result, we may have missed some descriptions of vital communities. However, we were especially interested in the ways in which vital communities have been described in previous empirical studies. The six studies included are from Europe, Canada and the United States. We did not find information concerning vital communities in other regions. There may be information in the grey literature, or vital communities may exist under other terms.

Conclusions and implications

For this study, we formulated the following research question: 'What is the meaning of the concept of vital communities and what descriptions, dimensions and characteristics have been distinguished in the scientific literature?' The concept of vital communities is broad and has only been defined in one empirical study. The analysis of the six studies included here has shown that three dimensions can be distinguished: (a) the aim of a vital community (the 'why'), (b) the mechanisms behind a vital community (the 'how') and (c) the typical characteristics of a vital community (the 'what'). If we want to understand the importance of vital communities and incorporate them into society, we must focus on the aim, the mechanisms and the characteristics. Therefore,

health care professionals, researchers and community workers may consider the following questions:

- What do community members want to achieve at the individual level or at the level of the community?
- Through which processes and underlying mechanisms can these goals be achieved, and which characteristics at the individual, group and entity levels should therefore be promoted or developed?

Consequently, further research into the relationship between the three dimensions of vital communities is recommended. In addition, it is recommended that (local) government, health care organisations, service providers, housing corporations, neighbourhood associations, community workers and other community stakeholders unite and seek opportunities for collaboration and cooperation. Further research is also recommended into the relationship between vital communities and ageing in place in order to ensure meaningful and effective support that can be of complementary interest for older people's quality of life while ageing in place.

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Chapter 4

Towards consensus according to experts on the theorised contribution of vital communities to successful ageing in place: a modified Delphi study

This chapter was submitted as:
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Towards consensus according to experts on the theorised contribution of vital communities to successful ageing in place: a modified Delphi study

Abstract

Older people value their independence and prefer to live in the environment they are familiar with, and can benefit substantially from vital communities. The objective of this study is to explore the theorised contribution of vital communities to successful ageing in place, as increasing numbers of older people in western societies, are living longer independently at home, while their need for support gradually increases. A modified Delphi study was conducted, and consisted of two stages. In the first stage, we carried out two panel discussions in order to develop statements representing the theorised contribution of the features of vital communities to the key themes of ageing in place. This was followed by the second stage which had three online Delphi rounds, and which aimed to reach a consensus among 126 international experts concerning the theorised contribution. The findings of this study showed a consensus among the experts about aspects that show the positive contribution with regard to the aim of vital communities (quality of life, belonging), and all the key themes of ageing in place (place, technology, social networks, support, personal characteristics). However, experts nuanced the theorised contribution of the mechanisms and typical characteristics of vital communities and the key theme of technology. According to the experts, whether technology contribute depends on the skills of older people and the type of technology. The findings of this study imply that vital communities could facilitate older people to age in place for as long as possible, while maintaining their quality of life.

Introduction

The world's population is ageing rapidly. Western societies are experiencing growth in the number and proportion of older people in their population. According to data from World Population Prospects (The United Nations (UN), 2019), one out of six people in the world (16 per cent) will be over the age of 65 by 2030. With the increase of older people and longevity in the world, ageing in place has become an important policy issue for governments and healthcare organizations (Thoma-Lürken et al., 2018; Yalcinoz et al., 2020). Along the same lines, the preference of older people themselves to age in place is widely recognized. Most older people value their independence, and prefer to live in the environment they are familiar with (Machielse, 2016; Vermeij, 2016), as this may positively contribute to maintaining a sense of self-reliance, self-management, and self-esteem (Milligan, 2012). 'The ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level', is defined as ageing in place (Centers for Disease Control and Prevention (2019). Grimmer et al. (2015) stated that ageing in place is mostly about the opportunity for older people to remain in their own community for as long as possible without having to move to a long-term care facility. Horner and Boldy (2008, p.: 356) defined

ageing in place as a 'positive approach to meet the needs of the older person, supporting them to live independently, or with some assistance, for as long as possible.' In different terms, ageing in place involves developing services and facilities that will allow a person to stay in their home or chosen environment for as long as they are able (Tobi et al., 2017).

In a scoping review, Pani-Harreman, Bours, et al. (2021) described five key themes related to the concept of ageing in place, including place, technology, social networks, support, and personal characteristics of older people. These five key themes consist of different aspects. For example, the key theme 'social network' includes: the relationship to living arrangements (Doblas, 2018), active ageing, engagement, participation (Dobner et al., 2016), and the importance of being a part of a community (Sixsmith & Sixsmith, 2008). Many older people gradually need more support to sustain their quality of life if they grow older. This support can be delivered by formal care combined with informal support. According to a study by Van Bilsen et al. (2006), social networks and social participation are key resources of care needs for older people who are ageing in place. In most cases, informal care is provided by family members, neighbours, friends, and the community they belong to (Camp et al., 2021). These informal carers are the main providers of light housework, shopping, social support, and financial support (Wilkinson-Meyers et al., 2014). According to a study by Fung (2020), informal social networks are resources that contribute to the quality of life of older people who are ageing in place.

Going beyond informal social networks, older people could substantially benefit from vital communities (Fung, 2020). Although one may assume that vital communities may share characteristics of social networks, communities may consist of many more people than networks, and may have explicit common goals or shared interests. Webber (2016) distinguished four different types of communities: (a) communities of interest, consisting of people who meet around a shared passion; (b) communities of place, consisting of people who have a connection through the area in which they live; (c) communities of action, consisting of people who gather around a cause or specific event; and (d) communities of practice, consisting of a group of people that act on an ongoing basis to develop their knowledge of a common interest by sharing individual resources, and by engageing in critical dialogue.

In a recent scoping review Pani-Harreman, Van Duren, et al. (2021) identified three main dimensions of vital communities: (a) 'Why', referring to the aim of a vital community); (b) 'How', referring to the mechanisms behind a vital community; and (c) 'What', referring to the typical characteristics of a vital community. The authors of this study defined a vital community as an entity with active, strong mutual social ties and inclusive relationships between residents, the private sector, the public sector, and civil

society. Based on a shared vision, openness, and trust it is able to cultivate and bundle relationships, and create an environment that can adapt and prosper in an ever-changing world, thus improving the individual and collective wellbeing of its member (Pani -Harreman, Van Duren, et al., 2021).

Knowledge about the support of older people while ageing in place by vital communities is scarce. A more thorough understanding of the theorised relationship between vital communities and ageing in place provides valuable information to healthcare professionals, governments, and community workers in the development of policies that suit the needs of older people. Therefore, the objective of the present study is to explore the theorised contribution of vital communities with regard to successful ageing in place. We have therefore formulated the following research question: What features of vital communities contribute to successful ageing in place, according to experts in the field of vital communities and ageing in place?

Methods

Design

A modified Delphi study was conducted between July 2020 and February 2021. The modified character of this study consists of adding panel discussions in preparation for the Delphi rounds. The Delphi technique is a widely used method to reach a consensus among experts by making use of several rounds of opinion collection and feedback (Hasson et al., 2000). Our modified Delphi study consisted of two stages. In the first stage, we carried out two panel discussions to develop statements that represent the theorised contribution of vital communities on successful ageing in place. In the subsequent second stage, three rounds of online questionnaires were completed using an online survey program (Enalyzer A/S, Copenhagen, Denmark).

Participants

Fourteen panellists were selected using a purposeful sampling method for stage one (Benoot et al., 2016). The panellists represent older people living at home and experts in the field of vital communities and ageing in place. Inclusion criteria for the panellists were expertise and experience in research and/or practical experience in the field of vital communities and/or ageing in place. Panellists must appear in the stakeholder framework used: 'who is who in the Neighbourhood' (Beter Oud, 2018). This framework aims to provide insight into the most important stakeholders in the field of support and care for older people.

For stage 2 (rounds 1–3), 126 experts in the field of vital communities and ageing in place were purposefully selected. The inclusion criteria were either (a) the first author (considered as researcher) and last author (considered as overall supervisor) of the included articles of previous scoping reviews regarding vital communities and ageing in place (Pani-Harreman, Bours, et al., 2021; Pani-Harreman, Van Duren, et al., 2021); or (b) experts of vital communities and ageing in place based on purposeful sampling (Benoot et al., 2016). Inclusion criteria included: (a) working in the areas of research or education, or healthcare or welfare, or the respective government agencies or knowledge institutes; (b) an education level of PhD, master's, bachelor's, or high school/ secondary education; and (c) more than one year of working experience in the field of vital communities and ageing in place. All identified experts (n = 126) were invited by email to participate in the Delphi study. The invitation also included a direct link to the first online questionnaire.

Stage 1: Panel Discussions to Develop Delphi

The objective of the panel discussions was to develop statements that show the theorised contribution of vital communities' successful ageing in place. The outcomes of the scoping reviews concerning vital communities and ageing in place (Pani-Harreman, Bours, et al., 2021; Pani-Harreman, Van Duren, et al., 2021) served as input for the discussion and development of these statements. The panellists were informed about the results of these scoping reviews, and were then led by a moderator on a discussion of the theorised contribution of the three dimensions of vital communities and the five key themes of ageing in place.

Stage 2: Delphi Rounds

The objective of stage 2 was to obtain consensus among experts on the theorised contribution of vital communities on successful ageing in place (represented by the statements). The web-based survey process comprised three rounds, each round taking approximately one month to administer. This administration period included the following activities: (a) delivery of the questionnaire, including reminders to the participants after two weeks; (b) analysis of the results; and (c) compilation of a new questionnaire that included the comments that were collected in the previous Delphi round. The purpose of the first Delphi round was to build a consensus on the theorised contribution. The purpose of the second Delphi round was to build preliminary consensus about the uncertain items of the first Delphi round. Finally, the third Delphi round was used to evaluate the results of rounds 1 and 2, and to re-evaluate whether the experts confirmed their answers.

In the first round, the final list of 15 statements (developed during stage 1) that show the theorised contribution of vital communities on successful ageing in place was presented. Each statement (Table 1) was rated on a ten-point Likert scale where 1 = strongly disagree and 10 = strongly agree. Interdependencies were identified as relevant

and/or important when they had a median of 7–10 and an interquartile range (IQR) of ≤ 2 (Keeney et al., 2011). Aspects with a median of 1–5 and an IQR ≤ 2 were considered as irrelevant and excluded. The remaining aspects (median = 6) were considered uncertain and rated again in the next Delphi round. There is no hard cut-off for the level of agreements in Delphi studies (Jorm, 2015). However, Hsu and Sandford (2007) and Feo et al. (2018) have argued previously that 70 per cent is an adequate level of agreement; therefore, we stated that the aspects had to be accepted by at least 70 per cent of the participants. During the second Delphi round, the aspects that were rated as uncertain were rated again using a binary answer option (relevant item versus no relevant item). At least 70 per cent of the participants had to rate an item as relevant to be included. Each participant who did not support the relevance of the uncertain aspects was given an opportunity to provide a reason why. In the last (evaluation) round, experts were provided with the panel's responses as an attachment in the invitation email for the third Delphi round, and were asked to re-evaluate and confirm their answers with the results of rounds 1 and 2. In addition, the experts were also asked to re-evaluate the reasons for rejection of the uncertain statements in round 2.

Analysis

Stage 1: the output of the panel discussions consisted of data derived from the recording of the discussion and minutes taken. The discussions were transcribed, and the transcriptions were analysed by using the directed content methodology (Armat et al., 2018; Hsieh & Shannon, 2005). The applied codes were the five key themes of ageing in place (place, technology, support, social networks, personal characteristics) (Pani-Harreman, Bours, et al., 2021) and the three dimensions of vital communities (the aim, mechanisms, and typical characteristics) (Pani-Harreman, Van Duren, et al., 2021). Two researchers conducted the analysis of stage 1. If no consensus was reached, a third researcher was consulted. The analysis of stage 1 yielded 15 statements. These statements were submitted to the panellists for a final member check. Panellists were asked if the statements were in line with the conversations that occurred during the panel discussions.

The analysis of stage two (frequencies, median, and interquartile range) of the Delphi rounds was conducted using SPSS version 25 (SPSS Inc., Chicago, IL, USA). Incomplete questionnaires were not included in the analysis because relevant data was missing in these questionnaires. Open answers of rounds 2 and 3 were analysed by the directed content methodology (Armat et al., 2018; Hsieh & Shannon, 2005).

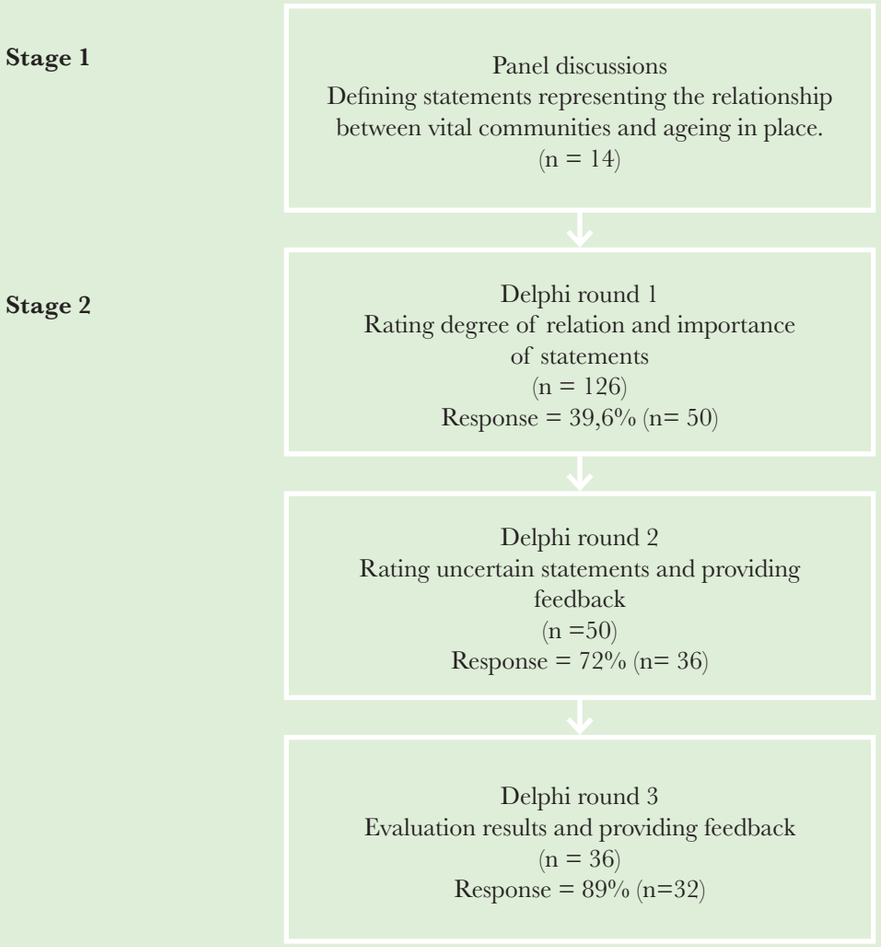
Results

Characteristics of the Panellists and Experts

In stage 1, fourteen unique panellists participated in the two panel discussions; there were seven panellists in each panel. In total, two of the panellists worked in the research sector, seven in the healthcare sector, one in the housing sector, two in the welfare sector, and one person represented older people ageing in place. The panel discussions resulted in 15 statements that theorised that vital communities might contribute to successful ageing in place.

In stage 2, 50 out of the 126 eligible experts consented to participate in the Delphi study, which corresponds to a response rate of 39.6%. In total, 47 per cent of the experts were working in the research and education sector, 14 per cent work in healthcare and government agencies, respectively, 9 per cent in the consultancy sector, 2 per cent in the welfare sector, and 14 per cent in a knowledge institute. In total, 56 per cent of the experts had a PhD, 35 per cent had university-level education, and 9 per cent had a bachelor's degree or high school education. Sixty-five per cent of experts had more than 10 years of experience in their current positions. The experts originated from eight countries: the Netherlands (N = 36), the United States, (N = 4), Spain (N = 2), New Zealand (N = 2), Canada (N = 1), Slovenia (N = 1), Scotland (N = 1), and Germany (N = 1). For the study flow, see Figure 1 'Study flow stage 1 and 2'.

Figure. 1
Study flow stage 1 and 2



Delphi Round 1

In the first round, 43 out of 126 experts (34 per cent) completed the online questionnaire. Seven (14 per cent) of the questionnaires were incomplete, and were not included in the analysis of the submitted statements because of the missing of relevant data. There was a consensus among experts for 11 out of 15 statements (Table 1). These 11 statements reflected the theorised contribution concerning the aim of vital communities and all five key themes of ageing in place (place, technology, social networks, support, and personal characteristics of older people). Four statements concerning the theorised contribution of the mechanism to promote vitality, typical characteristics of vital communities, and technology were scored as uncertain, and had to be rated again in Delphi round 2.

Delphi Round 2

In the second round, 36 out of 43 (83.7%) participating experts that responded in round one completed the questionnaire. In addition to the relevant contributions identified in Delphi round 1, there was a consensus among experts about one additional statement, namely the contribution of supportive technologies and active participation in a social network, such as video calling to help older people living in their own home to maintain meaningful social contacts. As shown in Table 1, no consensus was reached among experts about three statements.

Statement 8: 'Technology makes giving and receiving support possible and easier for older people living in their own home' was rejected because, according to ten experts, whether technology makes giving and receiving support possible and easy depends on the skills of older people to be able to use the technology. The type of technology also plays a role in this (n = 5). Three experts indicated that giving and receiving support is possible and easy depending on the type of support.

Statement 13: 'Participation in community activities by older people living in their own home is stimulated by good online communication' was rejected because, according to seven experts, whether participation in activities is stimulated by good online communication depends on the skills of older people to use online communication tools. Five experts indicated that it is not good online communication that stimulates older people to participate, but the environment, the community, and the kind of activities that are organized. One expert argued that online communication is not a substitute for physical activities.

Statement 15: 'A large diversity in the composition of a community leads to a more independent life for older people living in their own home' was rejected because,

according to seven experts, whether older people led a more solitary life depends on the personal characteristics of older people, and has less to do with the diversity in the composition of the community. Experiencing insecurity in the community can also lead to a more solitary life for older people, according to two experts. Four experts answered that the type of diversity is important. Nine experts indicated that, in their opinion, there is no link between diversity in the composition of the community and the solitary life of older people living at home.

Table 1.
Results Delphi round one and two, percentage of consensus on the statements representing the contribution of vital communities to successful ageing in place

Statements	Consensus Round one	Consensus Round two	Median IQR
1: The quality of life of older people living in their own home is promoted by a safe residential environment.	90.7%		9 8/10
2: A feeling of attachment to the place where you live is of great importance for older people living in their own home.	93%		9 8/9
3: Supportive technology, such as video calling, helps older people living in their own home to maintain meaningful social contacts.	65.2%	80.6%	7 6/9
4: The experienced quality of life is positively influenced when older people living in their own home participate actively in the community.	88.4%		8 8/10
5: Older people living in their own home who give support to and receive support from others feel more connected with the community.	97.7%		9 8/9
6: The community can contribute to the experienced quality of life, even in the case of older people living in their own home who are in a vulnerable position.	100%		9 8/10
7: Senior friendly adaptations in the neighbourhood increase the possibilities of being active in the community for older people living in their own home.	86%		8 7/10
8: Technology makes giving and receiving support possible and easier for older people living in their own home.	65.1%	58.3%	7 6/9
9: Helping and being helped stimulates the interaction in the community for older people living in their own home.	90.7%		8 8/9
10: Neighbours promote the active participation of older people living in their own home when they attend activities together.	97%		8 7/10
11: Good cooperation between formal and informal organisations promotes the quality of support for older people living in their own home.	93%		9 8/9
12: Older people living in their own home who take the initiative experience more social interaction.	95.3%		9 7/10
13: Participation in community activities by older people living in their own home is stimulated by good online communication.	42%	61.1%	6 5/7
14: For older people living in their own home, having trust in the community is a pre-condition of being able to accept informal support.	81.4%		8 7/9
15: A large diversity in the composition of a community leads to a more independent life for older people living in their own home.	39.5%	41.7%	6 4/8

Delphi Round 3

During the third round, we presented the results of rounds one and two. Eighty-nine per cent (32 out of 36) of the participating experts completed the questionnaire. Eighty-eight per cent of the experts confirmed that they agree with the results of the first two rounds, with a median of 8 (IQR 6.75/8). For the additional comments of the experts, see Table 2.

Table 2.
Additional comments from experts, round 3 re-evaluation and reasons for rejection of the uncertain statements in round 2.

n = 36 Response = 32 (89 %)

N	Additional comments (and/or)
13/26	I agree with the results.
9/26	The formulation of the statements provides little opportunity for nuance.
5/26	Other (method, process, inapplicable)

Participants were provided with the panel's responses, and asked to evaluate the given reasons for rejection. For the results of this evaluation, see Table 3.

Table 3.
Re-evaluation of results: stated reasons for disagreements by the participants

n = 43 Response = 32 (74.4%)

Which of the arguments below do you agree with? Multiple answers are possible.	**True**	**False**	**Missing**
8: According to the panellists, whether technology makes giving and receiving support possible and easy depends on:			6.3%
• the skills of older people to use technology	87.5%	6.3%	
• the type of technology used	68.8%	25.0%	
• the type of support (instrumental, emotional)	50.0%	43.8%	
• the form of contact (direct, physical, online)	50.0%	43.8%	
• other:	18.8%	75.0%	
13: According to the panellists, whether the participation of older people in community activities is encouraged by good online communication depends on:			6.3%
• the skills of older people in using online communication technology	75.0%	18.8%	
• not good online communication technology, but the environment, the community, and the kind of activities that are organized encourages older people to participate in activities	50.0%	43.8%	
• other:	25.0%	68.8%	
15: According to the panellists, whether a great diversity in the composition of a community leads to a more solitary life for elderly people depends on:			6.3%
• the personal characteristics of older people	78.1%	15.6%	
• not diversity, but experiencing insecurity in the community can lead to a more solitary life for older people	43.8%	50.0%	
• the kind of diversity	59.4%	34.4%	
• other:	15.6%	78.1%	

Discussion

The findings of this modified Delphi study demonstrated that vital communities might contribute to successful ageing in place. After all, there was a consensus among the participating experts for about on average 80 per cent of the statements. This applied in particular to the contribution of a vital community to the place, support, and social networks themes. No consensus was reached about the theorised positive contribution of technology and the mechanisms and typical characteristics of vital communities. According to the experts, the use of technology does not promote reciprocity and active participation in a social network. This result probably reflects the gap between theory and practice because technology and communication tools can no longer be ignored in the context of ageing in place (Silvius et al., 2020; Van Hoof & Marston, 2021). According to the participants of this Delphi study, the main reason for rejection is that the added value of technology depends on the skills of older people to use technology. This is also found in other studies that demonstrate a lack of skills concerning the adoption of technology among older people (Berkowsky et al., 2017; Hargittai et al., 2019). On the other hand, other research shows that technology, such as an accessible computer system aimed to improve communication, interaction, and participation, reduced loneliness, and increased perceived social support and wellbeing of older people (Czaja et al., 2018). In addition, the use of technology for successful ageing in place will depend on purposeful alignments in the technical, organizational, and social configuration of support, rather than the skills of older people using technology (Procter et al., 2014). Literature concerning technology to support ageing in place is scarce (Ollevier et al., 2020). We therefore recommend further in-depth research that investigates the added value of technology in relationship to reciprocity and active participation in a social network.

Results of this study further demonstrate that according to some experts, there was no link between diversity in the composition of the community and the solitary life of older people living at home. Whether older people led a more solitary life depended on the personal characteristics of older people and had less to do with the diversity in the composition of the community. However, the findings of a systematic review showed that programme-based intergenerational interactions express positive associations with older adults' physical health, psychosocial health (e.g. reduced depression), cognitive function, social relationships, and wellbeing/quality of life (Zhong et al., 2020). Moreover, engagement in intergenerational activities was linked with increased physical and social activities (Zhong et al., 2020). It would be of interest to conduct further research regarding the relationship between the demographic composition of vital communities and the personal characteristics of older people.

It may be of interest to discuss our findings concerning the contribution of vital

communities to successful ageing in place more in detail. While vital communities may facilitate ageing in place, age-friendly communities are also key sources of support, and contribute to the wellbeing of older people who are ageing in place. Age-friendly communities (a) provide health, recreational, and socialization opportunities; (b) encourage civic engagement; (c) improve accessibility of the built environment; and (d) increase access to services that help older residents to meet basic needs (The World Health Organization, 2007). In addition to age friendly communities, social networks are also sources of support, and contribute to the wellbeing of older people who are ageing in place (Gardner, 2011; Vos et al., 2020) . As supported by other studies, social networks contribute to ageing in place, both directly as providers of social support and Instrumental Activities of Daily Living (IADL) (Burt, 1997; Camp et al., 2021; Kahn & Antonucci, 1981), and more generally as enablers of health and wellbeing (Berkman, 2000; Cornwell & Laumann, 2015; Huber et al., 2016). The question that needs to be answered is why and when vital communities have added value (rather than age-friendly communities or social networks) in providing support for older people ageing in place. We assume that vital communities are a powerful resource of social support. In fact, the social support of vital communities extends beyond IADL provided by social networks. The additional support vital communities can provide to people ageing in place goes beyond this practical support, and addresses the perceived quality of life. Further, although one may assume that age-friendly communities and social networks may share characteristics of vital communities, differences such as size, composition, and shared goals can be distinguished. The social networks of older people consist of children, grandchildren, neighbours, and friends (Vos et al., 2020), while a vital community includes several formal and informal network structures (Mandell, 1999), and is used to reinforce all its members' sense of belonging and quality of life (Letcher & Perlow, 2009). This is in contrast to age-friendly communities, which are focussed on the wellbeing of older people in societyThe majority of experts confirmed a strong relationship between the aim of a vital community, feelings of belonging, and the key theme of place. According to the participants of this Delphi study, a feeling of attachment to the place where you live is of great importance for older people. However, constructivist studies do not support the idea that older people all have a desire to remain in place, and have demonstrated that ageing in place is also about agency and choice in how to use place (Van Hoven & Douma, 2012). In addition, the findings of a study by Hansen and Gottschalk (2006) showed that older people are willing to leave their familiar living environment due to a desire to move closer to their children. On the other hand, the findings of this Delphi study support the findings of other studies, in confirming that the maintenance of autonomy, independence, identity, and feelings of belonging are crucial for older people (Coleman et al., 2016; Peace et al., 2011; Shank & Cutchin, 2016). Therefore, we propose that vital communities do have the potential to provide additional support to older people ageing in place. However, further research will be necessary to develop this idea.

Strengths and Limitations

This study has several strengths and limitations that need to be discussed. One strength is that a modified Delphi study was chosen as the research design. Prior to the Delphi rounds, two panel discussions took place with Dutch panellists. Involving these panellists in this preparatory phase helped to make the realistic connection between vital communities and ageing in place, and the development of statements representing the theorised contribution. The Dutch panellists experience and expertise were helpful in translating theoretical knowledge concerning vital communities and ageing in place into daily practice.

This study has also some limitations. In stage 1, only one panellist was an older person ageing in place. It might be quite a weakness for only one older person to have been involved in this study, as the views of this stakeholder group seem likely to be underrepresented, with a possible bias and/or unbalanced results being a consequence.

In stage 2, at first: a high non-response rate (66 per cent) in the first Delphi Round, and the relatively high number of incomplete questionnaires (14 per cent), may have affected the selectivity of the sample and the interpretation of findings. Secondly: a large sample of experts that consisted of both academics and practitioners from eight countries participated; however, older people ageing in place were not involved in this stage, which means that their perspective of the contribution of vital communities to ageing in place is not included in this study. Most participants (76 per cent) were from the Netherlands. This may imply that the findings relate specifically to Dutch policies and knowledge about vital communities and ageing in place. However, selection bias may have occurred, as most experts were identified based on sufficient Dutch and/or English language speaking skills to fill in the surveys. Consequently, experts, especially those from non-English-speaking countries, might have been underrepresented in the sample.

Conclusion

In conclusion, this modified Delphi study showed a theorised contribution of the features of vital communities to successful ageing in place, according to experts with different backgrounds. The contribution shown implies that vital communities could facilitate older people in ageing in place for as long as possible while maintaining their quality of life. However, experts nuanced the contribution of technology, and the mechanisms and typical characteristics of vital communities. Results of this study further showed that diversity in the composition of the vital community does not positively influence the personal characteristics of older people. Although we are aware of the abstract nature of the findings, this study is an initial contribution to the body of knowledge on the contribution of vital communities to ageing in place and to the contention that older people could benefit from vital communities. We recommend future research regarding the activation of vital communities in facilitating older people ageing in place through, for example, the development of an approach for and by professionals from practice, for health and social care staff, and for local and national policies.

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Chapter 5

The Development of a method to activate vital communities' facilitation of older people ageing in place: a community-based participatory research study

This chapter was submitted as:
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The development of a method to activate vital communities' facilitation of older people ageing in place: A community-based participatory research study

Abstract

Objectives

This study aims to develop a method that can be of assistance for community members, professionals, volunteers, care partners and older people when selecting helpful strategies and interventions to activate a community to facilitate ageing in place.

Methods

A community-based participatory research methodology was applied to involve parties in an iterative and interactive approach to develop the activation method.

Results

This study resulted in the creation of the Community Activation Compass, a guide and infographic containing a set of development steps, strategies, interventions and formats that could be of assistance to activate vital communities' facilitating ageing in place.

Discussion

Activating a community could be an intensive, time-limited intervention and is often multi-disciplinary in nature. An inclusive approach seeks to work with all kinds of people and organisations. Still, supporting ageing in place by vital communities may just seem the right thing to do.

Introduction

The ageing population is emerging as a key policy issue for governments and healthcare organisations. One reason for this is that the number of older people in populations around the world is increasing (World Health Organization, 2021). In Europe, the percentage of people aged 65 and over is expected to account for over 30% of the population by 2060 (World Health Organization, 2021). Within the Europe, approximately nine out of ten older people in Germany, France, Finland and the United Kingdom live independently in their own homes. In the Netherlands, the percentage is even higher (95%) (Strandell & Wolf, 2019). In addition, older people prefer to live independently and to stay in their own homes, a situation known as *ageing in place* (Wiles et al., 2012). Many older people, however, face declining health, limitations in their functioning and/or other complex issues that affect their ability to live independently. As a result, the demand for care and support for older people will continue to

increase (De Klerk et al., 2019). European welfare states with ageing populations promote the substitution of expensive forms of care, such as residential care, with less expensive forms, such as ageing in place with additional support.

The Canadian Index of Wellbeing (Scott, 2010) describes *vital communities* as those that can cultivate and marshal strong, active and inclusive relationships among residents, the private sector, the public sector and civil-society organisations in order to create, adapt to and thrive in the changing world and thus improve the individual and collective well-being of citizens. The aim of vital communities is to meet individual and common needs: 'in a vital community people of all generations work together to find the right balance between meeting individual needs and meeting the needs of the community as a whole' (Sinkienė et al., 2017). Vital communities seem to be able to contribute to ageing in place and the quality of life directly as providers of support (Vitman-Schorr & Khalaila, 2022). There is limited evidence on how to activate communities to facilitate ageing in place. Hence, this study aims to develop a method that can be of assistance to community members, professionals, volunteers, care partners and older people to select helpful strategies and interventions to activate a community in order to facilitate ageing in place. We, therefore, formulated the following research question: 'What method can activate a community to support older people ageing in place?' This insight is needed to enhance the quality of life of older people who are ageing in place. A more comprehensive understanding of the development phases, the helpful strategies and the interventions for activating communities could be beneficial for community members in activating a vital community and customising the support they give older people.

Methodology

Context and Design

The research was conducted in a living lab specially set up for this study in the south of the Netherlands. The living lab is a physical location as well as a joint approach in which participating parties experiment, co-create and test in a lifelike environment, delimited by geographical and institutional boundaries (Ghosh et al., 2018). A design-oriented research methodology was applied to involve parties in an iterative and interactive approach (Coulter et al., 2013; Verschuren & Hartog, 2005).

Study Population and Sampling

Participants in this study were older people (n=20) and other stakeholders involved in practice from the housing, healthcare and welfare sectors, municipalities and local associations (n=33) living and working in the community setting of the living lab. The older people were recruited by distributing a flyer through the letterboxes in the

neighbourhood. The selection of the stakeholders was based on snowball sampling (Benoot et al., 2016; Polit & Beck, 2008). The inclusion and exclusion criteria are shown in Table 1.

Table 1.
Inclusion and exclusion criteria study population

Study population	Inclusion criteria	Exclusion criteria
Older People	Age ≥ 75	No Dutch speaking ability
	Independent living with some formal and/or informal support	
	Score Tilburg Frailty Indicator 0–4 (Gobbens et al., 2010)	
	Living in the living lab environment	
Stakeholders from Practice	Working in the housing, healthcare, or welfare sectors or for a municipality	
	Delivering (in)formal care or activities aimed at older people	
	Members of local associations in the living lab environment	

Participants were informed in writing that their participation in the study was voluntary and that they were free to end their participation whenever they wanted. The study was approved by the regional Medical Ethical Review Board in the Netherlands (METCZ20210166) and aligned with the principles outlined in the Declaration of Helsinki. This study did not fall under the scope of the Medical Ethical Review because it did not involve subjecting participants to actions or imposing a manner of behaviour on them. The online sessions via Microsoft Teams were recorded with the verbal permission of the participants.

Data Collection

The approaches in this study followed the principles of co-creation by involving stakeholders as full and equal partners in all phases of the research process. Co-creation leads to outcomes that are more likely to be acceptable, valuable and enduring compared to traditional research (Ahmed et al., 2019; Jull et al., 2017). To develop the activation method, a systematic development process was followed comprising five phases: 1) needs assessment, 2) design, 3) selection, 4) finalising for further evaluation and 5) testing and improvement (Coulter et al., 2013). The phases are detailed in the following section.

Needs-Assessment Phase. The first phase of the data collection was a needs assessment performed by context mapping (Stevens et al., 2021) and was carried out by older people. Context mapping is a co-creative method to gain insight into the living environment, emotions and needs of participants, who draw a collage or mood board and tell their story. Context mapping goes a layer deeper than the usual interview methods do (Stevens et al., 2021).Twenty older people who were ageing in place signed up for these meetings in small groups and were asked to express their needs for support while ageing in place. The output of these group conversations, mood boards, and minutes taken during the sessions were analysed and translated into a list of support needs. In addition to the meetings with older people, we organised two online sessions (using Microsoft Teams) with other 33 stakeholders involved. We obtained two smaller groups for the online sessions because smaller groups might be more suitable for complex topics, give the participants more time to voice their views and provide more detailed information (Moser & Korstjens, 2018). During these online stakeholder sessions, we presented the results of the needs assessment with older people and asked the stakeholders for additions and comments. In the second part of these online stakeholder sessions, we asked the participants what they thought was necessary to activate a community. In addition, we made an inventory of the preferred design of the method in practice. During this inventory, we used open-ended questions regarding the preferred design without giving any examples.

Design Phase. Based on the gathered data from phase 1, the second phase aimed to develop prototypes (a valid method that addressed the user requirements) containing a set of steps, strategies and interventions for activating a community to facilitate ageing in place.

Selection Phase. The selection phase aimed to select the most suitable prototype. During an online session, the researcher presented the developed (Muijeen et al., 2020) prototypes via a PowerPoint presentation to the participating stakeholders. After the presentation, based on a prepared script (Muijeen et al., 2020), the researcher asked the

participants to give their first reaction to the developed prototypes, including the content and design of the prototypes. The participants were also asked to choose the most applicable prototype.

Finalising Phase. Phase 4 aimed to determine the final version of the chosen prototype. The researcher processed the received feedback of phase 3 in a final test version for evaluation and dissemination.

Testing and Improvement Phase. Phase 5 aimed to test and improve the final prototype in a maximum of three iterations, involving all participants (older people and stakeholders) by cognitive walkthrough (Lyon et al., 2021). This phase consisted of three physical meetings in the living lab environment. During the first meeting, the researcher presented the final test version and asked participants to evaluate this version on paper for its relevance, comprehensiveness, comprehensibility (Terwee et al., 2018) and usability (Maramba et al., 2019; Vlachogianni & Tselios, 2022). The testing took place by the use of the co-creation method of evaluation cards containing pre-established hypotheses (Osterwalder & Euchner, 2019). The participants discussed how they could use the prototype and what steps they should take to activate a community. They noted their feedback on the evaluation cards. During the second meeting, the improved versions were presented, and the participants were asked whether their feedback from the first round had been properly incorporated into this version and whether they had any additions. A third and final meeting took place in which the final version was presented. During this meeting, all participants involved were asked how this guidance could be implemented and developed further in practice.

Analyses

The data, consisting of minutes and mood boards from the needs assessment with the older people, were deductively coded (Hsieh & Shannon, 2005) by researcher one (KPH). This analysis was compared with the analysis of researcher two (CK) and determined based on consensus. If no consensus could be reached, a third researcher (JvD) was consulted. The categories were based on the six dimensions of the Positive Health approach contributing to people's ability to deal with the physical, emotional and social challenges in life. The dimensions used were body functions, mental well-being, meaning, quality of life, participation and daily functioning (Huber, 2014). The analysis resulted in an overview of support needs. The data, existing minutes and recordings from the stakeholder sessions were deductively coded (Hsieh & Shannon, 2005) by researcher one (KPH) by the use of the OGSM (Objective, Goals, Strategies and Measurement) model (Bohn Stafleu van & Loghum, 2014). This analysis was compared with that of researcher three (JvD) and determined based on consensus. The used categories were objectives, goals, strategies and measures (Bohn Stafleu van & Loghum, 2014). The data, existing minutes and evaluation cards from the testing sessions were deductively coded (Hsieh & Shannon, 2005) by researcher one (KPH). This analysis was compared with that of researcher three (JvD) and determined based on consensus. The used categories were the pre-established hypotheses to test the relevance, comprehensiveness, comprehensibility (Terwee et al., 2018) and usability of the created method (Maramba et al., 2019; Vlachogianni & Tselios, 2022).

Results

Characteristics of the Participants

In phase 1, the needs assessment, ten out of twenty older people participated in the four meetings in the living lab environment. The other ten participants cancelled their participation due to the Covid-19 pandemic. Table 2 shows the characteristics of the participants.

Table 2.
Characteristics of participants, needs assessment: older people (n = 10)

Characteristics	Results
Average score on the Tilburg Frailty Indicator (TFI) (Gobbens et al., 2010)	2.1
Experiencing more than two chronic illnesses	3 out of 10
Experiencing lack of support of people in their own living environment	3 out of 10
Experiencing feelings of loneliness and sadness	7 out of 10
Female	8 out of 10
Male	2 out of 10
Average age	75–80 years

In total, 22 out of 33 stakeholders participated in the two online stakeholder and/or test sessions. Five stakeholders worked for the municipal government, two in the health-care sector, two in the housing sector, six in the welfare sector and seven in voluntary organisations and senior citizens' associations.

Need Assessments for Older People

Due to the Covid-19 pandemic, four sessions took place in groups of two or three older people. According to the participants, vital communities can contribute to ageing in place for the categories of: quality of life, participation, daily functioning and meaning (Huber, 2014), especially in the areas of living arrangements, social contacts, the ability to ask for support, taking care of oneself and having a meaningful life. This could be achieved by facilitating services and facilities, suitable housing, senior-friendly design of public space, a pleasant and safe living environment, activities in the neighbourhood, information and communication, (in)formal support, domestic help, mobility and participation. Table 3 provides an overview of the results.

Table 3.
Results, need assessments: older people

According to the participants, vital communities can contribute to ageing in place for the categories:	**In the field of support for:**	**By facilitating:**
Daily functioning	Being able to ask for support Taking care of yourself	• Information and communication • Services and facilities • (In)formal support • Independent living • Domestic help • Mobility • Accessibility of the living environment
Quality of life	Feeling happy Enjoyment Housing circumstances Feeling safe	• Well-being • Services and facilities • Suitability of the property • Design of the public space
	Having enough money	• Pleasant living environment • Budget friendly
Participation Meaning	Doing fun things together Being taken seriously Social contacts Doing meaningful things Having a meaningful life Lifelong learning	• Interventions and events in the neighbourhood • Services and facilities • Information and communication • Participation • Participation • Independent living

Online Stakeholder Sessions

Two online stakeholder sessions took place. The participants recommended dividing the activation process into four logical steps: mapping out the current situation, drawing up a plan, implementing a plan and safeguarding the activation process. In addition to these four process steps, the participants provided an overview of goals, strategies, performance indicators and interventions. The goals are related to: what do we want to achieve by a vital community in specific terms? The strategy: what is the best way to achieve these goals? The measures: what are our critical performance indicators? The interventions: what are we going to do? Table 4 shows the results of the sessions.

Table 4.
Results from online stakeholder sessions

Objectives (What are we striving for?):
Forming a vital community together to facilitate ageing in place.

Goals (What do we want to achieve in concrete terms?)	Strategy (What is the best way to achieve this?)	Measures (What are our critical performance indicators?)	Interventions (What are we going to do?)
• Quality of life: Safe and pleasant living environment No loneliness and/or sadness • Well-being: Happy older people • Belonging: Participation Empowerment	• Increase openness, trust and awareness through information and communication • Apply co-creation • Start small and grow autonomously • Activate people to implement ideas themselves by using a booster to get things going • Facilitate initiatives by professionals • Promote collaboration between residents and professionals • Connect key figures (ambassadors), residents and professionals in the neighbourhood • Promote intergenerational traffic by diversity in the composition of residents and housing arrangements • Reinforce the existing initiatives	• Fewer feelings of loneliness and sadness • Happier residents • Larger social network • Increased co-reliance • Increased reciprocity • Lower healthcare demand • Fulfilment of needs	• Create and start an accessible place for social sessions • Ask residents themselves • Awaken self-organising capacity (give a taste of more and take small steps) • Establish a loneliness contact point • Promote meeting in public spaces (greenery, benches) • Get to know each other • Increase sense of security • Ensure that meetings take place • Use social media • Use digital platforms • Inform about what already exists: e.g., newsletters • Use professional communication channels • Create a social information map • Promote reciprocity by encouraging (e.g., students learn to knit) • Make sure professionals are visible in the neighbourhood to stimulate the connection • Train volunteers to help older people increase their social networks

Quick Scan

In addition, during the online stakeholder sessions, the stakeholders recommended developing a quick scan to map the vitality and development stages of the community. The development of this quick scan was not foreseen in advance, but, according to the participants, a more specific activation plan needed to be drawn up based on the

development phase. The quick scan should be part of process step 1, mapping the current situation, and is developed on the basis of Wenger's (2002) growth model for communities of practice. This growth model is in line with the wishes of the stakeholders. According to Wenger et al. (2002), a community needs time and dedication to grow and passes through a number of phases as it does. During these phases, it has different support needs and different energy levels. The development phases of a community are potential, forming, maturing, self-sustaining and transforming (Wenger et al., 2002). Based on Wenger's theory and a scoping review concerning the conceptualisation of vital communities (Chapter 3), the authors and participants developed and validated a quick scan containing four development phases, ten building blocks and 40 statements to map the vitality of a community

Design

Based on the gathered data (see Table 3), six prototypes were developed during the design phase. These prototypes represented: 1) the resources for a vital community, 2) the combination of process steps, strategies and interventions, 3) the development phases of a vital community, 4) the community discovery learning circle, 5) the community empowerment wheel and 6) the community assessment tool. These prototypes were designed in several forms: a) a prototype of a website, b) a set of guidelines, c) roadmap, d) an infographic, e) an app, f) a Excel Microsoft file. These prototypes are visually represented in terms of content and design.

Selecting Preferred Form

During the selection phase, the participants recommended a set of guidelines (b) and an infographic (d) as preferred forms. The set of guidelines is a document in which all steps, strategies and interventions are described. The purpose of the proposed infographic is to provide a quick overview of the entire method and how to activate a community.

Testing and Improvement

During the first test session, participants rated the four process steps: 1) mapping out the current situation, 2) drawing up a plan, 3) implementing a plan and 4) safeguarding as relevant. Within these steps, however, the participants still missed the evaluation step, the focus on sustainable solutions, an inclusive society and the use of small success stories. These parts have been added to the guidance. In the second step, drawing up a plan, a format for a business plan based on the OGSM model (Bohn Stafleu van & Loghum, 2014), was proposed. Participants, were more supportive, however, of the use of the Business Model Canvas (Osterwalder & Euchner, 2019). According to the

participants, this model is more commonly used in practice. The participants rated the proposed strategies as relevant. The user-friendliness of the guidance and infographic were rated as moderate (66%). According to the participants, more support for guiding is needed. The introduction of the method could be improved by means of video animations in an online environment. Table 5 presents an overview of the results of test session 1.

Table 5.
Results, test session 1: Evaluation cards

Evaluation card	Results	Explanation	Improvement
1. Steps:			
Relevance	Highly relevant	Not applicable	Not applicable
Completeness	Not complete	Evaluation is missing (PDCA) Add focus on sustainable solutions Add focus on an inclusive society Add focus on the use of small success stories	Add to step 4
2. Formats:			
Relevance	Relevant	Business Model Canvas is more suitable.	Include in the guidance instead of the OGSM model
Completeness	Complete	Not applicable	Not applicable
3. Strategies:			
Relevance	Highly relevant	Not applicable	Not applicable
Completeness	Complete		

Evaluation card	Results	Explanation	Improvement
4. Usability			
	Moderate (66%)	More support is needed.	Video animations in an online environment.

During the second test session, the participants indicated that the points for improvement from session 1 had been properly integrated. They did, however, have two additions: namely, in steps one and three, add a second bullet ('attention to individual customisation' and 'meet collectively', respectively).

Final Version

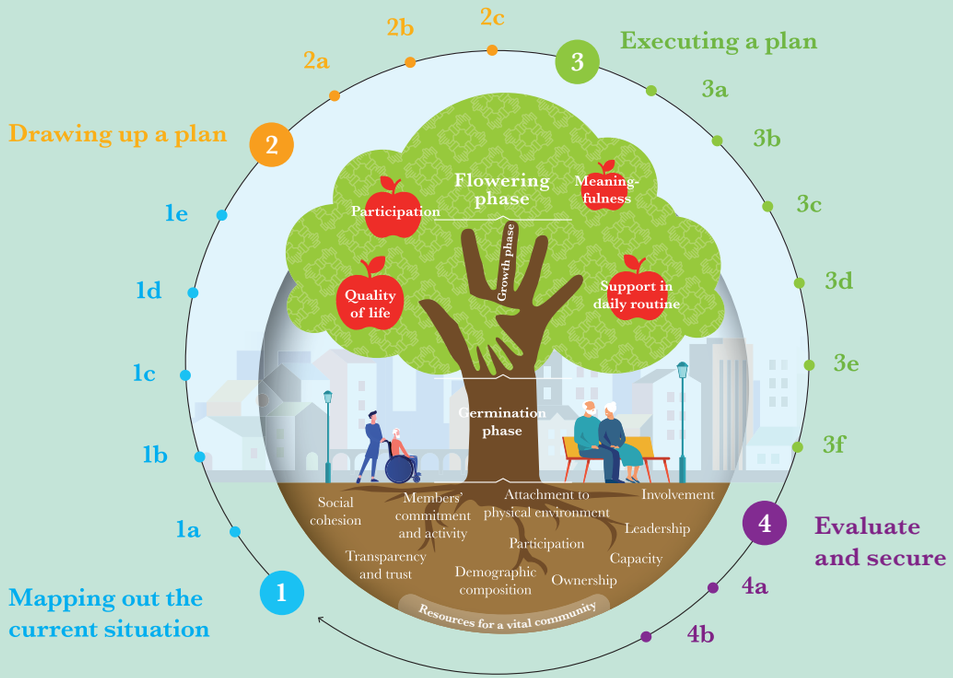
The final version, named the Community Activation Compass and the output of this design-oriented study, consists of guidance and an infographic. A tree was chosen as a metaphor for the visualisation of the infographic. Hence, with this metaphor, the tree roots, the growth phases and the proverbial fruits can be visualised. The tree roots or resources of a vital community were defined as social cohesion, member commitment and activity, ownership, participation, leadership, involvement, openness and trust, demographic composition, physical environment and capacity (blinded for review). The tree itself represents the development phases of the community: the sowing phase, germination phase, growth phase and flowering phase. The apples symbolise the proverbial fruits of support for older people, such as quality of life, participation, daily functioning and meaning. The infinite circle around the tree visualises the process steps to be followed with strategies, interventions and formats that can be helpful in taking the community to the next development phase. Figure 1 shows the infographic.

Figure 1.
Infographic Community Activation Compass

Activating a community to facilitate ageing in place
Community Activation Compass for activating a (vital) community in support of older people

For whom?
The Community Activation Compass is intended for initiators of a vital community. This could be

a housing corporation, healthcare organisation, welfare organisation and/or the municipality. Moreover, this resource could als prove useful for collaboration among residents, associations, professionals from the housing, care and welfare sector and municipalities.



1a Performing a needs assesment among the older people in question.
1b Analysis of the neighbourhood
1c Gathering information about existing initiatives
1d Establishing contracts
1e Analysis of the community's vitality by means of the Quick Scan.

2a Creating value
2b Realizing value
2c Bringing in value

3a Small initiatives
3b Meeting collectively
3c Key figures
3d Catalyst
3e Fun and conviviality
3f Information and communication

4 If the vital community is in the flowering phase
4a Evaluating
4b Securing

Discussion

The aim of this study was to develop a method that could help community members, professionals, volunteers, care partners and older people, to select helpful strategies and interventions to activate a community in order to facilitate ageing in place. The findings of this study resulted in the Community Activation Compass.

Theoretical and Practical Implications

The participants recommended dividing the activation process into four logical steps: 1) mapping out the current situation, 2) drawing up a plan, 3) implementing a plan and 4) evaluating and safeguarding. With this method, the activation of a community could be achieved. Furthermore, the community-development process, according to Vincent (2014) consists of approximately the same but more detailed steps: 1) establishing an organising group, 2) creating a mission statement, 3) identifying community stakeholders, 4) collecting and analysing information, 5) developing an effective communications process, 6) expanding the community organisation, 7) creating a vision statement, 8) creating a comprehensive strategic plan, 9) implementing the plan and reviewing and evaluating the planning outcomes and 10) creating new goals and objectives as needed. According to Vincent and John (2014), the Plan Do, Check and Adjust cycle is a key aspect of community development. It is also important, however, to realise that the activation of a community is a dynamic process—a set of steps that does not necessarily follow a sequential path. The steps may not follow the exact sequence above, and some can occur concurrently (Vincent & John, 2014). In addition, once the community is activated, keeping alive its potential (to have a positive effect on people ageing in place) requires application of the Plan, Do, Check and Adjust circle as well.

The stakeholder meetings have yielded several strategies that, according to the participants, contribute to activating communities. These strategies were logically divided among the four steps. The suggested strategies could contribute to the activation process but are not yet complete; after all, these strategies were developed from the context of the living lab and put forward by the participants. Nevertheless, the strategies to be applied depend on and vary with the development phase of the community (Webber & Dunbar, 2020; Wenger et al., 2002). In addition to the development phase, the mechanisms of effectiveness and contextual factors of the community may also influence the strategies to be deployed (Moore et al., 2015a). Therefore, a process evaluation of the set of guidelines in practice is recommended.

The Community Activation Compass include two formats: a quick scan and the BMC model (Qastharin, 2016). The quick scan is part of the first step and a tool for mapping

the vitality of the community. Other measuring instruments, however, are also available to map the vitality of communities or living arrangements, such as the Quality of Life Index (Leidelmeijer et al., 2014b). This measuring instrument, however, is based on the five dimensions: housing, physical environment, facilities for residents, safety and, in particular, the residential environment (Leidelmeijer et al., 2014a). Therefore, the quick scan has a broader perspective and also indicates the vitality of social (social cohesion and participation) and organisational (capacity and leadership) aspects. This broader perspective and its social and organisational dimensions are important for activating communities.

Participants suggested the BMC model (Qastharin, 2016) as a format through which to draw an activation plan. According to them, this canvas is a commonly used model in practice. Visually representing an activation plan through this canvas tool supports developing and communicating a more holistic and integrated view of a business model or, in this case, an activation plan. The Triple Layered Business Model Canvas, however, is an interesting tool for exploring sustainable and socially oriented plans. It extends the original business model canvas by adding two layers: an environmental layer based on a life-cycle perspective and a social layer based on a stakeholder perspective. When taken together, the three layers of this canvas make more explicit how vital communities generate multiple types of value: 1) economic, 2) environmental and 3) social (Joyce & Paquin, 2016).

According to the participants in this research, the developed Community Activation Compass has added value for activating communities. The steps, strategies, interventions and formats provided are seen as highly relevant and complete. Its user-friendliness, however, could be improved. Participants recommended a web-based version with short videos to explain the steps, strategies, interventions and formats.

The expected effect of the developed Community Activation Compass is the activation of communities, which in turn will contribute to the quality of life of older people ageing in place. The participating older people expressed the importance of vital communities in terms of quality of life, daily functioning, participation and meaning. This is confirmed by the findings of Robertson et al. (2022) demonstrating the importance of communities in supporting older people and their experienced individual quality of life; they argue for a movement beyond the concept of quality of life and towards the inclusion of perspectives regarding communal well-being, alongside the role communities play in influencing quality of life. By developing conceptions of quality of life in social relations and community cohesion—in particular how quality of life is influenced by perceptions of solidarity and social justice including across generations—assessing quality of life at community level will help drive cultural change in policy-making and practice. (Robertson et al., 2022). Furthermore, according to

a study by Cleland et al. (2021), communities contribute to five salient quality of life dimensions: independence, social connections, emotional well-being, mobility and activities. To activate a community could be an intensive, time-limited intervention and is often multi-disciplinary in nature. The activation of communities, supported by the guidelines, is an inclusive approach that seeks to work with all kinds of people and organisations. It requires skilled professionals who are willing to adapt their practice, as well as receptive older people, families and care partners. Still, supporting ageing in place in vital communities may be just the right thing to do. Hence, (Leidelmeijer et al., 2014b) the great majority of older people prefer to remain in their own homes and communities as they age (Wiles et al., 2012), and there is a demand for more efficient health and social care support (De Klerk et al., 2019).

Limitations and Recommendations for Future Research

Our study has several strengths. First, we used a design-oriented research methodology to involve parties in an iterative and interactive approach (Coulter et al., 2013; Verschuren & Hartog, 2005). The approaches in this study followed the principles of co-creation by means of involving stakeholders as full and equal partners in all phases of the research process. Second, to enhance the trustworthiness of the study, the data-analysis process was done independently, by two reviewers. This study may have also been subject to certain limitations, however. First, ten of the twenty participants opted out of the needs assessment with seniors in the neighbourhood due to the Covid-19 pandemic. Online meetings as an alternative to physical meetings with this group of older people, unfortunately, turned out to be impossible. Hence, the data collected during the meetings may not be complete. Secondly, the age of the ten participants was between 75 and 80. This implies that the support needs of those aged >80 were not taken into account first-hand. Thirdly, when recruiting the professionals, general practitioners, practice nurses and occupational therapists were not available to participate in this design-oriented study. Their vision has therefore not been included in the set of guidelines. The development of this set of guidelines took place in a living lab. How the guidance will work in practice must be researched further. Therefore, it is recommended that a systematic process evaluation of the application of the guidance in practice be carried out in which three components are evaluated: 1) the implementation, 2) the mechanisms through which change or activation occurs and 3) the context in which this takes place (Moore et al., 2015b).

Conclusion

The Community Activation Compass, to support the activation of a community in facilitating ageing in place, consists of four process steps (mapping out the current situation, drawing up a plan, implementing a plan, and evaluating and safeguarding). These four steps provide possible strategies, interventions and formats (the quick scan and Business Model Canvas). All steps, strategies, interventions and formats were described in a set of guidelines and an infographic. Based upon the gathered data and feedback in the co-creation sessions, the compass is likely to add value for communities and older people ageing in place. This contribution particularly relates to the perceived quality of life, participation, daily functioning and meaning. Still, well-monitored and documented future implementations and application of the guidance should provide evidence for this claim; this is the next step we intend to take.

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Chapter 6

Experienced level of usefulness of a quick-scan for mapping the vitality of communities

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Abstract

Most older people prefer to keep living independently in their own home. This often requires support from people in their immediate circle. However, it is not a given that those in their immediate circle are active enough to provide this support. By performing a quick-scan, it can be determined how vital the community is and what points for attention need to be addressed.

The vital community as a solution

In the Netherlands, 90 to 95% of older people still live in their own home (Actiz, 2022), and most of them are happy about this (Wiles et al., 2012). As older people who live independently are faced with increasingly complex problems, the demand for informal and other forms of care and support will increase. At the same time, there are increasing shortages of care and other professionals, and the potential number of informal carers is decreasing (De Klerk et al., 2019). European welfare states with an ageing population, including the Netherlands, are encouraging the replacement of expensive forms of intramural care by cheaper forms, such as supplementary support at home to enable older people to continue to age in place (World Health Organization, 2021). Supplementary support can be provided by vital communities (Peak, 2021). Older people who participated in a study in a living lab in the province of Limburg stated that a vital community can contribute to their quality of life, participation in society and sense of purpose and can offer them support in their day-to-day activities. According to the older people in the study, vital communities can help them to keep living independently in various ways. Based on their statements, a list of these contributions has been compiled that is shown below in Table 1. This list is based on the impact of a vital community on the ability of older people to perform day-to-day activities and on their quality of life, ability to participate in society and sense of purpose. However, it is not a given that communities are vital enough to provide this support. That dependson what stage of development a community is in. The following stages can be distinguished (Webber & Dunbar, 2020; Wenger et al., 2002): initiation stage, formation stage, growth stage and fruition stage. These stages of development differ in terms of the level of support and leadership being provided by the initiators, and the connectedness between the community members. In the initiation stage, for example, there is little connectedness between the members, so a high level of energy from the initiator or initiators is required. In the growth stage, there is more connectedness between the members, so less support from the initiator or initiators is required (Wenger et al., 2002). In practice, however, activating communities is a complex challenge that is influenced by many actors. A guidance with information about the steps to be taken and strategies and actions to be deployed could offer initiators support in this process.

Table 1.
What vital communities contribute according to older people ageing in place

What vital communities contribute	By providing support in terms of:	By facilitating:
Day-to-day activities	Ability to ask for help Ability to take care of yourself	• Information and communication • Services and facilities • Formal/informal support • Living independently • Help with domestic chores • Mobility • Accessibility in the neighbourhood
Quality of life	Feeling happy Ability to enjoy yourself Living conditions Feeling safe Coping financially	• Well-being • Services and facilities • Suitability of your home • Design of public spaces • Pleasant living environment • Affordability
Participating	Doing fun activities together Being taken seriously Staying in touch with others Doing meaningful activities	• Activities in the neighbourhood • Services and facilities • Information and communication • Participating
Sense of purpose	Living a meaningful life Lifelong learning	• Participating • Living independently

Development of a quick-scan as part of the guidance

In a design-oriented study conducted by Maastricht University and Zuyd University of Applied Sciences, 12 older people, 22 professionals and the authors of this article jointly developed a guidance in a living lab in Limburg. This guidance consists of a guideline and an infographic. With this guidance, initiators such as municipal civil servants and staff of housing corporations and care and welfare organisations can get to work on activating the community. During the various development sessions in the living lab, the participants stated that they were also in need of a simple tool to quickly assess the vitality of the current community. Such a tool would enable them to quickly get a sense of what stage of its development the current community is in. This insight would then allow them to make more targeted choices on the steps to be taken, and strategies and actions to be deployed. Based on the existing literature on the stages of development and building blocks for a vital community (see Table 2), a draft quick-scan was developed in a process of co-creation. This draft quick-scan consisted of a short questionnaire in which respondents were asked about aspects based on the ten building blocks for a vital community. For each aspect/building block, they were asked to choose one of four statements that best described their current situation with regard to this aspect. The statements each represented a specific stage of development for the relevant building block and were assigned the following scores:

- 1 = initiation stage
- 2 = formation stage
- 3 = growth stage
- 4 = fruition stage

Table 2.
Building blocks for a vital community

Building blocks	Description
Social cohesion	Degree of cohesion, connectedness and solidarity within groups and communities.
Involvement and activity level of members	Entrepreneurship and degree to which members actively get involved to achieve a collective goal.
Ownership	Feeling and taking responsibility.
Participation	Participating in society, such as by working, studying and/or volunteering.
Leadership	Providing leadership and facilitating.
Involvement	Amount of time, attention, work and effort that people are willing to invest in the community.
Transparency and trust	Transparency and social safety.
Demographic structure	Structure of the population, such as in terms of age, ethnicity, income and education level.
Physical environment	Degree to which people feel connected with the physical environment and with others who work and live there.
Capacity	Available resources, including financial resources, meeting spaces, human resources and time.

Usefulness of the quick-scan

Following the development of the draft quick-scan in the living lab, the usefulness of this quick-scan was evaluated by fifteen experts. These experts worked for nationwide platforms, such as Platform 31 and Movisie, governmental organisations, such as the Netherlands Institute for Social Research (SCP), and other organisations, including those conducting research into housing, formal and informal elderly care, community care, social innovation, civic participation and the quality of life in neighbourhoods. The experts were asked to fill in an online questionnaire. This questionnaire included questions about the relevance, comprehensiveness and understandability (Terwee et al., 2018) of the formulated building blocks for a vital community and the accompanying statements and stages in the development process of a vital community. The online questionnaire also asked the experts about the relevance of the scores assigned to each of the statements and the cut-off points for the scores. This particularly concerned the question of whether it would be preferable to use hard cut-off points or rather a continuum. In total, 15 of the 21 experts we approached completed the questionnaire – a response rate of 71%. The experts considered most of the building blocks (n=8 out of 9) relevant for activating a vital community and for the intended target group. According to the experts, the 'resilience' building block was not relevant, as they took the view that resilience results from the vitality of the other building blocks. The experts stated that two building blocks were missing: 'demographic structure' and 'capacity'. In their comments, the experts operationalised the 'demographic structure' building block as the population structure in terms of aspects such as age, ethnicity, income and education level. The experts described the 'capacity' building block as referring to resources, including financial resources, meeting spaces, human resources and time. The questionnaire also asked the experts about the suitability of the statements. Many of the experts stated that the statements were largely suitable in relation to the relevant building blocks. In their comments, a substantial number of experts gave feedback and advice on points to consider or suggestions for improvements to the statements. The experts observed that the statements did not always cover the full scope of the building blocks. They stated that social cohesion, for example, can be evident from more aspects than outlined in the draft quick-scan, is multidimensional and comprises much more than only the connectedness between groups and interpersonal contacts. With regard to the stages of development and the scores assigned to them, most of the experts stated that they preferred assigning scores on the basis of a continuum rather than hard cut-off points. According to the experts, it is wrong to assume that the development of communities always steadily advances to a more positive state. In fact, some vital communities may fall back to an earlier stage of development. Therefore, the development of a vital community is not a linear process, and the sum total of the scores is merely an indication of the community's current stage of development. In the evaluation, we also asked the experts to assess the understandability for the intended target group of the formulated building blocks and statements. The experts stated that a number of concepts are multidimensional and open to multiple interpretations. They also found the descriptions of the building blocks to be quite abstract. The experts advised making the building blocks in the quick-scan more concrete by providing a brief explanation. In addition, they advised that the users of the quick-scan should reach agreement on a set of shared definitions to be formulated for the building blocks and statements. The feedback has been incorporated in the final version of the quick-scan; see Figure 1. A copy of the full quick-scan can be requested from the authors of this article.

Future

Based on this evaluation, it can be concluded that the vitality of a community can be mapped by means of the developed quick-scan. This creates a useful basis for further activation. According to the experts, the stages of development, building blocks and statements we used are relevant, suitable and comprehensive with respect to the assessment of a community's vitality. Furthermore, the building blocks and statements are understandable for future users of the quick-scan. Finally, the quick-scan provides tools enabling targeted actions for each building block to vitalise a community. The outcomes of the evaluation have various implications for the future of professional practice, teaching and research. It would be useful for both professional practice and research to perform a process evaluation in order to run a pilot with the quick-scan and to optimise it. Further research has already been planned in this respect, including in a number of pilot areas in Limburg.

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Chapter 7

General discussion

General discussion

This dissertation aimed to develop a method to support initiators living or working in a community in drawing up and implementing an activation plan for the provision of support for older people ageing in place. Therefore, the relationship between the conceptualisation of ageing in place and vital communities is explored and described. These studies provide the basis for developing and testing the Community Activation Compass. The dissertation consists of a knowledge and a practical flow, respectively presenting the conceptualisation of ageing in place and vital communities, the relationship between these two concepts, the development and testing of the Community Activation Compass, and the validation of a quick-scan that indicates what stage a community is currently at and shows directions for maturing the community (Figure 1).

Figure 1.
Illustration of the study flows with reference to the corresponding chapters

Knowledge flow:
The conceptualisation of ageing in place, **chapter 2**
The conceptualisation of vital communities, **chapter 3**
The relationship between ageing in place and vital communities, **chapter 4**

Practical flow:
The development and testing of the Community Activation Compass, **chapter 5**
The validation of a quick-scan, **chapter 6**

This general discussion summarises the main findings from the studies, followed by a discussion about methodological and theoretical considerations. Finally, the chapter includes general conclusions.

Main results

This dissertation resulted in the conceptualisation of ageing in place (**chapter 2**) and vital communities (**chapter 3**) and knowledge concerning the theorised relation between vital communities and ageing in place (**chapter 4**). With this theorised relationship in mind, the Community Activation Compass – comprising guidance, an infographic containing useful process steps, strategies and interventions to active a community, and a quick-scan – was developed and validated (**chapters 5 and 6**).

The first study results in new scientific knowledge with regard to the conceptualisation of ageing in place. The conceptualisation of ageing in place was mapped through a scoping review and provided an overview of existing definitions and the five key themes (place, support, social networks, technology, and personal characteristics) of ageing in place. One can say that whether older people can live independently at home while retaining their quality of life partly depends on these five themes. The second study, a scoping review with regard to the conceptualisation of vital communities, also provided new scientific knowledge. For the activation of a community into a vital community, the three defined dimensions of a vital community should be in place: the 'why', the 'how', and the 'what'. The 'why' of a vital community refers to its aim, to build structures and tools to support and create a long-lasting impact for older people ageing in place. Vital communities also reinforce the sense of belonging to a community, improve the perceived quality of life, and improve the well-being of older people ageing in place. The 'how' refers to the mechanisms for activating a community. These mechanisms are useful strategies – creativity and innovation, partnership, community and service exchange, active participation, community capacity, community skills, stable leadership and funding, perturbation, and external change. The 'what' refers to the typical characteristics of a vital community. Otherwise, what characteristics make a community a vital community? These characteristics are described on a community level, a collective level, and an individual level. The theorised relationship between ageing in place and vital communities was evaluated by a Delphi study. International experts in the field of ageing in place and vital communities were asked to respond to statements representing the relationship regarding these concepts. The main results of this third study in the knowledge flow is that, according to experts in the field of ageing in place and vital communities, there is potential for creating a positive relationship between the key themes of ageing in place and the three dimensions of a vital community. Summarised, this knowledge flow delivers a well-grounded conceptualisation of the concept of ageing in place and the phenomenon of vital communities as well. In addition to the knowledge flow, a specific product has been developed as a result of the last two studies during the practical flow of this research, namely the Community Activation Compass with a quick-scan to map the vitality of a community. The compass consists of guidance and an infographic with development phases,

tools, process steps, strategies, and interventions to activate communities. One of the developed tools is a quick-scan, which can be used to map the vitality of the community. This quick-scan is based on ten resources of a vital community which are present to a greater or lesser extent and which form the foundation of community vitality. These resources are social cohesion, member commitment and activity, ownership, participation, leadership, involvement, openness and trust, demographic composition, physical environment, and capacity. The extent to which these resources are present provides an indication of the development phase in which the community currently is. This quick-scan was validated for content and usability during the last study. For more information on the Community Activation Compass, the infographic and quick-scan are included in the appendix of this dissertation.

Methodological considerations

In this paragraph, a reflection on the overall research design, with the knowledge and practical flow, the position of the Delphi study, and the lack of a process evaluation is discussed. This is followed by a reflection on the strengths and weaknesses concerning the living lab, which was especially set up for this research. Next, the added value and the limitations of the co-creation approach during the research process will be discussed.

Design

The discussion points concerning the overall design are: the (dis)advantages of the chosen research design, the position of the Delphi study at the knowledge flow, and the lack of a process and effect evaluation phase. This dissertation used a design-oriented research approach containing a knowledge flow and a practical flow (Van Aken & Andriessen, 2011). Characteristics of the chosen research design include that design-oriented research is very suitable for solving complex problems, such as the activation of communities in order to facilitate ageing in place. Design-oriented research uses existing theories and models for root cause analysis (Smit, 2018). Therefore, the concepts and the relationship between ageing in place and vital communities are explored. This is followed by a practical flow for the selection and combination of existing solutions when designing the Community Activation Compass and the quick-scan. However, the research cycle of design-oriented research has a long-term character, which can create uncertainty for the future: how will ageing in place and the context of vital communities develop in the long term? This is opposite to the design thinking method with its short-cycle character and reasoning from problems to solutions and back again. However, the theoretical basis, which provides the framework for the development of the Community Activation Compass and quick-scan, is missing in the design thinking

method. Design-oriented research is also less user-oriented and places less emphasis on the design requirements of the stakeholders involved. In retrospect, in terms of layout and design, the Community Activation Compass and the quick-scan can certainly be improved during the last phase (process evaluation) of the research cycle. In short, the research-oriented research approach is characterised as 'learning before doing' instead of 'learning by doing' (Smit, 2018).

The studies included in these two flows are presented in Figure 1. Design-oriented research often has an iterative character in which a number of phases are followed: 1) retrieve knowledge or needs, 2) develop solutions, 3) test and improve, and 4) process and effect evaluation (Van Aken & Andriessen, 2011). In phase 1 of this study, two scoping reviews were performed. The results of these form the basis of this study. The knowledge flow is concluded with a modified Delphi study. The Delphi technique is a widely used method for reaching a consensus among experts by making use of several rounds of opinion collection and feedback (Hasson et al., 2000). The modified character of the Delphi study consists of adding panel discussions in preparation for the Delphi rounds. The first methodological consideration is that it was difficult to translate the more abstract and theoretical results of the first two studies into sound statements that reflect the theorised relationship in practice. Therefore, we conducted two preliminary panel discussions, by panellists from practice, to translate the theoretical results into more specific and practical statements that represent the theorised contribution of vital communities on successful ageing in place. However, despite this modification, the results of the Delphi study remain abstract and theoretical. This was partly caused by the background of the participants in the Delphi rounds, purposefully selected, being experts in the scientific field of vital communities and ageing in place. In retrospect, to avoid these abstract and theoretical outcomes, it would probably have been better to explore the relationship between both concepts during the practical flow of this research by applying co-creative methods. For example, this could have been carried out during the needs assessment with the older people and stakeholders. As a result, the translation of the theoretical results into practice would probably have been more meaningful. On the other hand, the contribution of the international experts reinforced the theoretical findings as well. Overall, the modified Delphi bridged theory and practice and is a logical step between the knowledge and practical flow.

In phases 2 and 3 (develop solutions, test and improve) or the practical flow, the Community Activation Compass is developed and tested in co-creation, in a real living lab, with stakeholders from practice involved. However, the design-oriented research approach also includes a fourth phase, process and effect evaluation (Van Aken & Andriessen, 2011). The lack of this fourth phase in the design constitutes the third methodological consideration. This is because, despite the fact that the Community Activation Compass was developed and tested in practice, it is difficult to state

whether and/or to what extent communities can be activated by the use of the developed compass; this depends on the implementation process, the mechanisms through which activation occurs, and the context in which this takes place (Moore et al., 2015). However, in retrospect, the combination of different methodologies, with an accent on conceptual studies at the start and practice research at the end, seemed to be a valuable mix. Based upon well-elaborated conceptualisations of both phenomena, the connection to real life is being made to explore how the potential (vital) communities have can be activated to deliver support to people ageing in place. Taking into account the actual needs and demands of older people next to the visions of professionals in care and also informal caretakers led to a promising method. However, it is also important to carry out the fourth phase of the design-oriented research. Therefore, the process and effect evaluation will be conducted in practice during postdoc research.

Strengths and weaknesses of living labs

In the practical flow of the study, a community-based participatory research methodology in a living lab was used to involve parties in an iterative and interactive approach (Coulter et al., 2013; Verschuren & Hartog, 2005). The living lab in this study was a physical location as well as a joint approach in which participating parties experiment, co-create, and test in a lifelike environment, delimited by geographical and institutional boundaries, in which to solve societal challenges by bringing together various stakeholders for collaboration and collective ideation (Ghosh et al., 2018; Hossain et al., 2019). An advantage of the use of a living lab is that it is a useful place to detect community needs and the needs of people, improve local development, and support and integrate social innovations (Edwards-Schachter et al., 2012). Despite this advantage, there are also some methodological considerations, because living labs face also some challenges, such as temporality, efficiency, community participation, user recruitment, and unpredictable outcomes (Edwards-Schachter et al., 2012; Haldane et al., 2019). These features will probably influence the results of the study. For instance, the temporality, as living labs often have a short-term focus on organisational needs. In this case, the living lab was exclusively set up for the development of the Community Activation Compass and closed at the end of the testing rounds. So, the long-term value of this living lab is difficult to demonstrate to user communities and society (Guzmán et al., 2013). Regarding efficiency, according to a study by Haldane et al. (2019), many challenges to successful and sustainable community involvement remain. Importantly, in living labs, there is little evidence on the effect of community participation in general in terms of outcomes at both the community and individual level of older people ageing in place (Haldane et al., 2019). Furthermore, community participation is widely believed to be beneficial to the development, implementation, and evaluation of health services (Haldane et al., 2019). There is also criticism with regard to community participation in living labs, because the participating stakeholders do not really reflect

the community. Due to differences in the human dimension, groups of people will be unable or unwilling to participate in the community within the living lab (Putters, 2022). Besides the differences in people, this is also caused by user recruitment. For this study, older people and stakeholders were actively and purposefully recruited to participate in the living lab. However, not all approached participants were willing or able to participate. Older people were recruited via a flyer in their postbox. However, the older people who participated were active older people who were capable of participating. Other older people have not registered to participate in the living lab, and thus their needs and ideas have not been taken into account. Among the stakeholders, we were missing the participation of care partners, general practitioners, practice assistants, occupational therapists, and physiotherapists. Despite various invitations to participate in the study, they did not join the sessions. The lockdown during the COVID-19 pandemic certainly had an influence on this. The participation of other older people and other stakeholders could have made a valuable contribution to the results of this study. It is difficult to state to what extent this distorts the findings, as further research would be required. As for unpredictable outcomes, the research process in a living lab is an iterative process, and living labs cannot guarantee the achievement of the anticipated results. Their activities often lead to unforeseen outcomes due to feedback from users. An unforeseen outcome or additional product of this study, for example, is the development of the quick-scan at the request of the participants, because they needed a tool to map the vitality of the community.

Another methodological considerations is trustworthiness, meaning the transferability of the research outcomes (Connelly, 2016; Dutilleul et al., 2010). According to Connelly (2016), the transferability of research outcomes to other contexts is partly determined by the participants in the living lab. Living labs comprise multiple stakeholders, who are often beyond organisational boundaries, and they cannot manage or control stakeholders but only motivate them to engage in innovation activities (Ståhlbröst & Bergvall-Kåreborn, 2011).

The added value and the limitations of co-creation

The approaches in the practical flow of this design-oriented research followed the principles of co-creation by means of involving older people and other stakeholders as full and equal partners in all phases of the research process. Co-creation is a 'magic concept' which, during recent years, has been embraced as a new reform strategy in public innovation, given the social challenges we are wrestling (Voorberg et al., 2015). Co-creation seems to be considered a cornerstone for social innovation in the public sector, a necessary condition to create innovative public innovations that actually meet the needs of the target group (Voorberg et al., 2015). Also, co-creation seems the right approach to apply in the case of the development and testing of the Commu-

nity Activation Compass. Co-creation with older people offers an improved understanding of the issues they face. Other reasons for this choice are active user involvement, the engagement of older people, and the development of a solution that actually meets the needs of the older people and stakeholders involved. However, there are also limitations. Involving older people in the process raises methodological and practical challenges (James, 2022). This includes creating a safe atmosphere, encouraging older people to actively participate in the conversation, using understandable language, leading the meetings without dedicating too much time to other subjects, and ensuring accessibility to the space where the meetings take place. According to the results of a scoping review of co-creation, Knight-Davidson et al. (2020) suggest that when co-creating with older adults, a level of creative thinking might be necessary, particularly in situations where user needs cannot be readily articulated, and this may indicate the need for less active user involvement methods. Reflecting on the process, these issues were solved by using content mapping methodology during the need assessment sessions with older people. We stimulated the creative thinking and involvement of older people through meeting in small groups. A safe atmosphere was created through an informal setting in a creative room while enjoying a cup of coffee and cake. During the meetings, participants were encouraged to actively participate in the conversation and create a mood board. For the development process of the Community Activation Compass, meetings were scheduled in the living lab with all stakeholders. These meetings, unfortunately, had to take place online due to the COVID-19 pandemic. During the online sessions, it was difficult to apply co-creative methods. In order to make the online meetings as interactive as possible, we worked with smaller groups (maximum 10 participants) and had a moderator to guide the sessions. Despite this limitation, the meetings were interactive and yielded useful data. After the lockdown, the follow-up sessions with stakeholders and older people could once again take place in person in the living lab. In small groups, we worked together on the development and testing of the Community Activation Compass. Brainstorming, discussion, and the use of test and learning cards were used during these meetings, which went well and yielded useful data. However, more creative techniques could have been used during the meeting to develop the Community Activation Compass. In retrospect, the COVID-19 pandemic during the practical flow period certainly influenced the results and the validity of this study. Critically, the question is to what extent the results are transferable to other contexts (Lincoln & Guba, 1985) and whether the Community Activation Compass is suitable for other applications in practice.

Theoretical considerations

First, a reflection is provided on ageing in place as a concept and its significance today in relation to human dimensions and the results of this dissertation. Second, the added

value of a vital community and other alternatives for vital communities as providers for support will be discussed more thoroughly. Third, the development of vital communities and the Community Activation Compass will be discussed.

The significance of ageing in place in relation to human dimensions

Ageing in place has a strong relationship with the general vision of old age. The rising number of people growing old(er) raises new demands and pressing challenges for care and support development. The majority of older people will age in their homes and communities rather than in institutionalised care facilities and settings (Dobner et al., 2016). Governments are committed to the ageing in place principle for a number of reasons. Due to the shortage in the labour market and the rising costs of healthcare, a transformation was necessary, and in 2015, a change from a welfare state to a participation society was initiated. This means that people become primarily responsible for their own lives and for those of people in their environment. The encouragement of citizenship, one's own responsibility, and one's own strength are core elements in this vision (van Hees et al., 2015). The assumptions about what citizens will or can do are often incorrect or turn out to be unrealistic (Veldheer et al., 2012). A point of discussion is whether ageing in place is feasible for everyone from a human dimension perspective. The results of this dissertation show that ageing in place is influenced by the personal characteristics of older people themselves, such as resilience, adaptability, and independence.

According to Putters and Olde Monnikhof (2022) the human dimensions of older people and the people who provide informal support must be taken into account. The human dimension is more than resilience, adaptability, and independence. It is determined by the living situation, values and norms, social position (economic, social, cultural, and personal capital), and people's self-reliance. These human dimensions illustrate how people are able and want to participate in society and in decision-making. An unrealistic appeal to self-reliance or support from the social network implies people in vulnerable positions do not always receive the support they need. There are many vital older people who want and are able to live independently at home for longer. There is also the opposite, like people who need support from time to time. The course of life is a major determinant, for example, the moment at which someone becomes dependent. People vary in their ability to take care of themselves or rely on others. The diversity in society means that managing standard solutions is becoming increasingly complicated, because they have to be person-centred and needs are constantly changing (Putters & Olde Monnikhof, 2022). In addition to the human dimension of older people living independently, the human dimension of those who provide informal support must also be taken into account. The results of this dissertation also show that vital communities have the potential to support older people ageing in place. However,

the mistake is to presume that community members, family, and the social network of older people are capable of and in a position to provide support to older people. An older person who has no children, no life partner, or a poor social network is no more likely devoid of social connections than is an older person surrounded by an extensive social network and assured of the right sort and level of support (Kagan, 2023). In summary, ageing in place certainly does not always contribute to the quality of life of older people living independently. It is therefore not a standard solution that can apply to everyone. Governments must take more account of the differences between people and how policies affect them.

The added value of vital communities for ageing in place compared to other approaches

This paragraph describes the added value of a vital community from the perspectives of theory and will be compared to other approaches that support older people ageing in place. The starting point is how we can support older people in ageing in place while maintaining their quality of life. According to the results of this dissertation, the support of a vital community seems appropriate. Vital communities in the immediate living environment of older people have the potential to support ageing in place in addition to formally organised support. In other words, vital communities could support older people within their living environment by delivering support, engaging older people and their social network, and improving resilience, adaptability, and independence. This assumption can be confirmed by the theories of environmental psychology and gerontology, ecological frameworks, and community psychology. First, by the theory of environmental psychology and gerontology (Lawton, 1985): according to the environmental gerontology theory, there is a strong relation between the well-being of older people and their socio-spatial surroundings, also known as communities (Lawton, 1985). Confirming this theory, there are interactions perceptible amongst older people and their diverse social and physical environments. Second, the added value of vital communities can be confirmed by ecological frameworks. With the help of ecological frameworks, six dimensions of the focus of communities' environments in relation to older people can be distinguished. The focus on 1) both social and physical environments, 2) proximal and distal environments and their interrelationships, 3) particular types of social structures and systems and their interconnections, 4) older people as leaders of change, 5) targeting subgroups of older adults, and 6) initiating person–environment changes at the time of a life transition (Greenfield, 2012). These six dimensions are especially useful for conceptualizing the initiatives' similarities and differences in terms of the features through which they intend to promote ageing in place. Third, the concept of vital communities has its roots in the early community psychology literature as well as in the development of community ecology (Sahney & Benton, 2008). Vital communities are used in a territorial sense, to refer to a geographic locality (Gusfield, 1975). They are also commonly used to describe a particular quality

of human relationships. These human relationships are also expressed as a sense of community. It is a feeling of belonging members have, a sense that members matter to one another and to the group, and a shared faith that members' needs will be met through their commitment to being together (McMillan, 1976). These two meanings (physical and relationships) get melded together to describe a physical place (the community) and a set of common ideals, delivering support to older people ageing in place (Miller, 1999). In summary, the added value of vital communities for ageing in place is based on human relationships, a feeling of belonging and common ideals, and the capacity to act together and develop and deploy resources. Empowering communities to foster the health and well-being of older people is key nowadays, hence the goal of the World Health Organization (WHO) is to optimise older people's functional ability (World Health Organization, 2020). A strong and vital community is able to fit people and organisations together so that people meet others' needs while also meeting their own (McMillan & Chavis, 1986).

The results of this dissertation and the theories described above confirm the added value of vital communities for ageing in place. However, the discussion point is that, in recent decades, various other approaches have been developed and implemented to support older people during ageing in place. A number of alternatives for vital communities are discussed below, without being exhaustive, such as senior friendly communities, co-housing communities for older people, and intergenerational co-housing. The creation of senior-friendly communities worldwide has been promoted by the WHO as a strategy to address the challenges posed by the converging trends of urbanisation and population ageing. This has resulted in an increase in the discussed number of strategies and initiatives that ensure policies, services, and products meet the needs of older people (Steels, 2015). The key characteristics of the WHO framework for senior-friendly communities are centred on promoting and encouraging active ageing. There are three pillars of active ageing: health, participation, and security, guided by the UN principles for older people (Steels, 2015). The senior-friendly communities approach focuses especially on interventions for older people with dementia, people with late-life depression, and informal caregivers. The methodology of the senior-friendly community approach consists of five steps: 1) creating an infrastructure for the senior-friendly community project, 2) including communities, 3) baseline assessments in the participating communities, 4) creating an activity buffet of a variety of activities promoting older people's well-being, and 5) implementing the activities (Schichel et al., 2020). Summarised, the aim of a senior-friendly community is framed by Schichel et al. (2020) as focusing on older people's public health, well-being, and quality of life. One-way traffic (the community and environment being senior friendly) is dominantly present. While in a vital community, the mutual exchange of giving and receiving support is key (Altpeter et al., 2014). Co-housing communities for older people aim to offer an alternative form of ageing in place. This form of housing

is sometimes described as ‘living together on one’s own’ (Bamford, 2005). Senior co-housing communities offer an in-between solution for older people who do not want to live in an institutional setting but prefer the company of their peers (Rusinovic et al., 2019). Residents of co-housing communities live in their own apartments but undertake activities together and support one another. The physical layout of co-housing comprises several independent homes in combination with shared spaces and facilities, which support living together and balancing privacy and communality (Beck, 2020). According to Rusinovic et al. (2019), senior co-housing communities offer social contacts and instrumental and emotional support. Residents set boundaries regarding the frequency and intensity of support. The provided support partly relieves residents’ adult children of caregiving duties, but it is not a substitute for formal and informal care. At the same time, a vital community can be the provider of formal and informal care, depending on the organisational composition of the vital community. A variation on senior co-housing is the intergenerational housing model, where older people live in communities that promote ties with younger generations (Suleman & Bhatia, 2021). Intergenerational housing models serve as a potential solution to address concerns regarding loneliness and help mitigate the consequences associated with social isolation. The added value of the concept of vital communities compared to other approaches can be explained by the differences in the target group, the focus, the processes, and the territorial boundaries. Table 1 provides an overview of these differences. In summary, it can be stated that the concept of vital communities is a total and holistic approach involving many parties. Vital communities focus on quality of life, belonging, and the mutual exchange of giving and receiving (in)formal support in the neighbourhood. It would be interesting for future research to find out if, how, and to what extent these approaches can reinforce each other. However, creating solutions to support older people ageing in place requires collaboration and coordination across multiple sectors and with diverse stakeholders, including older people. Collaboration between the domains of care, housing, welfare, and the municipality in a community does not happen automatically. The challenge is how can we remove this compartmentalisation of the various domains and collaborate on this task across domains. This challenge needs to be explored on short term in practice.

Table 1.
Examples of differences in approaches for ageing in place

Approaches for ageing in place	Target groups	Focuses	Processes	Territorial boundaries
Vital communities (Altpeter et al., 2014)	Intergenerational Multi-disciplinary (housing, healthcare, welfare, municipality	Quality of life Belonging Informal and formal support	Mutual exchange of giving and receiving support	Neighbourhood
Senior-friendly communities (Schichel et al., 2020; Steels, 2015)	Older people with dementia or with late-life depression and informal caregivers	Promoting and encouraging active ageing Health, participation, and security	One-way traffic (the community and environment being senior friendly) is dominantly present.	Neighbourhood
Senior co-housing (Bamford, 2005; Beck, 2020; Rusinovic et al., 2019)	Older people	Social contacts and instrumental and emotional support	Two-way traffic, undertake activities together and support one another	Building
Intergenerational co-housing (Suleman & Bhatia, 2021)	Intergenerational families	Loneliness and social isolation	Two-way traffic, giving and receiving informal support	Building

The development of vital communities

As previously stated, the challenge is how to unlock the potential of communities to support older people living independently at home. Therefore, an activation method called the Community Activation Compass was developed. The compass helps to draw up a clear plan for working appropriately on the potential of a vital community so it can be activated and grow to the next maturity level. The theory used for community development or growth is derived from the theory of communities of practice (Webber & Dunbar, 2020; Wenger et al., 2002). This theory is based on the degree of energy and ownership in the various development phases. However, the first discussion point is: is more also better? Community development is deliberate action taken to elicit desired structural changes. Growth, on the other hand, focuses on the quantitative aspects of strategic, social, economic, and physical growth within the context that more is better. One should carefully distinguish, then, between indicators that measure growth versus development. By these definitions, a community can have growth without development and vice versa. The important point to note, however, is that development not only facilitates growth but also influences the kind and amount of growth a community experiences (Phillips & Pittman, 2008). Reflecting on this theory, it can be concluded that this dissertation assumes a combination of growth and development. The level of energy is closely linked to growth, while the level of ownership can have consequences for the structure and composition of the community. A second point of discussion is: the activation of a community does not strictly follow a linear process, and some communities are more successful or resilient than others. The question is: is it inevitably a question of the members living within a specific community and their level of capability? Alternatively, it could be a question about the types of resources that different communities bring to bear in pursuing opportunities and tackling challenges. According to Scott (2009), a part of the answer lies in the strength and quality of community relationships and networks. Urban sociology highlights the important role a neighbourhood's social infrastructure plays in the development of vital communities. Furthermore, Fong et al. (2021) suggest that the socio-spatial context can enable participation, can support positive social identities, facilitates a sense of well-being, and is a potential connector to the community. Common strategies to activate communities are the participation of local partners and volunteers, in-person activities, accessibility, reciprocity, and neighbourhood-specific solutions. Additional adaptive strategies include intergenerational ties, emphasizing fun, and flexibility (Oh et al., 2021). Vital communities certainly are not a miracle cure that will solve all problems. Vital communities do not function in a vacuum. Rather, they work in conjunction with other parties, resources, and values to shape the development trajectory of individuals and communities (Scott, 2009).

Conclusions

It can be concluded this research delivers a well-grounded conceptualisation of the concept of ageing in place and the phenomenon of vital communities as well. Next, the relationship between ageing in place and vital communities is being explored. In conclusion, it can be stated that vital communities do have a certain potential to support older people ageing in place. However, activation (unlocking the potential previously mentioned) of the community is not always a self-initiating process. It often needs strategies, interventions, effort, and time to unlock and reveal the possible support a vital community could provide. A Community Activation Compass to guide this activation has been developed. According to the participants of the co-creation process that led to the compass, the compass certainly has the potential to fulfil its aim: to increase the support older people ageing in place experience from the community that surrounds them.

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Chapter 8

Impact

Impact

If we look at the perspective of ageing in the Netherlands, we notice the following trends and developments. It is expected that in 2040 about 4.8 million people aged 65 and over will live in the Netherlands. We are the European leader in terms of total healthcare costs in general per capita. There is a shortage of around 80,000 qualified healthcare professionals, and the demand for nursing-home units in the Netherlands will explode to 240,000 by 2040. In addition, most older people want to live independently for as long as possible (Van Bloois, 2022). The Dutch government is committed to an integrated care agreement with programmes such as the programme for housing and support and the programme for elderly care (Kiers & Ahli, 2023). The three principles of these programmes are 'yourself if possible', 'at home if possible', and 'with digital support if possible'. The results of this dissertation and the developed Community Activation Compass meet these three principles by providing a method to activate communities that enables independent living for older people. A reflection of the impact and relevance of the results of this dissertation is given in this paragraph. This reflection focuses on the main goals of the research, its relevance to science, society, and education, to which target group the results are relevant, and what activities are planned for sharing the gained knowledge.

Scientific impact

The focus of this research was how can we maintain or create the 'place to be' for older people who want to remain living at home and age in place. To establish this connection, cooperation between community members, entrepreneurs, the municipality, and institutions is very important. As a researcher, I started a project in the city centre of Geleen. Together with older community members, entrepreneurs, the municipality, and institutions, we developed a solution to support seniors living at home, with the aim that seniors, as full members of our society, can continue to live in their own homes for as long as possible. Using co-creation, we will work together on this great challenge to create a vital community. Therefore, we created the Community Activation Compass as guidance, supporting initiators of a vital community in drawing up and implementing an activation plan in order to create the place to be.

Relevance
Contribution to science

The main results of this research are threefold. First, insight is provided into the concept of ageing in place and the main factors that make independent living possible. In a scoping review (Chapter 2) we showed that a lot of research is already being done on ageing in place. However, an overview of this concept was still lacking. The need for

this scientific knowledge is apparent from the Cambridge University Press report that the scoping review was the most popular and most downloaded article in 2022 in the journal *Ageing and Society*. In addition, several (poster) presentations are provided for other researchers at the National Gerontology Congress and Care4 Congress (International Scientific Nursing and Midwifery Congress) in Leuven (Belgium). Second, insight is given into the concept of vital communities using the three dimensions: why, how, and what (Chapter 3). Little scientific knowledge is available about the concept of vital communities. It is a popular term used in various applications. The added value of this research to science is the description of the three dimensions and the drawing up of a broad definition of vital communities. Third, as the final contribution of this research to science, a Community Activation Compass has been developed, using a research method in which all key stakeholders, including older people, are involved. Not only are the results of this research relevant for researchers, but also the design-oriented method that was used. After all, actively involving all stakeholders in the development of new knowledge provides added value for science and practice. The fact that this design-oriented research design is appreciated by other researchers in the field is evident from the awarding of the Janneke Witsenburg award during the National Gerontology Congress in 2022.

Contribution to society

This research on vital communities had already impacted society before it was completed. The living lab in the centre of Geleen was specially initiated for this research and facilitated by Stadslabs Sittard-Geleen. This organisation supports social initiatives and connects residents, entrepreneurs, government, and institutions in the municipality to work together. As City Makers, they form various 'City Experiments', such as this design-oriented research. During the meetings in the living lab, contact arose between older people, volunteers, and professionals. For example, two participants started 'Club Silver' with the support and facilitation of Stadslabs Sittard-Geleen. This club provides older people with the opportunity to meet in an accessible way. In addition, informal meetings are currently taking place between the participating older people and professionals to explore which other small initiatives can be started.

Figure 1.
Announcement in the newsletter of senior citizens association 'Bie os in the klous'

THE'SILVER CLUB' THE PLACE TO BE

For some people, Sundays are quiet and boring days. But, what if you can play cards or craft together with other people? Or just have a cup of coffee and a chat with your neighbours? We make this possible at the 'Stadskamer M35' in Geleen. With a nice cup of coffee and delicious pie, donated by the local bakery. The 'Stadskamer M35" is a place to be and to meet your neighbours.

Opening hours: every Sunday from 11 a.m. to 4 p.m. Location: Markt 35 in Geleen

See you, next Sunday!!!

The potential contribution to society mainly concerns the social sectors: housing, healthcare, welfare, and municipalities. Together they face the social challenges of the increasing ageing of the population and promoting the place to be for older people. Using the Community Activation Compass developed in this study to support initiators, they can take multidisciplinary initiatives to activate communities. The expected impact consists of supporting older people to live independently for as long as possible. Community support may also reduce the pressure on informal care partners. This solution is also an answer to the shortage in the labour market in terms of healthcare professionals and the increasing costs of healthcare. After all, through the cooperation between formal and informal parties, the support of elderly people living independently becomes a shared responsibility. In addition to this expected social impact in the longer term, the development of the Community Activation Compass has already had an impact. On June 22, 2023, the Compass was presented at the conference 'Spil in de Wijk' in Kerkrade. At least three municipalities volunteered to create a living lab to implement and apply the compass under the umbrella of the postdoc research that will be executed from September 2023 until September 2025.

Contribution to education

The contribution of this research to education consists of a number of initiatives. With the knowledge about vital communities, a Zuyd University minor has been developed for three years of study in collaboration with the faculties of facility management, social work, nursing, and occupational therapy. During this study module, students learn to work together across the domains to vitalise communities in practical situations. Vital communities has also been the main theme for the international study weeks of the faculty of facility management for several years. During these international weeks, students from Heerlen (Netherlands) worked together with students from Kufstein (Austria), Zurich (Switzerland) and Frankfurt (Germany) to activate communities in the centre of Heerlen. In addition, the results of this research offer challenging opportunities to connect students, lecturers, researchers, and practitioners in the future. This is in the form of internships and project assignments in living labs to be determined later, in which communities are formed around concrete activation activities and students can work together (in the field) on 'lifelike assignments' in a multidisciplinary setting. With this, interprofessional collaboration and learning in communities can be stimulated. The knowledge and tools developed find their way to education and research centres, with regard to the transition theme of smart living for hotel and facility management, healthcare, social work, and built environment, among others. Precisely because communities must be supported and activated from the various domains (economy, housing, care, welfare), the results of this research offer good opportunities for developing interdisciplinary education, which is an important ambition for the near future. The postdoc research (See contribution to society) will focus on the development of a module in which professionals from municipalities, healthcare, welfare, and social housing associations learn how to apply the compass in a way it will positively impact the quality of life of people ageing in place.

Target groups

The research results are interesting and/or relevant to several target groups, in particular for the initiators of vital communities. These initiators may include professionals from the social sectors of housing, (health)care, and welfare. However, the results are also relevant for policy officers of municipalities who develop policies with regard to ageing in place and the quality of life of older people. In addition to the formal organisations, the research results are also interesting for associations that are committed to the quality of life of older people, such as neighbourhood associations and other elderly associations. With the help of the Community Activation Compass, the target group described above can draw up and implement their own activation plan in order to raise the community to a higher level and create the place to be for older people living independently at home.

Activities

The above target groups are involved in various ways and informed about the research results, so that the knowledge gained can be used in the future. For example, in June

2023, a workshop was held during the congress ‘Spil in de Wijk’ for professionals from housing, care, welfare, municipalities, and volunteers. The workshop included a presentation of the research results followed by a discussion on their application in various contexts. In addition, postdoc research is planned for the short term. This postdoc research completes the circle of conducting design-oriented research. Develop, implement, evaluate, and adjust in order to achieve meaningful impact for practice, education, and research. This postdoc research aims to implement and evaluate the Community Activation Compass for feasibility, usability, and added value. The central question is: To what extent does the application of the Community Activation Compass contribute to the increased vitality of the community, and which adjustments to the approach are desirable based on the experiences with those applications?

The final improved version of the Community Activation Compass will be made digitally available for practice. In addition, future dissemination activities (e.g. workshops) are being developed and given to the target group regarding the application of the Community Activation Compass.

Summary

This dissertation provides insight into how communities can be activated to support older people ageing in place. In addition, this dissertation shows what the concepts of ageing in place and vital communities mean according to the scientific literature, and what relationship can be distinguished between these two concepts. Conducting research into this relationship is important, because it provides insight into whether vital communities have the potential to support older people ageing in place. Various studies with various research methods have been set up to investigate this. First, a systematic literature review in the form of a scoping review was performed on the concept of ageing in place (**Chapter 2**). Second, a scoping review was performed on the concept of vital communities (**Chapter 3**). Third, the hypothesised relationship between vital communities and ageing in place was evaluated by international experts on ageing in place and vital communities (**Chapter 4**). Finally, a method and a quick -scan were developed in a living lab as a tool for initiators to draw up and implement an activation plan (**Chapters 5 and 6**). This section summarises all the studies described in this dissertation.

Chapter 1 contains a general introduction that describes the demographic developments and, in particular, the impact of ageing on healthcare and on formal and informal support. This shows that there are sufficient reasons to support ageing in place while preserving the quality of life of older people. The concepts of ageing in place and vital communities are explained here. This chapter also describes the aims and design of this dissertation as well as the studies on which it is based. A systematic literature study in the form of a scoping review (**Chapter 2**) identified 34 studies describing the concept of ageing in place. The results of this scoping review identified five main themes. These main themes: place, social networks, support, technology, and personal characteristics of older people, could be named as the factors to enable ageing in place. A second scoping review of the concept of vital communities (**Chapter 3**) identified only six studies on this topic. The results of this second scoping review showed that the conceptualisation of a vital community is based on three dimensions, namely the 'why', 'how', and 'what': the goal of a vital community, the processes behind a vital community, and the typical characteristics of a vital community. The aim of the third study (**Chapter 4**) was to study the supposed relationship between vital communities and ageing in place. This study was carried out using the Delphi method, in two phases. During the first phase, two panel discussions took place to define statements representing the supposed theoretical relationship between vital communities and ageing in place. The panel discussions were followed by the second phase, using three online Delphi rounds, which aimed to reach consensus among 126 international experts on the theorised relationship between vital communities and ageing in place. The results of this study showed consensus among the experts on aspects that showed a positive contribution regarding the aim of vital communities (quality of life, belonging) and all key themes of ageing in place (place, social networks, support, technology, and personal characteristics). However, the international experts nuanced the theorised relationship with regard to technology. Whether technology contributes to ageing in place depends, according to the experts, on the skills of the older people and the type of technology. The findings of this study imply that vital communities can support older people to age in place for as long as possible while still preserving their quality of life. This third study concludes the theoretical flow of this dissertation.

In the practical flow of this dissertation, a method is developed to activate communities with the aid of design-oriented research (**Chapter 5**). This fourth study aimed to develop a method that supports members of the community (professionals, volunteers, informal caregivers, and older people) in selecting useful strategies and interventions to activate a community to support older people ageing in place. A design-oriented study in a living lab with co-creative techniques was applied to involve as many parties as possible in an iterative and interactive approach to develop the activation method. This study resulted in the creation of the Community Activation Compass, guidance, a quick-scan, and an infographic with a series of development steps, strategies, interventions, and formats, which could support the activation of communities in facilitating ageing in place. During the development of the Community Activation Compass, the participants indicated a need for a quick-scan to map the vitality of the current community. This quick-scan was developed and validated on content and usability by 15 experts (**Chapter 6**).

Chapter 7 contains the main findings and implications of the studies presented in this dissertation. Methodological considerations with regard to design, the application of living labs, and co-creation are also explained. Theoretical considerations with regard to the vision of ageing in relation to the human dimension, the added value of vital communities compared to other initiatives, and the development of vital communities are also discussed. Finally, the impact is described. In this paragraph, reflection is given on the impact and relevance of the results of this dissertation. This reflection focuses on the main goals of the research, its relevance for science, society, and education, for which target group the results are relevant, and which activities are planned to share the knowledge gained. Finally, recommendations are made for both practice and future research

Samenvatting

Dit proefschrift geeft inzicht in de wijzen waarop communities geactiveerd kunnen worden om zelfstandig wonende ouderen te ondersteunen. Daarnaast laat dit proefschrift zien wat de concepten ageing in place en vital communities inhouden volgens de wetenschappelijke literatuur en welke relatie er bestaat tussen deze twee concepten. Het onderzoeken van deze relatie is van belang omdat dit inzicht geeft in de vraag of vital communities de potentie hebben om zelfstandig wonende ouderen te ondersteunen. Verschillende studies met diverse onderzoeksmethodieken zijn opgezet om dit te kunnen onderzoeken. Ten eerste is er een systematisch literatuuronderzoek in de vorm van een scoping review uitgevoerd naar het concept ageing in place (**Hoofdstuk 2**). Ten tweede is er een scoping review uitgevoerd naar het concept vital communities (**Hoofdstuk 3**). Ten derde is de vooronderstelde relatie tussen vital communities en ageing in place geëvalueerd door internationale experts op het gebied van ageing in place en vital communities (**Hoofdstuk 4**). Tot slot is in een living lab een methode en een quick-scan ontwikkeld als hulpmiddel voor initiatiefnemers om een activeringsplan op te stellen en uit te voeren (**Hoofdstuk 5 en 6**). Deze paragraaf vat alle studies die beschreven staan in dit proefschrift samen.

Hoofdstuk 1 bevat een algemene introductie die ingaat op demografische ontwikkelingen en met name de impact van vergrijzing op zorg en op formele en informele support. Hieruit blijkt dat er voldoende aanleiding is voor het ondersteunen van ageing in place, met behoud van kwaliteit van leven. De begrippen ageing in place en vital communities worden hierin toegelicht. Tevens beschrijft dit hoofdstuk zowel de doelstellingen en opzet van dit proefschrift als de studies die hieraan ten grondslag liggen. Een systematisch literatuuronderzoek in de vorm van een scoping review (**Hoofdstuk 2**) identificeerde 34 studies welke het concept ageing in place beschrijven. De resultaten van deze scoping review toonden vijf hoofdthema's aan. Deze hoofdthema's zijnde: plaats, sociale netwerken, support, technologie en persoonlijke kenmerken van ouderen, vormen als het ware de factoren die ageing in place mogelijk maken. Een tweede scoping review naar het concept vital communities (**Hoofdstuk 3**) identificeerde slechts zes studies over dit onderwerp. De resultaten van deze tweede scoping review toonden aan dat de conceptualisering van een vital community gebaseerd is op drie dimensies. Namelijk de 'why', 'how' en ''what' of te wel; het doel van een vital community, de processen achter een vital community en de typische kenmerken van een vital community. Het doel van het derde onderzoek (**Hoofdstuk 4**) was om de vooronderstelde relatie tussen vital communities en ageing in place te onderzoeken. Dit onderzoek werd uitgevoerd met behulp van de Delphi-methode, in twee fasen. Tijdens de eerste fase vonden twee paneldiscussies plaats om stellingen te definiëren welke de vooronderstelde theoretische relatie vertegenwoordigden tussen vital communities en ageing in place. De paneldiscussies werden gevolgd door de tweede fase met behulp van drie online Delphi-rondes, die tot doel had een consensus te bereiken onder 126 internationale experts over de theoretische relatie tussen vital communities en ageing in place. De resultaten van deze studie toonden consensus aan onder de experts over aspecten die de positieve bijdrage laten zien met betrekking tot het doel van vital communities (kwaliteit van leven, erbij horen), en alle hoofdthema's van ageing in place (plaats, sociale netwerken, support, technologie en persoonlijke kenmerken). De internationale experts nuanceerden echter de theoretische relatie met betrekking tot technologie. Of technologie bijdraagt, hangt volgens de experts af van de vaardigheden van ouderen en het type technologie. De bevindingen van dit onderzoek impliceren dat vital communities, ouderen kunnen ondersteunen om zo lang mogelijk zelfstandig te blijven wonen, met behoud van hun kwaliteit van leven. Met deze derde studie wordt de theoriestroom van dit proefschrift afgesloten. In de praktijkstroom wordt met behulp van ontwerpgericht onderzoek een methode ontwikkeld om communities te activeren (**Hoofdstuk 5**). Deze vierde studie had tot doel om een methode te ontwikkelen die leden van de community (professionals, vrijwilligers, mantelzorgers en ouderen) kan helpen bij het selecteren van nuttige strategieën en interventies om een community te activeren om zelfstandig wonende ouderen te ondersteunen. Een ontwerpgericht onderzoek in een living lab met co-creatieve technieken werd toegepast om zoveel mogelijk partijen te betrekken bij een iteratieve en interactieve aanpak om de activeringsmethode te ontwikkelen. Deze studie resulteerde in de creatie van het Community Activerings Kompas, een handreiking, een quick scan en een infographic met een reeks van ontwikkelingsstappen, strategieën, interventies en formats die zouden kunnen helpen om communities te activeren en ageing in place te faciliteren. Tijdens het ontwikkelen van de Community Activerings Kompas gaven de deelnemers aan behoefte te hebben aan een quick-scan waarmee de vitaliteit van de huidige community in kaart gebracht kan worden. Deze quick-scan werd ontwikkeld en vervolgens gevalideerd door 15 experts op inhoud en bruikbaarheid (**Hoofdstuk 6**).

Hoofdstuk 7 bevat de belangrijkste bevindingen en implicaties van studies die gepresenteerd zijn in dit proefschrift. Tevens worden methodologische overwegingen met betrekking tot het design, de toepassing van living labs en co-creatie toegelicht. Ook komen theoretische overwegingen met betrekking tot de visie op ouder worden in relatie tot de menselijke maat, de toegevoegde waarde van vital communities ten opzichte van andere initiatieven en de ontwikkeling van vital communities aan bod. Ten slotte wordt de impact beschreven. In deze paragraaf wordt een reflectie gegeven van de impact en relevantie van de resultaten van dit proefschrift. Deze reflectie richt

zich op de hoofddoelen van het onderzoek, de relevantie ervan voor wetenschap, maatschappij en onderwijs, voor welke doelgroep de resultaten relevant zijn en welke activiteiten gepland zijn om de opgedane kennis te delen. Tenslotte worden aanbevelingen gedaan voor zowel de praktijk als voor toekomstig onderzoek.

Publications

Publications

Katinka E. Pani-Harreman, Gerrie J.J.W. Bours, Sandra M.G. Zwakhalen, Joop M.A. van Duren (2023). De ervaren bruikbaarheid van een quick-scan voor het in kaart brengen van de vitaliteit van gemeenschappen. Under review, Geron

Katinka E. Pani-Harreman, Gerrie J.J.W. Bours, Sandra M.G. Zwakhalen, Joop M.A. van Duren (2023). The development of a guideline to activate vital communities facilitating older people ageing in place; a community based participatory research. Submitted to the Journal of Aging and Health

Katinka E. Pani-Harreman, Gerrie J.J.W. Bours, Michel M.H.C Bleijlevens, Gertrudis I.J.M. Kempen, Sandra M.G. Zwakhalen, Joop M.A. van Duren (2023). Towards consensus according to experts on the theorised contribution of vital communities to successful ageing in place: a modified Delphi study. Submitted to Aging International

Pani-Harreman, K. E., van Duren, J. M., Kempen, G. I., & Bours, G. J. (2022). The conceptualisation of vital communities related to ageing in place: a scoping review. European Journal of Ageing, 19(1), 49-62.

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Bours, G., Pani-Harreman, K., & van Duren, J. (2019). 'Dagbesteding anders': interviews met ouderen, professionals en vrijwilligers. Geron, 21(1).

K.E. Pani-Harreman, R. Valk, S. van der Linden (2018). In vital communities werken aan een veerkrachtige samenwerking. Onderwijs Innovatie.

Presentations

K.E. Pani-Harreman, J.M.A. van Duren. Integrale wijkversterking en het activeren van communities (2023). Conference Spil in de Wijk, Kerkrade

K.E. Pani-Harreman. Poster presentation. The development of a guideline to activate vital communities facilitating older people ageing in place (2022). Nationaal Gerontologie Congres, 's Hertogenbosch. Winnar Janneke Witsenburg price.

K.E. Pani-Harreman. Poster presentation. The development of a guideline to activate vital communities facilitating older people ageing in place (2022). Zuyd Event, Maastricht

K.E. Pani-Harreman, J.M.A. van Duren. Integrale wijkversterking en het activeren van communities (2021) Conference Gezondheidsakkoord, Sittard

K.E. Pani-Harreman. Poster presentation. Scoping review ageing in place (2020). Nationaal Gerontologie Congres, Ede

K.E. Pani-Harreman. Poster presentation. Scoping review ageing in place (2019). CARE4 – International Scientific Nursing and Midwifery Congress, Leuven

K.E. Pani-Harreman. Masterclasses Vital Communities 40th anniversary (2018). Zuyd University Applied Science, faculty facility management, Heerlen

K.E. Pani-Harreman. Vital communities and the relation with FM (2017). Conference meeting Euro FM, Heerlen

K.E. Pani-Harreman. Research proposal PhD-track (2017). Conference meeting research group Euro FM, Oslo

Curriculum Vitae

Curriculum Vitae

Katinka Pani-Harreman was born on May 5, 1963 in Heerlen. In 1987, she completed her bachelor study 'Toegepaste Huishoudwetenschappen', the predecessor of the Facility Management course of Zuyd University of Applied Science in Heerlen. After the graduation, she started her professional career in Facility Management. In the role of manager and policy officer, she has gained many practical work experience at large organisations such as the former DSM, Sodexo, Sphinx and Sevagram. During her career at Sevagram, the passion for elderly care and facilitation older people raised. Despite this passion voor facilitating older people, in 2011, she made the switch to education and started working as a lecturer at the Facility Management Academy in Heerlen. She makes this choice in order to be able to share her knowledge with young talent. In 2014 Katinka obtained her Master of Science Degree at the Master Facility and Real Estate Management (University of Greenwich, Zuyd Hogeschool). The subject of the Master thesis was 'Successful change and performance improvement the art of balancing'. A study of successful change management in (elderly) care. Conducting this study also the passion for research arose. In 2015, she joined the Facility Management research group (Zuyd University of Applied Sciences). In 2017, alongside her work as a lecturer, she started her PhD trajectory 'The place to be: guiding the activation of a community to facilitate ageing in place' at Maastricht University under the supervision of Prof. Dr. Ruud Kempen late, Prof. Dr. Sandra Zwakhalen, Dr. Gerrie Bours and Dr. Joop van Duren

Handreiking voor het activeren van gemeenschappen

SAMEN IMPACT CREËREN VOOR ZELFSTANDIG WONENDE OUDEREN

Handreiking voor het activeren van een gemeenschap om zelfstandig wonende ouderen te ondersteunen.

Auteur: Katinka Pani-Harreman
Datum: 22 juni 2023

Inhoudsopgave

Voorwoord

Voor u ligt een concept handreiking voor het opstellen van een plan om een gemeenschap te activeren om zelfstandig wonende ouderen te ondersteunen. Zo lang mogelijk zelfstandig wonen in een fijne omgeving en de regie hebben over je eigen leven. Wie wil dat nou niet op zijn oude dag? Een vitale gemeenschap kan volgens zelfstandig wonende ouderen hierin ondersteunen. Daarom zijn we in een living lab in de gemeente Sittard-Geleen samen aan de slag gegaan met het ontwikkelen van een handreiking welke helpt om gemeenschappen te activeren.

De ideale vitale gemeenschap bestaat niet en zal waarschijnlijk ook niet vanzelf ontstaan. Daar zijn initiatiefnemers voor nodig en natuurlijk betrokken bewoners, mantelzorgers, vrijwilligers, corporaties, zorginstellingen, gemeente en andere welzijnspartners. Deze handreiking is dan ook bedoeld om jullie te helpen, te inspireren en te enthousiasmeren om samen de handen ineen te slaan en aan de slag te gaan.

Er zijn verschillende manieren om de vitaliteit van gemeenschappen te activeren. Welke het beste past, hangt af van de vitaliteit van de gemeenschap, de bewoners, de samenwerkende partijen en de context.

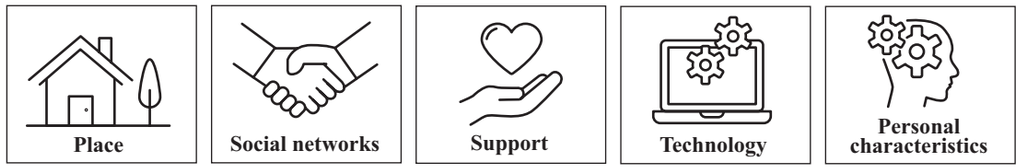
Haal de vraag op bij ouderen zelf, faciliteer kleine initiatieven, zoek de verbinding op, pak kansen, werk samen, zoek helpende handen en bouw door. Zet jullie kennis en professionaliteit in. Ik wens jullie mooie resultaten toe voor en met onze zelfstandig wonende ouderen.

Katinka Pani

1. Aanleiding voor het ontwikkelen van de handreiking

De Nederlandse samenleving vergrijst in een rap tempo. Ouderen hebben de wens om zo lang mogelijk zelfstandig te wonen en regie te hebben over hun leven. Ook de Nederlandse overheid zet in op het bevorderen en mogelijk maken van “ageing in place”. Belangrijke aspecten van ageing in place zijn: wonen, de woonomgeving, sociale netwerken, geven en ontvangen van support, ondersteuning door middel van technologie en persoonlijke kenmerken van ouderen zelf.

Figuur 1.
Belangrijke thema’s die ageing in place mogelijke maken



Volgens de resultaten van recente onderzoeken kunnen vitale gemeenschapen bijdragen aan ageing in place. Met een vitale gemeenschap wordt een samenwerkingsverband bedoeld die zich inzet om het welzijn, de kwaliteit van leven en het meedoen van ouderen te bevorderen. De bedoeling van een vitale gemeenschap is dat (oudere) bewoners meer onderling contact krijgen, meer naar elkaar omzien en samen activiteiten uitvoeren. Dit kunnen kleine- maar ook wat grootschaliger initiatieven zijn zoals het creëren van sociale ontmoetingsplekken in de wijk. Tijdens de opstart van een vitale gemeenschap is ondersteuning vanuit wonen, zorg en welzijn aan te raden. Het idee is wel dat bewoners zelf de activiteiten verder oppakken.

Tijdens gesprekken geven zelfstandig wonende ouderen aan, dat vitale gemeenschappen een belangrijke bijdrage kunnen leveren aan de kwaliteit van leven, het meedoen, ondersteuning in dagelijks functioneren en zingeving. Denk bijvoorbeeld aan: hoe je woont, de sociale contacten en activiteiten in de buurt, hulp bij het huishouden, boodschappen doen, en/of klusjes aan huis. Vitale gemeenschappen kunnen dus betekenisvolle ondersteuning bieden aan ageing in place, maar doen dat (nog) niet altijd. Het

activeren van gemeenschappen is dan aangewezen.

Deze handreiking kan helpen bij het in beeld brengen van zaken als: waar staan we nu als gemeenschap? Langs welke weg kunnen we initiatieven ontwikkelen en wat moet daarvoor concreet gebeuren? Daarom is deze handreiking ontwikkeld om de 'geleerde lessen' van betrokkenen in het living lab in de gemeente Sittard-Geleen aan jullie mee te geven en hiermee jullie eigen activeringstrajecten te ondersteunen.

Voor wie?

Deze handreiking is bedoeld voor initiatiefnemers van een vitale gemeenschap. Dit kan zijn een woningcorporatie, zorginstelling, welzijnsorganisatie en/of de gemeente. Maar denk ook aan een samenwerking tussen bewoners, verenigingen, professionals uit de wonen-, zorg- en welzijnssector en gemeenten.

Wat?

De handreiking helpt bij het nemen van de juiste stappen om een gemeenschap in de praktijk te activeren in iedere fase van het ontwikkelproces.

Hoe?

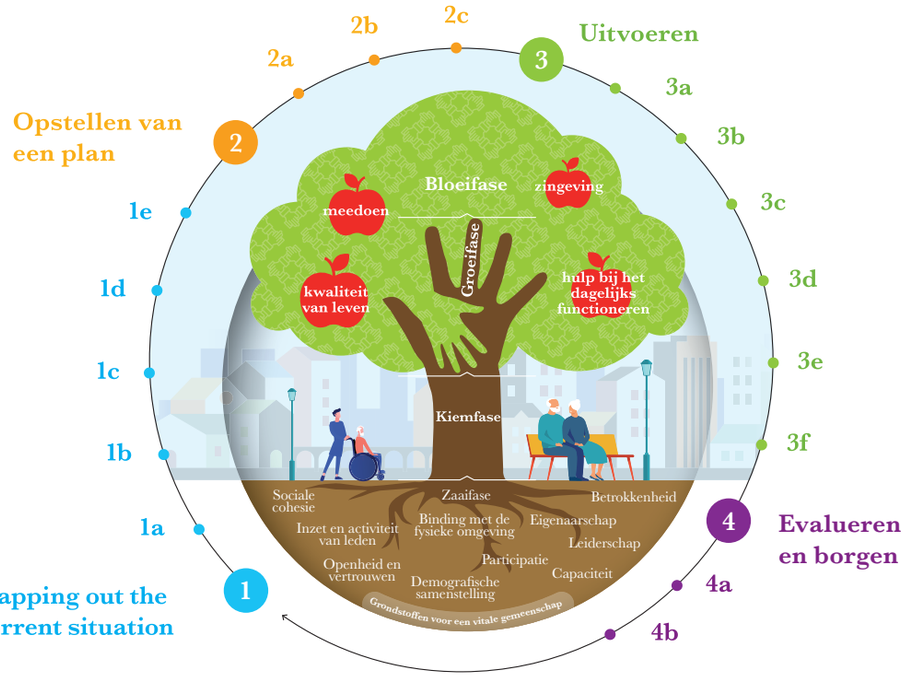
Deze handreiking wordt ondersteund door een infographic en een metafoor in de vorm van een boom met grondstoffen en vier processtappen als een grote slinger om de boom met als doel een activeringsplan te ontwikkelen. Als het plan in werking treedt, zal opbouw van de vitale gemeenschap verlopen volgens 4 ontwikkelfasen van de boom.

Figuur 2.
Infographic voor het activeren van gemeenschappen

Samen impact creëren voor zelfstandig wonende ouderen
Handreiking voor het activeren van een (vitale) gemeenschap om zelfstandig wonende ouderen te ondersteunen.

Voor wie?
Deze handreiking is bedoeld voor initiatiefnemers van een vitale gemeenschap. Dit kan zijn een

woningcorporatie, zorginstelling, welzijnsorganisatie en/of de gemeente. Maar denk ook aan een samenwerking tussen bewoners, verenigingen, professionals uit de wonen-, zorg- en welzijnssector en gemeenten.



1a De vraag ophalen bij zelfstandig wonende ouderen
1b Analyse van de wijk/buurt
1c Informatie verzamelen over bestaande initiatieven
1d Contacten leggen
1e Analyse van de vitaliteit van de gemeenschap met behulp van de Quick Scan

2a Waarde creëren
2b Waarde realiseren
2c Waarde binnenhalen

3a Kleine initiatieven
3b Collectief ontmoeten
3c Sleutelfiguren
3d Vliegwiel
3e Plezier en gezelligheid
3f Informatie en communicatie

4 Indien de vitale gemeenschap zich in de bloeifase bevindt.
4a Evalueren
4b Borgen

2. Wat is een vitale gemeenschap

Met een vitale gemeenschap wordt een samenwerkingsverband bedoeld die zich inzet om het welzijn, de kwaliteit van leven en het meedoen van ouderen te bevorderen. Uit de resultaten van de studie over vitale gemeenschappen blijkt dat deze bestaat uit een aantal grondstoffen. De grondstoffen zijn voorwaardelijk voor de ideale vitale gemeenschap.

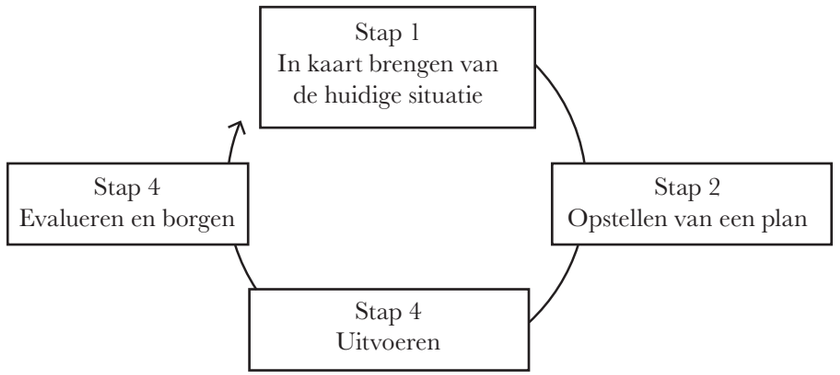
1. **Sociale cohesie**, de mate van samenhang, verbondenheid en solidariteit binnen groepen en gemeenschappen.
2. **Inzet en activiteit van leden**, ondernemerschap en de mate waarin de leden zich actief inspannen om een gezamenlijk doel te bereiken.
3. **Eigenaarschap**, verantwoordelijkheid voelen en nemen.
4. **Participatie**, meedoen aan de samenleving, zoals werken, studeren en/of het verrichten van vrijwilligerswerk.
5. **Leiderschap**, regie en facilitering.
6. **Betrokkenheid**, de mate van tijd, aandacht, werk en moeite die iemand over heeft voor de gemeenschap.
7. **Openheid en vertrouwen**, de mate van transparantie en sociaal veiligheid.
8. **Demografische samenstelling**, de opbouw van de bevolking bijvoorbeeld: leeftijd, afkomst, inkomen, opleiding, etc.
9. **Binding met de fysieke omgeving**, de mate waarin de bewoners binding hebben met de fysieke omgeving en de mensen die daar wonen en werken.
10. **Capaciteit**, (financiële) middelen, kennis, menskracht, tijd.

3. Hoe activeer je een gemeenschap

Het activeren van een gemeenschap begint met het in kaart brengen van de huidige situatie. Een vitale gemeenschap heeft alleen kans van slagen als de deelnemende partijen een gemeenschappelijk doel hebben. Er dient een zogenoemde 'aanleiding of noodzaak aanwezig te zijn. Denk aan buurten en wijken met een relatief hoog percentage zelfstandig wonende ouderen, veel eenzaamheid en een lage sociale cohesie. De noodzaak, bereidheid tot samenwerking en het hebben van een gemeenschappelijk doel zijn de belangrijkste randvoorwaarden om een gemeenschap te activeren.

Naast het gemeenschappelijk doel is het ook nodig om de vraag of anders gezegd de behoefte aan ondersteuning op te halen bij de ouderen zelf, het verzamelen van informatie over initiatieven die er al zijn en een analyse van de huidige vitaliteit van de gemeenschap. Met deze informatie wordt een activeringsplan opgesteld voor de uitvoering. De uitvoeringsfase vraagt de meeste inspanning. Na afloop blijft een beperkte ondersteuning van de initiatiefnemers meestal nodig om de positieve lijn te borgen. De ontwikkeling van een vitale gemeenschap is geen linieer proces. Er zullen momenten zijn van terugval. Op deze momenten is meer energie en ondersteuning nodig van professionals. De vier stappen om gemeenschappen te activeren zijn weergegeven in figuur 3.

Figuur 3
Vier stappen voor het activeren van vitale gemeenschappen



4. Stap 1. In kaart brengen van de huidige situatie

Het is nuttig om voldoende tijd en energie te besteden aan deze eerste stap. Het vormt immers de basis voor een succesvolle activering. Deze eerste stap bestaat uit vijf onderdelen:

1. de vraag ophalen bij zelfstandig wonende ouderen,
2. een analyse van de wijk/buurt,
3. contacten leggen,
4. de informatie verzamelen over bestaande initiatieven en
5. een analyse van de vitaliteit van de gemeenschap.

4.1 Vraag ophalen

Haal de vraag naar ondersteuning van de zelfstandig wonende ouderen op. Denk dus niet voor deze doelgroep maar vraag wat hun behoeften zijn. Een model wat hierbij behulpzaam kan zijn is Positieve Gezondheid. Dit model kent 6 thema's. De kwaliteit van leven, meedoen, hulp bij het dagelijks functioneren, zingeving, mentaal welbevinden en lichaamsfuncties. Aan de hand van deze thema's kan het gesprek worden aangegaan met ouderen over de mogelijke bijdrage van een vitale gemeenschap aan het zelfstandig wonen. Meer weten over positieve gezondheid, check de toolbox in deze handreiking.

Organiseer bijeenkomsten in de buurt/wijk maar denk ook aan huisbezoeken, wensbomen neerzetten, etc. Ga ook in gesprek met sleutelfiguren in de buurt/wijk en leg de verbinding tussen bewoners en professionals.

4.2 Aandacht voor individueel maatwerk

Naast het collectieve proces is het ook belangrijk om oog te hebben voor individuele aandachtspunten. Indien bij het ophalen van de vraag bij zelfstandig wonende ouderen, individuele aandachtspunten aan de orde komen, neem deze dan mee. Biedt maatwerk. Op deze wijze kun je ouderen mee laten doen in de gemeenschap.

4.3 Analyse van de wijk/buurt

Analyseer de uitgangssituatie, hoe ziet de buurt/wijk eruit. Denk aan de bevolkingsopbouw (leeftijdsopbouw, nationaliteit, etniciteit en beroep) aantal en soorten woningen, voorzieningen, winkels etc. Hiervoor kun je gebruik maken van bestaande wijkanalyses met demografische gegevens en de kennis van zorgaanbieders, woningcorporaties, gemeenten en welzijnsorganisaties. Deze informatie is vaak beschikbaar bij de gemeenten of te vinden via websites. Voor handige websites, check de toolbox in deze handreiking.

4.4 Contacten leggen

Leg contact met andere partijen die een rol hebben (wonen, zorg, welzijn, gemeente) en verken de bereidheid en noodzaak tot samenwerking. Deze stap is cruciaal, als er geen bereidheid en noodzaak is zal er weinig energie zijn om samen te werken. Denk ook aan het benaderen en samenwerken met het wijkplatform, buurtvereniging, gebieds- of wijkregisseur van de corporatie, de wijkmanager van de gemeente.

4.5 Informatie verzamelen

In de praktijk zijn er al heel veel goede initiatieven en activiteiten georganiseerd door verschillende partijen. Verzamel informatie over al deze initiatieven in de buurt/wijk die er al zijn. Bundel deze informatie en maak bijvoorbeeld een sociale kaart als deze er nog niet is.

4.6 Analyse van de vitaliteit

Voer een analyse uit van de huidige vitaliteit van de gemeenschap. Deze analyse kun je uitvoeren met behulp van een quick-scan (QR-code/link naar de quick-scan). De quick-scan is een globale evaluatie van de gemeenschap, waarbij de belangrijkste kansen, knelpunten en verbetermogelijkheden worden benoemd. Een vitale gemeenschap bestaat uit tien grondstoffen. Namelijk: sociale cohesie, inzet en activiteit van leden, eigenaarschap, participatie, leiderschap, betrokkenheid, openheid en vertrouwen, demografische samenstelling, de fysieke omgeving en beschikbare capaciteit.

Een juiste invulling van deze grondstoffen levert meer kans op succes voor een vitale gemeenschap. Door het invullen van de vragenlijst blijkt al snel hoe vitaal de grondstoffen van gemeenschap zin. De stellingen die je kiest staan niet gelijk aan 'goed' of

‘fout’, maar geven een inschatting van de ontwikkelingsfase waarin de gemeenschap zich nu bevindt. Inzicht daarin is van belang om te bezien hoe je naar het ‘next level’ komt.

De ontwikkeling van een vitale gemeenschap bestaat uit een aantal fases:

- Zaaifase
- Kiemfase
- Groeifase
- Bloeifase

Indien de score van een bouwsteen lager is dan de groeifase, dan is er werk aan de winkel en verdient deze bouwsteen aandacht in het plan van stap 2. In de infographic (de boom) zie je de vier bovenstaande ontwikkelfasen waarin een vitale gemeenschap zich kan bevinden.

De zaaifase
Ontdek en stimuleer

De vitale gemeenschap begint doorgaans als losse (sociale)netwerken (of initiatiefnemers) die het potentieel hebben om meer verbonden met elkaar te worden. Het energieniveau van de leden is op dit moment nog laag, maar zal beginnen toe te nemen door kleine initiatieven. Een grote inbreng en facilitering van initiatiefnemers is in deze allereerste fase nodig.

De kiemfase
Faciliteer en creëer impact

Als leden verbindingen en relaties met elkaar opbouwen, beginnen ze samen te komen in een gemeenschap. Ze zullen in dit stadium de mogelijkheden onderzoeken en het energieniveau van de leden zal toenemen naarmate de gemeenschap zich ontwikkelt. De initiatiefnemers hebben minder directe inbreng nodig terwijl dit gebeurt, en zouden de groep in staat moeten stellen onderlinge banden te smeden.

De groeifase
Focus en groei

De groeifase kenmerkt zich doordat de gemeenschap groeit in lidmaatschap, activiteit

en inzet. De gemeenschap zal sterke banden gaan vormen en het wederzijds vertrouwen zal groeien. De energie van leden kan aanvankelijk afnemen naarmate de gemeenschap volwassener wordt, maar zal gestaag groeien. Initiatiefnemers zullen in dit stadium meer gestructureerde input nodig hebben om de ontwikkeling van de community te ondersteunen.

De bloeifase
Eigenaarschap en vertrouwen

Als de gemeenschap zich in de bloeifase bevindt zal voldoende activiteit en inzet van haar leden hebben om door te gaan met minder inspanning van de initiatiefnemers. Leden worden eigenaar van activiteiten en initiatieven die ze creëren en delen. De energie van leden tijdens deze fase zal over het algemeen hoog blijven, maar er zullen ook momenten zijn van terugval. Initiatiefnemers hebben zo min mogelijk input nodig, aangezien leden zelf een deel van de leiderschapsrol op zich nemen.

5. Stap 2. Opstellen van een plan

Op basis van stap 1 (in kaart brengen van de huidige situatie) stel je een plan op, om een gemeenschap te activeren. Voor het opstellen van een activeringsplan kun je onderstaande stappen volgen en format gebruiken. Het format is gebaseerd Business Model Canvas (BMC) model. Deze methode is zeer geschikt voor op een gestructureerde manier in kaart brengen van 9 bouwstenen die van belang zijn voor een geslaagd plan. Voor een template en uitleg van het BMC model zie de toolbox in deze handleiding. Het is zeer aan te bevelen om dit samen met alle betrokkenen uit te voeren. Dit draagt namelijk bij aan een gedeelde verantwoordelijkheid en een gezamenlijk draagvlak om zo impact te kunnen maken. Indien je meer wil weten hoe je samen impact kunt creëren, en hoe je het BMC-model kunt toepassen, check dan de Co-creatie impact kompas in de toolbox.

Begin met de bouwstenen voor waarde creëren (doelgroepen en waarde propositie), daarna 'waarde realiseren' (kernpartners, kernactiviteiten, kernmiddelen, klantrelaties, kanalen) en tenslotte 'waarde binnenhalen' (kostenstructuur, inkomstenbronnen).

5.1 Waarde creëren

Definieer samen de gezamenlijke sociale 'droom' van de vitale gemeenschap. Wat is de stip aan de horizon. Het gaat hier om de 'waarom' vraag en dient zowel inspirerend als richtinggevend zijn. Waarom willen we een gemeenschap activeren. Denk hierbij aan impact creëren voor zelfstandig wonen ouderen zoals bijdragen aan de kwaliteit van leven, minder eenzaamheid onder ouderen, bevorderen van het mee doen, etc. etc. Alles dat volgt hangt af van deze 'droom'. Het is dus belangrijk het dat alle betrokkenen hierover ook echt overeenstemming hebben. Noteer deze droom het vak 'waarde propositie'. In het vak doelgroepen beschrijf je de doelgroep die je wilt bereiken.

5.2 Waarde realiseren

In het vak kernpartners noteer je alle betrokken partijen, denk bijvoorbeeld aan wonen, zorg, welzijn, gemeente, wijkplatform, buurtvereniging, etc. De infographic van 'wie is wie in de wijk' in de toolbox kan hierbij behulpzaam zijn.

Formuleer samen de concrete doelen en activiteiten die je wilt gaan uitvoeren. Probeer deze doelen zo SMART mogelijk te maken Wie doet wat en wanneer en noteer deze in het vak 'kernactiviteiten'.

Daarna bepaal je, hoe deze doelen bereikt worden, welke kernmiddelen of grondstoffen zijn nodig? Selecteer hiervoor eerst de grondstoffen uit de quick-scan die aandachtnodig hebben. Dat zijn alle grondstoffen die lager scoren als 3 in de quick-scan. Noteer deze grondstoffen in het vak 'kernmiddelen'.

In het vak 'kanalen' noteer je hoe je de informatie en communicatie naar de doelgroep gaat regelen. Uit gesprekken met ouderen blijkt dat ze dit onderdeel erg belangrijk vinden. Daarnaast werk je uit op welke wijze je de relatie met zelfstandig wonende ouderen gaat onderhouden en noteert deze ideeën in het vak 'klantrelaties'.

5.3 Waarde binnenhalen

In het BMC-model wordt gesproken over kostenstructuur en inkomstenbronnen. Bepaal wat welke financiële kosten, tijd, energie er nodig zijn om het plan uit te voeren. Noteer dat in het vak 'kostenstructuur'.

In het vak 'inkomstenbronnen' noteer je de opbrengsten van het plan. Naast financiële opbrengen (minder zorgkosten) zijn er vooral maatschappelijke en sociale opbrengen. Denk aan een inclusieve samenleving, minder eenzaamheid, een betere kwaliteit van leven etc.

6. Stap 3. Uitvoeren

De uitvoering van het plan kan stapsgewijs worden uitgevoerd. Hieronder worden een aantal tips van professionals uit de praktijk gegeven als inspiratie.

Mevrouw N: "Ik vind het leuk om samen met ander dames te handwerken. Maar ook om jonge mensen dit te leren. Een breicafé beginnen lijkt me erg leuk. Maar ik weet niet hoe en waar."

Stimuleren en faciliteren van 'kleine' initiatieven

Stimuleer mensen om 'kleine' initiatieven te nemen. Koester de initiatiefnemers. Laat (oudere) bewoners zelf kleinschalige, concrete initiatieven nemen. Sluit aan bij initiatieven die er al zijn. Hebben bewoners een zetje in de goede richting nodig? Of weten ze niet waar ze informatie kunnen vinden. Faciliteer initiatieven alleen zolang als het nodig is. Maak het niet te groot, begin klein en laat initiatieven autonoom groeien. Zorg voor goede kleine voorbeelden die tot de voorbeeldig spreken.

Collectief ontmoeten

Stimuleer en facilitair het collectief ontmoeten. Creëer ontmoetingsplekken in de wijk/buurt die laagdrempelig zijn. Een sociale ruimte waar mensen elkaar kunnen ontmoeten, zonder iets te moeten.

Sleutelfiguren

Sleutelfiguren zijn de spin in het web. Zij weten wat er speelt in de buurt/wijk. Het is belangrijk om sleutelfiguren in de wijk te hebben die signaleren en handelen, maar ook om het contact in het algemeen levend te houden. Zet sleutelfiguren in als ambassadeur, zij kunnen op een laagdrempelige manier contacten bevorderen.
Vliegwiel

Laat processen op een natuurlijke manier op gang komen. Een vliegwiel of aanjager is voldoende om mensen te activeren en processen op gang te krijgen.

Plezier en gezelligheid

Start een gemeenschap met plezier en gezelligheid. De gemeenschap kan zich dan geleidelijk ontwikkelen van 'plezier en gezelligheid' naar 'support, plezier en gezelligheid'

Meneer A: "Het zou helpen als ik een contactpersoon in de buurt heb, waar ik terecht kan met mijn ideeën. Ik wil graag meedenken met de gemeente om het marktplein anders in te richten. Denk aan meer groen en bankjes."

Mevrouw G: "Ik ben opzoek naar een leesclubje, maar kan nergens informatie vinden of zoiets bij ons in de buurt bestaat."

Informatie en communicatie

Informatie over alle activiteiten in de buurt zou handig zijn voor veel ouderen. Denk aan een fysiek boekje, prikborden maar ook digitale informatievormen. Zorg ervoor dat professionals zichtbaar zijn in de wijk. Denk aan een fysiek contactpunt en/of een sociale ontmoetingsplek.

7. Stap 4. Evalueren en borgen

Indien het plan tot uitvoering is gebracht is het aan te raden om samen met alle betrokkenen te evalueren of de gestelde doelen behaald zijn en eventueel acties bijgesteld moeten worden. Deze evaluatie kan uitgevoerd worden met behulp van het ingevulde BMC-model uit stap 2. Na bijstelling kan een herzien BMC-model worden ingevuld. De uitdaging is om de groei en de vitaliteit van de gemeenschap duurzaam te borgen. Volgens experts wordt dit onder andere bereikt door het bevorderen van een inclusieve samenleving waar jong en oud samenwerken aan een vitale gemeenschap.

8. Toolbox

Voor het doorlopen van de stappen kan onderstaande informatie behulpzaam zijn.

Onderwerp	**Te raadplegen bij:**
Co-creatie Kompas	https://www.limeconnect.nl/successen/co-creatie-impact-kompas/
Business Model Canvas model	The Triple Layered Business Model Canvas – A Tool to Design More Sustainable Business Models | Sustainable Business Model.org
Positieve gezondheid	https://www.iph.nl/
Quick scan	20220523 Quick-scan.xlsx
Planbureau voor de leefomgeving	https://www.pbl.nl/publicaties/hoe-is-het-leven-in-jouw-regio
ABCD methode (Asset-Based Community Development)	https://www.movisie.nl/interventie/abcd
Leefbaarometer	https://www.leefbaarometer.nl
Checklist hoe bereik je ouderen	https://www.beteroud.nl/tips-tools/tools/checklist-hoe-bereik-je-ouderen?
10 praktijktips om ouderen te betrekken bij projecten	https://www.beteroud.nl/tips-tools/tips/10-praktijktips-om-ouderen-te-betrekken-bij-projecten
Demografische gegevens	https://allecijfers.nl/buurt/geleen-centrum-sittard-geleen
Informatieplatform voor gezond en vitaal ouder worden in de regio 046	Home - Vitaal in 046
Wie is wie in de wijk	https://www.beteroud.nl/tips-tools/tools/wie-is-wie-in-de-wijk

Quick-scan

Let op, per bouwsteen slechts één stelling selecteren!

Kies per bouwsteen, de stelling, welke het beste past in de huidige situatie.

Sociale cohesie (de mate van samenhang, verbondenheid en solidariteit binnen groepen en gemeenschappen)	**Selectie**	**Ontwikkelfase/strategie**
Er is sprake van losse (sociale)netwerken die het potentieel hebben om meer verbonden met elkaar te worden.	☑	Initiatieffase: ontdek en stimuleer cohesie
Leden van de gemeenschap, bouwen relaties en verbindingen met elkaar op en beginnen samen te komen in de gemeenschap.	☐	
De gemeenschap groeit met betrekking tot de sociale cohesie.	☐	
De gemeenschap kenmerkt zich door een sterke sociale cohesie.	☐	
Inzet en activiteit van leden (ondernemerschap en de mate waarin de leden zich actief inspannen om een gezamenlijk doel te bereiken)		
Mensen zijn nog weinig actief binnen de gemeenschap.	☐	
Het nemen van initiatieven komt op gang.	☑	Vormingsfase: facilitair initiatieven en faciliteiten
Mensen zijn actief binnen de gemeenschap.	☐	
Mensen zijn zeer actief binnen de gemeenschap.	☐	
Eigenaarschap (verantwoordelijkheid voelen en nemen)		
Mensen voelen en nemen weinig verantwoordelijkheid voor het nemen van initiatieven.	☐	
Mensen worden door initiatiefnemers gestimuleerd om zelf initiatieven te nemen.	☐	
Mensen worden eigenaar van activiteiten en initiatieven en hebben weinig ondersteuning nodig.	☑	Groeifase: focus op groei
Mensen zijn eigenaar van activiteiten en initiatieven die ze zelf creëren en delen.	☐	
Participatie (meedoen aan de samenleving, zoals werken, studeren en/of het verrichten van vrijwilligerswerk)		
Mensen van de gemeenschap doen nog maar weinig mee.	☐	
Mensen hebben behoefte aan het ontmoeten van anderen, het meedoen komt langzaam opgang.	☐	
Mensen worden door de gemeenschap gestimuleerd tot actieve deelname.	☐	
Mensen doen actief mee binnen de gemeenschap.	☑	Bloeifase: werk aan eigenaarschap en vertrouwen
Leiderschap (regie en facilitering)		
Initiatiefnemers van de gemeenschap bieden een directe inbreng en facilitering.	☐	
Initiatiefnemers van de gemeenschap bieden minder directe inbreng en facilitering.	☐	
Initiatiefnemers van de gemeenschap ondersteunen/faciliteren de gemeenschap alleen op basis van behoefte.	☐	
Initiatiefnemers van de gemeenschap ondersteunen/faciliteren de gemeenschap zo min mogelijk, aangezien leden zelf de leiderschapsrol op zich nemen.	☐	
Betrokkenheid (de mate van tijd, aandacht, werk en moeite die iemand over heeft voor de gemeenschap)		
Mensen voelen zich betrokken bij de gemeenschap door wonen en/of werk.	☐	
Mensen voelen zich betrokken bij de gemeenschap door de sociale binding met anderen.	☐	
Mensen zijn onderling zichtbaar betrokken.	☐	
Mensen ervaren een hoge mate van betrokkenheid in de gemeenschap.	☐	
Openheid en vertrouwen (transparantie, sociaal veilig)		
De gemeenschap is een sociale omgeving waar mensen zich veilig voelen om kleine initiatieven te nemen.	☐	
De gemeenschap is een sociale omgeving waar het wederzijds vertrouwen groeit.	☐	
De gemeenschap is een sociale omgeving waar men vertrouwen heeft in elkaar.	☐	
De gemeenschap is een sociale omgeving waar sprake is van groot onderling vertrouwen.	☐	
Demografische samenstelling (opbouw van de bevolking bijvoorbeeld: leeftijd, afkomst, inkomen, opleiding, etc.)		
De demografische samenstelling van de bevolking biedt mogelijkheden tot vorming van een gemeenschap.	☐	
De demografische samenstelling van de bevolking biedt mogelijkheden om de groei van de gemeenschap te stimuleren.	☐	
De demografische samenstelling van de bevolking stimuleert de groei van de gemeenschap.	☐	
De demografische samenstelling van de bevolking brengt de gemeenschap tot bloei.	☐	
Binding met de fysieke omgeving (de mate waarin de bewoners binding hebben met de fysieke omgeving en de mensen die daar wonen en werken)		
De fysieke leefomgeving nodigt niet uit tot ontmoeten/leggen van contacten.	☐	
De fysieke leefomgeving zet aan het onderling ontmoeten van mensen.	☐	
De fysieke leefomgeving zet aan tot het vormen van sociale verbindingen tussen mensen.	☐	
De fysieke leefomgeving bevordert de leefbaarheid in de buurt/wijk	☐	
Capaciteit ((financiële) middelen, kennis, menskracht, tijd)		
De gemeenschap beschikt over te weinig capaciteit om groei te stimuleren.	☐	
De gemeenschap beschikt over voldoende capaciteit om groei te stimuleren.	☐	
De gemeenschap beschikt over toenemende capaciteit om groei te stimuleren.	☐	
De gemeenschap beschikt over de juiste capaciteit om zelfstandig te functioneren.	☐	

Living lab in ageing and long-term care

Living lab in ageing and long-term care

This thesis is part of the Living Lab in Ageing and Long-Term Care, a formal and structural multidisciplinary network consisting of Maastricht University, nine long-term care organizations (MeanderGroep Zuid-Limburg, Sevagram, Envida, Cicero Zorggroep, Zuyderland, Vivantes, De Zorggroep, Land van Horne & Proteion), Intermediate Vocational Training Institutes Gilde and VISTA college and Zuyd University of Applied Sciences, all located in the southern part of the Netherlands. In the Living Lab we aim to improve quality of care and life for older people and quality of work for staff employed in long-term care via a structural multidisciplinary collaboration between research, policy, education and practice. Practitioners (such as nurses, physicians, psychologists, physio- and occupational therapists), work together with managers, researchers, students, teachers and older people themselves to develop and test innovations in long-term care.

Academische werkplaats ouderenzorg limburg

Dit proefschrift is onderdeel van de Academische Werkplaats Ouderenzorg Limburg, een structureel, multidisciplinair samenwerkingsverband tussen de Universiteit Maastricht, negen zorgorganisaties (MeanderGroep Zuid-Limburg, Sevagram, Envida, Cicero Zorggroep, Zuyderland, Vivantes, De Zorggroep, Land van Horne & Proteion), Gilde Zorgcollege, VISTA college en Zuyd Hogeschool. In de werkplaats draait het om het verbeteren van de kwaliteit van leven en zorg voor ouderen en de kwaliteit van werk voor iedereen die in de ouderenzorg werkt. Zorgverleners (zoals verpleegkundigen, verzorgenden, artsen, psychologen, fysio- en ergotherapeuten), beleidsmakers, onderzoekers, studenten en ouderen zelf wisselen kennis en ervaring uit. Daarnaast

evalueren we vernieuwingen in de dagelijkse zorg. Praktijk, beleid, onderzoek en onderwijs gaan hierbij hand in hand.

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Dankwoord

Dankwoord

Onderzoek doen naar het activeren van communities om zelfstandig wonende ouderen te ondersteunen was mijn grote wens. Dit omdat ik graag iets wil toevoegen aan de kwaliteit van leven van ouderen in de wijk. Mijn eigen leefomgeving was hiervoor ook een grote inspirator. Daarnaast wilde ik mij verder professionaliseren in het doen van onderzoek en de verslaglegging hiervan. Toen de gelegenheid zich aanbood heb ik deze mooie uitdaging met twee handen aangegrepen en heb ik gedurende het traject geen enkel moment spijt gehad van deze keuze. Promoveren doe je natuurlijk niet alleen. In de afgelopen zes jaar heb ik veel support mogen ontvangen van het promotieteam, familie, collega's, vrienden, de klankbordgroep, en alle deelnemers aan het onderzoek. Om te beginnen wil ik iedereen hartelijk bedanken die direct of indirect heeft bijgedragen aan de totstandkoming van dit proefschrift. Er zijn een aantal mensen die ik in het bijzonder wil benoemen. Dit betekent echter niet dat als ik je naam niet heb uitgeschreven, je niet van waarde bent geweest.

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Bij de start van het promotieonderzoek vormde zich al snel een promotieteam, bestaande uit Ruud Kempen (zaliger) als promotor, Gerrie Bours en Joop van Duren als co-promotoren. Gedurende het traject is Ruud ons helaas ontvallen. Deze tegenslag hadden we in eerste instantie niet verwacht en kwam hard aan. Ruud, wat was jij een

fijne en betrokken man. Een geweldige leermeester. Kritisch naar proces, inhoud en verslaglegging en altijd heel oprecht. Dank je wel voor alles wat ik van jou mocht leren.

Gerrie, toeval bestaat niet, je kwam niet zomaar op mijn pad. Toen jij lid werd van de kenniskring van het lectoraat Facility Management, hadden we gelijk een klik. Jouw kennis en ervaring op het gebied van onderzoek heeft mij heel erg geholpen in dit traject. Als ik worstelde met de onderzoeksopzet of theorie had jij altijd weer literatuur voor mij om me verder te helpen. Je wees me de weg bij Maastricht Universiteit en bracht me altijd, just in time, in contact met de juiste mensen. Je positieve coaching en betrokkenheid deed me altijd goed, zodat ik na onze gesprekken weer nieuwe energie en inspiratie had om de volgende stap te maken.

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Sandra, jij hebt midden in het promotietraject de rol van Ruud overgenomen. Een goede match en een superfijne samenwerking. Jouw betrokkenheid en aandacht voor het promotieonderzoek voelt goed. Tijdens de promotie overleggen had ik altijd het gevoel dat jij mij begreep en hielp met het verwoorden van mijn ideeën. Kortom, ik mag ronduit zeggen dat ik zeer geboft heb met dit team.

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Bij de aanvang van het promotieonderzoek is een klankbordgroep geformeerd die een representatieve weergave is van de leden van een vital community. De rol van deze klankbordgroep was om tijdens het promotietraject gevraagd en ongevraagde feedback te geven op het onderzoeksproces en de resultaten. Zeker in de eerste helft van het traject is de klankboardgroep regelmatig bij elkaar gekomen om de opzet en het proces en de inhoud te bespreken. Beste Karin, Math G., Kay, Astrid, Math N., Martin, Jerôme, Marja, Jacqueline en Twan dank jullie wel voor jullie inzet en betrokkenheid bij dit onderzoek. Jullie gevraagde en ongevraagde feedback heeft mij erg geholpen en zeker bijgedragen aan het mooie eindresultaat.

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Zonder mijn lieve familie had ik vast nooit de stap gezet om te promoveren. Toen ik mijn wens kenbaar maakte bij Lino en Anna-Chiárá was haar eerste reactie: “Ooh nee, dan ga je zeker weer avonden, weekenden en tijdens vakanties op je werkkamer zitten schrijven, dat vinden we niet zo gezellig”. Daar kon ik wel inkomen, dus hebben we een compromis gesloten, ik zou dat alleen doen als het echt nodig was. Tijdens de lockdown vanwege de Coronapandemie was het alleen thuiswerken aan het onderzoek niet zo gezellig. Ik miste de sociale contacten en de mensen om mij heen. Daar had Anna-Chiárá een oplossing voor gevonden. Iedere dag maakte we tijdens de lunchpauze een korte wandeling onder het genot van een koffie to Go. Deze goede gewoonte hebben we ook na de lockdown gecontinueerd. Ik mag zeker zeggen dat wij inmiddels koffie experts zijn geworden en weten waar je de lekkerste koffie van Sittard krijgt. We hadden afgesproken dat we samen zouden afstuderen. Dat is mij niet helemaal gelukt, mijn planningen waren steeds erg optimistisch en ambitieus. Maar, wat fijn dat je vandaag samen met Saskia naast me staat als paranymf en me supportert! Lino, ook jij stemde in met mijn wens. Na 36 jaar huwelijk weet je inmiddels, dat ik mijn zinnen altijd doordrijf en dingen tot een goed einde wil brengen. Zonder jouw steun was dat zeker niet gelukt. Je relativerende, nuchtere kijk op dingen, zorgde ervoor dat ik met beide benen op de grond bleef. Lino en Anna-Chiárá, dank jullie wel voor jullie onvoorwaardelijke liefde en steun.

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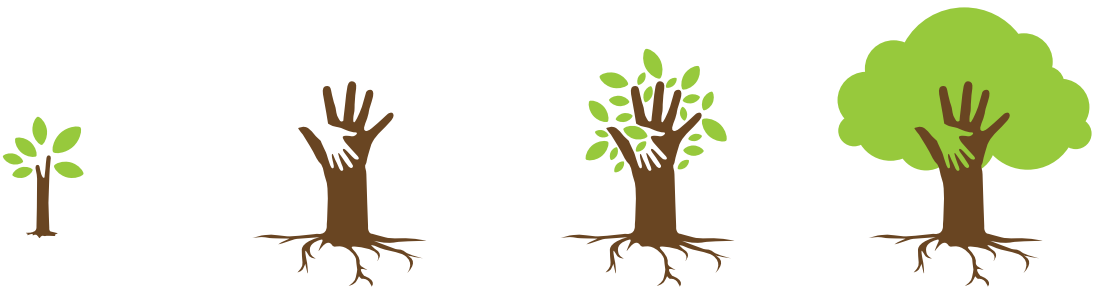
Katinka

22 februari 2024



Dedicated to the older people, ageing in place,
in my own neighbourhood,
who inspired me to carry out this research.