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## ***Age UK's fit for the future Project***

### **Evaluation Report**

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## Executive Summary

### **Introduction**

**Fit for the future** is a person-centred programme with the overall objective of supporting the physical health and mental well-being of older people living with at least one long-term health condition, with a primary focus on those with declining health and/or mental well-being. The programme aims, to achieve its objectives through the provision of holistic, co-ordinated services and activities which improve participants' quality of life and enable them to maintain their independence for longer, while delaying the need for more intensive and costly health and social care interventions. In line with the wider focus of the **fit as a fiddle** portfolio, the emphasis is on providing community led projects with a strong volunteer base, something which is viewed as key to ensuring sustainability over time.

### **Background and policy context**

- The Government is increasingly adopting a 'preventative approach' when forming policies relating to meeting the needs of older people.
- The literature indicates that participation in health and wellbeing programmes has an overall beneficial effect for those taking part, in relation to physical health, mental wellbeing, and for overcoming social isolation.
- **Fit for the future** is a fairly unique programme which makes direct comparisons with other health and wellbeing projects in relation to impact, outcomes, and cost, somewhat difficult.
- There is a paucity of evidence about the efficiency and cost-effectiveness of changing health behaviours in relation to disadvantaged groups and there is a great deal more research work needed in this area.

### **Methods**

- The methods used to inform this research include: analysis of monitoring data and background documents; a longitudinal paper-based survey of older people; a paper-based survey of volunteers; case studies of 55 older people; and qualitative interviews with 56 stakeholders.

### **Implementation**

- Local Age UKs have adopted a variety of approaches to recruiting or referring older people to the programme.
- Most older people were referred to **fit for the future** from Age UK services, self-referral and by 'other' health professionals, but, overall, less so by GPs.
- All participating local Age UKs provided services relating to physical activity and social interaction. Eight ran services related to healthy eating, and seven offered one-to-one support services.

- Due to the individualised, tailored nature of the support provided, the types of services or activities beneficiaries took part in varied quite considerably, both between areas and amongst individuals.
- The different ways in which support has been provided and delivered includes: signposting; referrals; provision of a broad range of activities; practical help; personal support and encouragement; and one-to-one advice.
- Older people viewed the social aspect of the programme as valuable.
- An additional unexpected outcome was the holistic nature of the programme due to the highly personalised support offered as a result of its implementation model.
- Convenience and accessibility were important considerations, with many older people appreciating the flexibility in terms of: time; location; transport options; fees; and composition of participants in the programme.

### ***Impact on older people***

- Older people participating in *fit for the future* often emphasised the connections between improved physical and mental well-being when they explained what the main benefits of the programme were for them.
- Some of the main benefits differed based on either the local area, or the characteristics of respondents, such as those relating to gender and ethnicity.
- Overall, there was a statistically significant positive change in well-being, life satisfaction and social isolation across timepoints 1-2 and 1-3. In the initial 3 months, almost half of respondents experienced an improvement in mental well-being, almost two-fifth in life satisfaction and almost a quarter in social connectedness (primarily social isolation). This was supported by interviews with older people, who reported that the programme had helped them feel less lonely and depressed and more confident through improving their levels of social connectedness.
- Whilst the findings overall indicate that the main positive changes occurred within the first three months of the project, when individual geographical areas were isolated, statistically significant positive changes were observed between the first and nine month timepoints for some areas (with significance not being reached in the first three months).
- Participants reported having a more positive attitude toward healthy eating with almost 40% increasing their fruit and vegetable intake over the 9 month survey period. Case study participants attending classes on nutrition and healthy eating highlighted that they gained new information and experiences about healthy eating through group activities, which motivated them to change their eating habits.
- Around 45% and 35% of participants experienced improvements in walking and physical activities that made them breath harder, with the average (median) increase being 10 minutes a day and 30 minutes a week respectively. Case study participants reported

positive changes to their health and social interaction due to taking part in physical activities through ***fit for the future***.

- While case study participants reported improvement in their particular health conditions due to taking part in ***fit for the future***, statistically significant changes relating to the management or prevention of LTC conditions were not found; nor were reductions in falls or unplanned visits to health professionals.
- The case studies showed how positive changes can be lost when circumstances change, and that continued support may be needed.
- The evidence from the case study interviews shows that some participants have not necessarily been able to engage with ***fit for the future*** in the same way or to the same degree as others due to the high level of reported need.

### ***Volunteers and volunteering***

- Volunteers carried out varied roles and got involved with ***fit for the future*** for a variety of reasons, the main ones being: to give back to the community; build social networks; gain skills and knowledge; and increase employability.
- Most volunteer survey respondents had learned new skills and gained in confidence, motivation, and self-esteem as a result of participating in ***fit for the future***.
- Almost half (48%) of volunteer survey respondents reported improvements to their mental wellbeing, with slightly less (35%) experiencing an increase in their physical health.
- Some activities were being managed and sustained almost entirely by volunteers.
- Some local Age UK partners reported difficulties recruiting sufficient volunteers to run ***fit for the future*** activities.
- Funding is required to sustain the work of volunteers, to ensure they are sufficiently trained and supported.

### ***Partnership building***

- The partnerships developed through ***fit for the future*** had a positive impact through enhancing existing work and activities of participating organisations and by raising awareness among statutory agencies of the contribution the voluntary and community sector can make to health and social care delivery.
- In some geographical areas, ***fit for the future*** enhanced the work of statutory agencies by complementing and/or improving *treatment outcomes* for patients in a direct and identifiable way.
- ***Fit for the future*** helped to strengthen relationships across different organisations working to deliver health and social care. However, many of these relationships stopped short of anything that could justify the label 'partnership'.

- Despite some successful collaborative work, little headway seems to have been made in partnership building with local authorities and many had struggled to engage GPs in their respective area.
- Some local Age UKs expressed disappointment due to a lack of referrals of ‘younger old’ people, with suggestions that in the future similar programmes should concentrate on tailoring marketing toward this group.
- Whilst some partner organisations benefitted from the increased number of referrals, others were unable to meet the increased demand for their services.

### ***Impact on wider health and social care system***

- In line with previous research evidence, it is suggested that ***fit for the future*** can help reduce the demand on health and social care services, thereby contributing to potential efficiencies and cost savings to the health and social care system.

### ***Evaluation tools***

- Some local Age UK partners felt it would have been beneficial if they had been consulted and given an opportunity to provide input into the survey design.
- Some stakeholders felt that the broad difference in each of the 11 areas in terms of how the programme was being implemented meant it would be difficult to evaluate its effectiveness overall. It was suggested that a more ‘consistent approach’ is adopted in both the delivery and evaluation of future work of this kind.

### ***Main Recommendations***

*Recommendation 1:* As one of the stated aims of the programme was to contribute toward reducing health care costs perhaps future programme evaluations of this kind should develop research tools which can better evidence measureable changes, such as the use of a control group, or perhaps focus the evaluation on a narrower set of factors, so that direct comparison between participating local Age UKs can be better compared.

#### *Recommendation 2:*

As a number of local Age UK partners reported struggling to enlist or retain volunteers, steps should be taken, moving forward, to look at ways to support organisations to develop a volunteer pool. Targeted resources should also be considered so that local Age UKs are able to offer support and training to volunteers.

*Recommendation 3:* Based on findings that older people may take referrals from health care professionals more seriously, and the reported benefits of partnership working, it is suggested moving forward that more consideration is given to how better links with the health care sector in particular, can be formed.

*Recommendation 4:* Ensure that when partner organisations refer to services that older people are provided with more information at the outset, as some case study respondents reported not being sure what the programme entailed when initially agreeing to take part. It is suggested that information detailing what the programme offers could be provided in a leaflet format, which could be placed in areas such as General Practices and Pharmacies.

## 1. Introduction

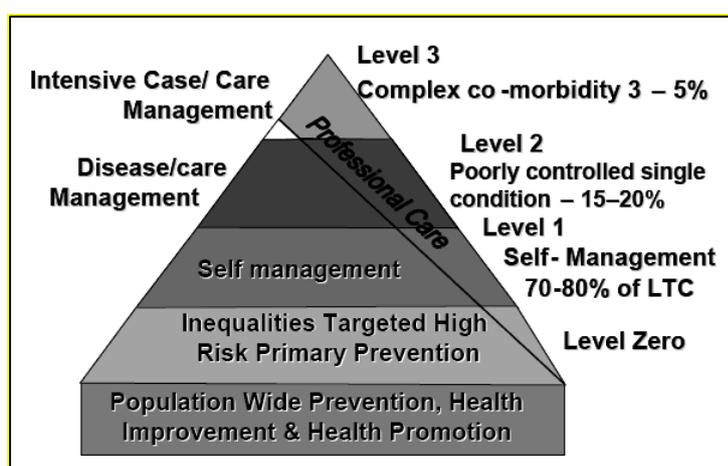
CIRCLE (Centre for International Research on Care, Labour and Equalities), University of Leeds has been commissioned by Age UK to evaluate the **fit as a fiddle** 2013-2015 portfolio which delivered £3.6m worth of projects. The portfolio of activity was funded by the Big Lottery Fund as part of the Well-being programme (which had a total of £165m funding), and incorporates three main themes: healthy eating; physical activity; and mental health. The portfolio includes three separate but interconnected programmes of activity (*fit for the future*; Cascade Training; and Dementia Friendly). This report focuses on the *fit for the future* element of the portfolio only and draws on findings based on empirical research undertaken between April 2014 and May 2015. Separate evaluation reports of both the Cascade Training and Dementia Friendly programmes have been produced (Alden et al, 2015 and Kispeter et al, 2015).

The report is separated into ten main sections. This first section provides an introduction and the second provides an overview of the *fit for the future* programme, the third considers the policy context within which it was developed, alongside an assessment of related research. This is followed by section four which outlines the methods used, and section five which discusses the way in which *fit for the future* was implemented. Sections six, seven and eight then go on to discuss the implications of the programme for: older people; volunteers; and stakeholders, looking at the impacts and outcomes for each of these groups. Section nine then discusses the lessons learned from the programme and section ten provides some conclusions and outlines potential policy implications.

## 2. The fit for the future programme

*Fit for the future* is a person-centred programme with the overall objective of supporting the physical health and mental well-being of older people living with at least one long-term health condition, with a primary focus on those with declining health and/or mental well-being. The programme includes, therefore, those living with one or more multiple health conditions, or who are at risk of developing a long-term condition (see Figure 1 – i.e. those at level 1/2 of the Kaiser Triangle (‘supported self-care’ and ‘disease management’), reaching out to people at level 0 (population)). The programme aimed to reach older people from groups who are traditionally overlooked in similar programmes, including older men, Black and Minority Ethnic (BME), and faith communities.

Figure 1 The Kaiser Triangle<sup>1</sup>



The following describes the levels listed in the Kaiser Triangle

- **Level 3:** Patients with multiple complex needs, at high risk of serious new adverse events, unscheduled care or emergency admissions.
- **Level 2:** Patients with one or more chronic diseases, or multiple risk factors, or poorly controlled single disease, or special needs.
- **Level 1:** Patients with a well-controlled single chronic disease, who self-manage most of the time.
- **Level 0:** The well public, the vast majority of the population, people not actually ill at any one time.

The *fit for the future* programme aims to achieve its objectives through the provision of holistic, co-ordinated services and activities which improve participants’ quality of life and enable them to maintain their independence for longer, while delaying the need for more intensive and costly health and social care interventions. In line with the wider focus of the

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<sup>1</sup> Source: NHS and University of Birmingham, 2006, ‘Improving care for people with long-term conditions: A review of UK and international frameworks’, Birmingham: University of Birmingham.

**fit as a fiddle** portfolio, the emphasis is on providing community led projects with a strong volunteer base, something which is viewed as key to ensuring sustainability over time.

Older people are recruited onto the programme and prior to any intervention, a trained Age UK staff member or volunteer meets with the older person to develop a tailored personal plan that best suits their health and well-being needs. Activities designed to meet the individual tailored plans are then provided by 'partner' organisations (often third sector), with an emphasis on group-based provision. The specific combination of activities that are offered focus on healthy eating, physical activity and mental well-being (the implementation of the programme is considered further in section 4). The programme has been implemented by 11 local Age UK partners: Blackburn with Darwen; Cheshire East; Exeter; Hillingdon; Lancashire; Leeds; Newcastle; Nottingham and Nottinghamshire; Rotherham; Warwickshire; and West-Cumbria.

***Fit for the future*** emerged as a result of positive learning from a previous Age UK project, called **fit as a fiddle**, and has further developed the key successful elements of this previous initiative.

### 3. Background, policy context and overview of related literature

It is widely acknowledged that the UK's population is ageing, with the Department of Health predicting that the number of people aged over 65 will increase by 51 per cent between 2010 and 2030, whilst the number of those aged over 85 is expected to double in the same period. Furthermore, by 2030 more than 40 per cent of households are predicted to comprise of people living on their own (Jowit, 2013; The King's Fund, 2013). A number of authors (Bardsley et. al., 2011; Victor, 2010; Wigfield et. al., 2013) advise that as people live longer, they are often affected, in later life, by long-term ill health and disabilities, which result in high costs to health and social care services (discussed later in this section). The **fit as a fiddle** portfolio 2013-2015 (including **fit for the future**) represents part of Age UK's efforts to maintain and improve the health and well-being of older people.

There is considerable evidence demonstrating that eating a healthier diet, reducing alcohol consumption, quitting smoking, and exercising regularly can have a major impact on reducing rates of chronic illness (World Cancer Research Fund and American Institute for Cancer Research, 2007; World Health Organization, 2002). More specifically, a longitudinal study of 2,235 men in Caerphilly, over a 35 year period commencing in 1979, found that adhering to 'healthy behaviours' similar to the regimen promoted by **fit for the future** – reducing smoking, maintaining an acceptable BMI, conducting regular physical exercise, partaking of high fruit and vegetable intake, and low/moderate alcohol consumption – led to significant reductions (between 64 and 73 %) in the onset of Type 2 diabetes, heart disease, stroke and dementia (Elwood *et al.*, 2013).

There is support in the available evaluative literature for the idea that health and well-being programmes are beneficial because of the *social interaction* that they engender, thereby ameliorating isolation, which is estimated to affect around 10 per cent of people over 65 (Bernard, 2013). The opportunity for social interaction was found to be an important motivation and benefit in a UK qualitative study of English adults over 50 years of age engaging in physical activity, for example (Finch, 1997). Studies by Riddoch and colleagues (1998), and Hardcastle and Taylor (2001; 2005), have also reported positive *social* benefits from exercise interventions involving older people. As can be seen in this report, promotion social interaction and reducing social isolation have been key aims and outcomes of the **fit for the future** programme. The following three subsections provide an overview of the policy context, followed by an analysis of previous evaluations which share some similarities with **fit for the future**, and concluding with an assessment of the efficiency and cost effectiveness of related health and well-being programmes.

#### **Policy Context**

Over the last few decades successive government strategies have adopted a preventative approach when forming policy and guidance around health and social care. Local authorities

have been directed to give regard to the physical and emotional wellbeing of older citizens, for example through the National Service Framework for Older People (Department of Health, 2001) and the Physical Activity Guidelines for Older Adults (NHS Choices, 2013). More recently the 2014 Care Act (HM Government, 2014) has made the promotion of wellbeing services for older people a legal requirement. This policy focus, alongside the availability of some funding to assist the development of specific schemes, has enabled a number of local authorities to develop programmes which share the broad aims of **fit for the future**. These initiatives focus on the promotion of wellbeing and a reduction of social isolation among older people through community led activities, with the primary aim being to delay or avoid costly health or social care interventions.

The National Evaluation of Partnerships for Older People Projects (POPSS), developed in 2005; Linkage Plus (from 2006, which built on the foundation of 'Opportunity Age'); and the later Ageing Well portfolio (which ended in 2012, see Harkness, 2012) form the main central government funded programmes over the last decade. Each has contributed to the evidence base around the benefits of adopting a holistic, preventative approach to improve the health and well-being of older people. For example, a POPPs evaluation found there had been reduced use of GP and emergency health services and reported improved quality of life (Harflett and Brown, 2014).

### ***Overview of comparative health and wellbeing programme evaluations***

**Fit for the future** is a fairly unique programme which makes direct comparisons with other health and wellbeing projects in relation to impact, outcomes, and cost, somewhat difficult. This was, indeed, noted in the previous **fit as a fiddle** evaluation, where the programme was said to be:

*... a unique portfolio due to its scope, scale and focus; there were no comparator programmes operating during its lifespan, either led by government or by other funders.*(Ecorys UK et al, 2012)

Moreover, where there are projects which show some similarities there is a dearth of evaluative material on the variable effects of interventions on different groups, and on the impact of interventions on reducing health inequalities (Blaxter, 2007; NICE, 2007). Albarracín *at al* (2005), in addition to this, demonstrate that the impact of interventions is contingent on gender, age, ethnicity and other population-specific factors, suggesting that generic interventions cannot be applied across populations with confidence. This they suggest provides a further potential limitation to the usefulness of material drawn from the evaluation of other health and well-being programmes.

This section provides an overview of two programmes which are both similar to **fit for the future** and have undergone a fairly robust evaluative process. It firstly considers the original

**fit as a fiddle** portfolio review, before discussing Project ACE and the South West Wellbeing Programme.

The previous **fit as a fiddle** portfolio, which ran between 2007 and 2012, adopted a range of qualitative and quantitative instruments to assess its effectiveness on older people, volunteers and stakeholders, including a three wave survey of older participants. It found positive outcomes for older people in terms of increased physical activity, healthy eating and improvements to mental wellbeing. Volunteers were found to be a cost effective way of delivering the portfolio of activities, and reported increased self-confidence and skills as a result of getting involved. In recognition of its success, the Big Lottery Fund provided follow on funding and **fit as a fiddle** was also identified as the ‘preferred model’ for healthy ageing services by Age Action Alliance (Ecorys UK *et al*, 2012).

Another initiative, Project ACE, run by the voluntary sector, aimed to test whether peer volunteering is an effective way of encouraging older people to take part in physical and social activities. As part of the evaluation, qualitative data was generated along with a three wave survey of both an intervention and control group (Public Health England, 2014). The evaluation found higher levels of activity and reported well-being for the intervention group, when compared to the control group. For example, 55 per cent reported an increase in vitality, compared to 22 per cent of the control group, and 68 per cent an increase in social wellbeing, compared to 42 per cent of the control group. The intervention group were also more likely to report an increase in life satisfaction (59%) than the control group (50%). One of the most striking differences was feeling that life was worthwhile, where 57 per cent of the intervention group agreed with this statement compared to none in the control group. Beneficiaries also reported taking part in more outside activities (from four to six in a week), compared to a *decline* among the control group (Public Health England, 2014). The main outcomes are summarised in Table 1.

**Table 1: Selected Outcomes from Project ACE\* - Percentage**

	<b>Intervention group</b>	<b>Control group</b>
Increased vitality levels	55	22
Increased social wellbeing	68	42
Increase in life satisfaction	59	50
Feeling life more worthwhile	57	0
Improved functional ability	50	11

\*Source Public Health England, 2014

Another collection of initiatives, The South West Wellbeing Programme, was awarded funding from the Big Lottery Wellbeing Fund between 2008 and 2011 to support a consortium of health and wellbeing projects in the South West Region. Similar to the **fit as a fiddle** portfolio, all bar one participating organisation was led by a community based third

sector organisation and the overarching aim was to improve physical and mental health and wellbeing. A broad portfolio of activities was offered including physical exercise, healthy eating, befriending, and art and crafts. The programmes adopted a personalised participant led approach, aspired to collaboration with local partners, emphasised group based initiatives, and the use of volunteers. Whilst some of the initiatives were aimed at all age ranges, the average age overall was 41-45 years (Jones et al, 2011).

An evaluation of the South West Wellbeing Programme found statistically significant increases in reported personal and social wellbeing scores for beneficiaries, where half of participants reported an improvement, and 58 per cent of participants had increased physical activity levels. Further, a third of beneficiaries had upped their fruit and vegetable intake, raising the percentage of those who were meeting public health guidelines from 26 per cent to 40 per cent at follow up (Jones et al, 2011:28). Alongside this, nearly half of participants (48%) reported improved overall life satisfaction and 63 per cent an improvement in mental health in terms of reduced depressive symptoms (Jones et al, 2011: 31). The evaluation concluded that all aspects of wellbeing were strongly related to participating in healthy eating, physical activity, and activities associated with mental health (Jones et al, 2011:34).

**Table 2: Selected outcomes from The South West Wellbeing Programme\* - Percentage**

Increased physical activity levels	58
Increased fruit and vegetable intake	33
Improved life satisfaction overall	48
Improvement in mental health in due to reduced depressive symptoms	63

\*Source Jones et al, 2011

### ***Efficiency including cost effectiveness of similar programmes***

Another important element to assess in relation to health and wellbeing programmes is efficiency, including cost-effectiveness. This is particularly important in times of resource constraint, and especially so given the current budgetary pressures on organisations charged with delivering health and social care, like the NHS, local authority social service departments, and third sector organisations. In light of this, it is becoming increasingly necessary for organisations to demonstrate that particular programmes represent value for money, alongside the benefits for participants (Harflett and Brown, 2014).

The high financial costs of physical inactivity in England have been well documented. A study by Lee *et al* (2012, cited by Walking Works, 2013), for example, attributed nearly one fifth of early deaths to physical inactivity. Furthermore, the Department of Health (2009) estimated that inactivity increases the chance of developing type 2 diabetes by between 33 and 50 per cent. It has also been identified that increased physical activity can delay the onset of dementia and Alzheimer’s disease, alongside reducing the risk of falls (Walking Works,

2013). Arguably of greater concern to policy makers is the fact that inactivity was estimated as costing the NHS alone between 1 and 1.8 billion a year in 2009 (Department of Health, 2009:15). In addition to this falls, which affect an estimated one in three people over 65 at least once a year, cost the NHS around £2 billion annually (Tian et al, 2013). Further, older age groups account for over half of all social care spending and two thirds of NHS expenditure is spent on people older than 65 (Holmes and Rossell, 2008). It is thus not difficult to see where the physical activities promoted and offered by *fit for the future* have the potential to generate significant cost savings.

Whilst some evaluations have demonstrated the effectiveness of community based projects in terms of improved wellbeing outcomes for older people, there is a dearth of reports which have concentrated on cost effectiveness (Harflett and Brown, 2014). For example, whilst the South West Wellbeing Programme evaluation recognised that improving understanding of economic and social returns can increase investment in health and wellbeing programmes (Jones et al, 2011:7), it nevertheless provides a limited analysis of the latter (i.e. potential cost benefits to the health and social care sector).

With specific regard to social isolation, it has been recognised as one of the chief factors underlying poor mental health and wellbeing (Bowling and Gabriel, 2007, cited by Watt and Blair, 2009:44). Further, it has been found that increasing social activity reduces the likelihood of an older person being placed in residential care, visiting their GPs, or requiring treatment to deal with depression (Windle et al, 2011). Yet only a few studies have attempted to consider how projects which aim to reduce social isolation may offer value for money (Harflett and Brown 2014: 4-5). Furthermore, there is a lack of research attempting to quantify the financial or individual benefits of reducing isolation for older people (Watt and Blair, 2009; Windle et al, 2011). Alongside this, there is limited research which has attempted to quantify the cost savings which might be achieved through adopting multi agency approaches. This probably due to the fact that this type of working will be context specific, and costs incurred will differ at the local level due to the differences between individual organisations. Therefore, it is likely that savings can only be assessed on a programme by programme basis, which, of course, can assist in maintaining individual projects if it can be shown how multiagency working leads to more efficient provision

The shortage of studies around cost effectiveness is likely, at least in part, to be due to challenges around predicting the costs of what has actually been prevented (Harflett and Brown, 2014:29). For example as Taylor (2004) notes, all financial calculations in such studies are based on hypothetical estimations and, in reality, the costs of delivering interventions and providing support to maintain a physically active lifestyle may be somewhat different, given that many people will not become or remain active. For example a project in the South West Wellbeing Programme portfolio, 'supporting GP services through Community Dance', reports claims of beneficiaries reducing medication as a direct

result of the programme (due to losing weight, no longer using inhalers, improvements in balance due to exercise) thus reducing the need for GP/hospital care (Jones et al, 2011: 61-62).

One particular type of activity that has been assessed specifically for the money it may save health services is balance classes such as Tai Chi (which are run in some areas as part of the ***fit for the future*** programme). Evidence has shown that if Tai Chi classes are run for a period of around 15 weeks, it can nearly halve the chances of an older person falling (Wolf et al, 1996, cited by Watt and Blair, 2009:29). It has further been calculated that exercise classes, in general, can lead to significant health and social care savings through delaying the need for hip fractures and preventing premature deaths (Davis and Ritters, 2009; Watt and Blair, 2009).

### **Summary**

- The Government is increasingly adopting a 'preventative approach' when forming policy related to meeting the needs of older people.
- The literature indicates that participation in health and wellbeing programmes has an overall beneficial effect for those taking part, in relation to physical health, mental wellbeing, and overcoming social isolation, demonstrating that well-designed and implemented health and wellbeing projects have the potential to lead to beneficial impacts.
- ***Fit for the future*** is a fairly unique programme which makes direct comparisons with other health and wellbeing projects in relation to impact, outcomes, and cost, somewhat difficult.
- There is a paucity of evidence about the efficiency and cost-effectiveness of changing health behaviours in relation to disadvantaged groups (Michie *et al*, 2008) and there is a great deal more research work needed in this area.

## 4. Methods

The evaluation of *fit for the future* is based on a variety of research methods and includes the following key stages:

**Analysis of monitoring data and background documents:** Documentary analysis and interrogation of management information data has been undertaken to produce a greater understanding of: the nature of *fit for the future*; its aims and objectives; how it has been implemented; and how well it has performed against its targets. This report draws on: data relating to referrals to the programme; quarterly monitoring data collected from local Age UK partners; the expression of interest documents prepared by local Age UK partners; and interviews with the managers of local Age UK partners and the Project Manager at Age UK National.

**A longitudinal paper-based survey of older people:** designed by Age UK, and completed by older people participating in *fit for the future* at three specific points: at the start of their involvement in the programme; three months; and nine months after the start of the intervention. Each of the 11 local Age UK partners aimed to reach a target of at least 100 older people completing each of the three surveys. In total, 1750 older people were recruited to *fit for the future*, and the research team received 1572 completed Survey One questionnaires in a format which was suitable for entry into the statistical software<sup>2</sup>. The data were subsequently entered into statistical software, (IBM SPSS Statistics 21), checked, cleaned and then analysed. Data from Survey One were used to outline the profile of participants, and are compared to data from the Health Survey of England in Section Four. Of the 1572 respondents, 1076 completed all three surveys<sup>3</sup>. A more detailed description of the tests used to analyse the survey data can be found in Appendix 1. The findings from these surveys are analysed in Section Five of this report to provide insights into the programme's impact on participating older people.

**A paper-based survey of volunteers:** designed by Age UK, and completed by volunteers who participated in *fit for the future*. A total of 21 completed surveys were received and the findings from these are reported on in Section Six of this report, when focusing on the programme's impact on volunteers. Information from the questions with a pre-selected

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<sup>2</sup> Most of the survey data were supplied by local Age UK partners in the form of completed paper surveys, with some data from Survey One being forwarded to CIRCLE in electronic format (extracted from Charity Log datasets). A few completed questionnaires were excluded from analysis because the respondent was younger than 50 (those who were only a few months younger than 50 when Survey One was completed were included).

<sup>3</sup> Of the 1572 respondents 1076 completed all three surveys, 313 completed only Survey One, 153 completed Surveys One and Two and 30 completed Surveys One and Three.

response option was entered into an Excel file, with thematic analysis being carried out on open ended replies.

**Case studies of 55 older people:** In addition to the largely quantitative data emerging from the survey of older people participants, the research team also conducted 55 case studies of older people to gain a greater and more in-depth understanding of the local operation of *fit for the future* and the specific impacts on participants. Five case studies of older people were carried out in each of the 11 areas where the programme was delivered. The case studies draw on interviews with the older persons and information supplied about participants' involvement in the programme. This information includes the tailored action / support plans developed at the start of the intervention and / or a summary of the initial assessment, and the actions undertaken by local Age UKs. 44 of the case studies (four in each locality) involved carrying out a face-to-face interview with the older person (light-touch case studies). 11 of the case studies (one in each locality) provide more in-depth data which involved, in addition to the face-to-face interviews, participants completing a diary booklet that focuses on their lifestyle and attitudes to healthy living in more detail, as well as interviews with members of their support network, such as friends, family, neighbours or home care workers.

All 55 case study interviews were conducted between May 2014 and April 2015. The interviews were semi-structured and each lasted between 45 and 60 minutes. All interviews were conducted face-to-face, with the exception of one, which was conducted by telephone, as requested by the interviewee. Each interview focussed primarily on older peoples' expectations, experiences and opinions about the programme, and explored what may have happened to the older person in the absence of *fit for the future*. Analysis of the case studies included an examination of the tailored plans and the diaries (for those who completed one). The case study interviews were transcribed and analysed using a thematic technique designed to capture a range of issues and their similarities / difference across respondents. Rather than presenting individual case studies here, themes emerging from the case study interviews are discussed in Sections Four, Five and Six (which explore both the implementation and the impacts of the programme) and extracts from the interviews are included to illustrate the findings.<sup>4</sup>

Of the case studies conducted, 60 per cent consisted of women and 40 per cent men, whose ages range from 54 to 95.<sup>5</sup> The case study interviewees live in a variety of residential settings, some of them come from a BME background and some are carers. Names and minor personal details of case study participants referred to in this report, and their friends

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<sup>4</sup> The detailed case studies are presented separately.

<sup>5</sup> The disproportionate amount of women interviewed is a reflection of the larger number of older women accessing the programme overall (see Section 4).

and family, have been changed to protect their anonymity. Table 3 in Appendix 2 gives a summary of basic information about the older people who were interviewed for case studies.

**Qualitative interviews with 56 stakeholders:** (equally distributed from each participating local Age UK partner area) were carried out to capture information about their expectations at the beginning of the programme, experiences of the partnership running the programme, suggestions for improvement, lessons learned for themselves and for their organisation, and their assessment of the programme's sustainability. Stakeholders were identified by the 11 local Age UK partners and included representatives of: Clinical Commissioning Groups (CCGs); General Practices; local authorities; local Age UK Partners; and voluntary sector organisations. Interviews with 56 stakeholders took place at the start of the *fit for the future* programme and subsequent interviews with 50 stakeholders (largely, but not entirely, the same people) were conducted as the programme was drawing to a close. Each interview lasted approximately 30 minutes and was conducted by telephone following a semi-structured interview schedule. The interviews were transcribed and analysed manually, looking for common themes and recurring issues. Stakeholders represented a range of organisations and Table 4 in Appendix 2 provides a summary of basic information about the stakeholders who were interviewed for this report.

**Presentation of data:** Findings emerging from the surveys and the qualitative interviews with older people (case studies) are presented alongside each other in this report in relation to the key themes. Quotes from case studies and interviews with stakeholders are presented to illustrate findings and to add specific detail to the discussion, with the sources identified, where appropriate. It is important to note that the sample of participants and stakeholders identified for interviews is not statistically representative, and their opinions do not necessarily reflect the views of all participants and stakeholders involved in *fit for the future*.

### **Summary**

- The methods used to inform this research include: analysis of monitoring data and background documents; a longitudinal paper-based survey of older people; a paper-based survey of volunteers; case studies of 55 older people; and qualitative interviews with 56 stakeholders.

## 5. Implementing *fit for the future*

In this section we outline the implementation of the programme, looking at: recruitment and referrals of participants; the profile of the participants recruited; the types of activities which were offered; the ways in which they were delivered; and the consequences of the unique implementation model of *fit for the future* for older people.

### **Recruitment and referral of participants**

Here we compare plans, as stated in expressions of interest by local Age UK partners, and current practices, drawing on the evidence provided through: the latest monitoring data on referrals to the programme; stakeholder interviews; tailored plans; and case studies of older people.

Originally it was anticipated that 1650 older people would engage in *fit for the future* across the 11 local Age UK partner localities. The monitoring data supplied by the local Age UK partners show that, with the exception of three areas, the recruitment targets have been met or exceeded, with 1750 older participants recorded as participating in the programme overall (see Table 3).

**Table 3: The number of older people engaged in *fit for the future* by area**

	<b>Planned</b>	<b>Actual</b>
Blackburn with Darwen	150	667
Cheshire East	150	438
Exeter	150	245
Hillingdon	150	155
Lancashire	150	530
Leeds	150	172
Newcastle	150	250
Nottingham and Nottinghamshire	150	1100
Rotherham	150	413
Warwickshire	150	179
West Cumbria	150	650
<b>Total</b>	<b>1650</b>	<b>4799</b>

Source: Age UK National, figures correct as of 28 July 2015.

Local Age UK partners planned to recruit participants via a number of different sources, through: health professionals, for example GPs and Community Mental Health Teams (CMHTs); social care; sheltered housing; existing local Age UK services; friends and families; and self-referrals (see Table 4). According to the most recent monitoring data collected from local Age UK partners, most older people were actually referred to *fit for the future* from: other Age UK services; by self-referral; and by ‘other’ health professionals, but, overall, less so by GPs. Two local Age UK partners, Nottingham and Nottinghamshire and Leeds have recruited a large proportion of participants via GPs as Table 4 shows. Rotherham and Warwickshire had particular success with referrals from sheltered housing.

**Table 4: Planned and actual referral routes to *fit for the future***

	<b>Planned</b>	<b>Actual referral routes (top three)</b>
<b>Blackburn with Darwen</b>	GPs (through CCGs)	No data at time of writing report
<b>Cheshire East</b>	Health and Social Care team	Self-referral Other health professional Other
<b>Exeter</b>	Health and Social Care team	Self-referral Other health professional Age UK services
<b>Hillingdon</b>	Age UK services, GPs	Age UK services Self-referral Sheltered housing
<b>Lancashire</b>	CCGs, Public Health, Health and Well-being Boards, CMHT, GPs	Self-referral Voluntary organisations Age UK services
<b>Leeds</b>	GPs	Age UK services GPs Self-referral
<b>Newcastle</b>	Self-referral, family and friends, Health professionals, GPs	Other Family and friends Other health professional
<b>Nottingham and Nottinghamshire</b>	Partner organisations, GPs	GPs Self-referral Voluntary organisations
<b>Rotherham</b>	Age UK services, GPs	Self-referral Sheltered housing Age UK services
<b>Warwickshire</b>	Sheltered housing, GPs	Sheltered housing
<b>West Cumbria</b>	Age UK services, Health practitioners	Age UK services Other Other health professionals

As can be seen from Table 4, many of the local Age UK partners relied on both self-referrals (7 of 11) and other Age UK services (6 of 11) as their main referral methods. This could mean that the services were not necessarily provided to newly engaged older people but were instead offered to those who were already accessing Age UK support of some kind. However, it may be that older people who were already engaged with Age UK were encouraged to access different services through *fit for the future*, such as accessing activities based on physical exercise or healthy eating, whereas previously they may have benefitted from more standard Age UK services. For example in Leeds and Blackburn and Darwen two participants initially found out about *fit for the future* activities when visiting the information and advice service. Another in Leeds had noticed posters advertising classes when she had visited the local Age UK café to meet a friend. Another example included an older couple, based in Hillingdon, who had initially benefitted from Age UK assistance with their gardening before getting involved with *fit for the future*.

The importance of health professionals and GPs in the referral process is clear from the data provided in Table 4 but also emerged in some of the detailed support / action plans, as well as in case study interviews with the older people who were participating in *fit for the future*. Some of the older people inferred that they sometimes took referrals from health professions more seriously than from other organisations. For example an older person in Nottinghamshire stated that he had received a letter from his General Practice inviting him to join an exercise group as part of the programme and would not have opened the letter had it been sent by Age UK or another voluntary organisation, saying that “*there is so much rubbish mail these days.*”

Case studies with older people participating in the programme also revealed that clarity about their referral to *fit for the future* is important. The exact reason for being referred to the programme by their GPs and the process of the referral was sometimes unclear and somewhat puzzling for some participants, as the examples provided below illustrate from older people interviewed in Nottinghamshire:

*No one knows who decided who gets invited.* (Ron, Nottinghamshire)

*I don't know why I was chosen, I think they just picked someone, I don't know how it worked out.* (Kate, Nottinghamshire)

Although the above examples demonstrate that some GPs are getting involved in referrals to *fit for the future*, as well as highlighting the importance of encouraging GPs and other health professionals to refer older people to the programme, some stakeholders also indicated that involving GPs in *fit for the future* was a challenging task, with some being reluctant to engage. This reluctance, often due to time constraints, is something that has been found in research elsewhere, for example in the identification

and provision of support to carers (Wigfield et al, 2012, 2015). Indeed, some potentially missed opportunities for referrals / social prescribing were identified from the case study interviews with older people. For example, one older person was found to have slightly elevated cholesterol levels and blood pressure during a routine GP check, and found out about an exercise group which was part of the programme by chance, as she puts it:

*My granddaughter brought a letter home from the school. It was about grandparents' day, and it really appealed to me. There I heard about the walks. ... I've just had [another] check-up and my cholesterol is very good, and so is my blood sugar. Before, my blood pressure and my cholesterol was borderline, so they put me on a small dose of medication. But exercise helped me a lot and it makes me a happier person.* (Tajinda, Blackburn with Darwen)

The stakeholders mentioned that the system of referring older people to **fit for the future** meant that parts of the health and social care system were becoming more 'joined up', with examples of referrals to the programme from the health sector. Examples cited included: district nurses and General Practitioners who provided older people with information and advice about available services and promoted the programme; social prescribing via referrals from General Practices or hospitals, including as a form of prevention, when a referral was made to prevent a health condition deteriorating; and CCGs discussing ways in which the programme's scope could be widened (see Section 7 for a more detailed discussion).

In addition to referrals from the sources highlighted in Table 4 and from the discussion above, some local Age UK partners proactively recruited participants in other ways. In both Hillingdon and Exeter, for example, the **fit for the future** programme was advertised in the local press. In Exeter the programme was also advertised at an annual event stall in the High Street, and in some localities local Age UK partners got in touch with existing clients (Blackburn, Leeds and West Cumbria).

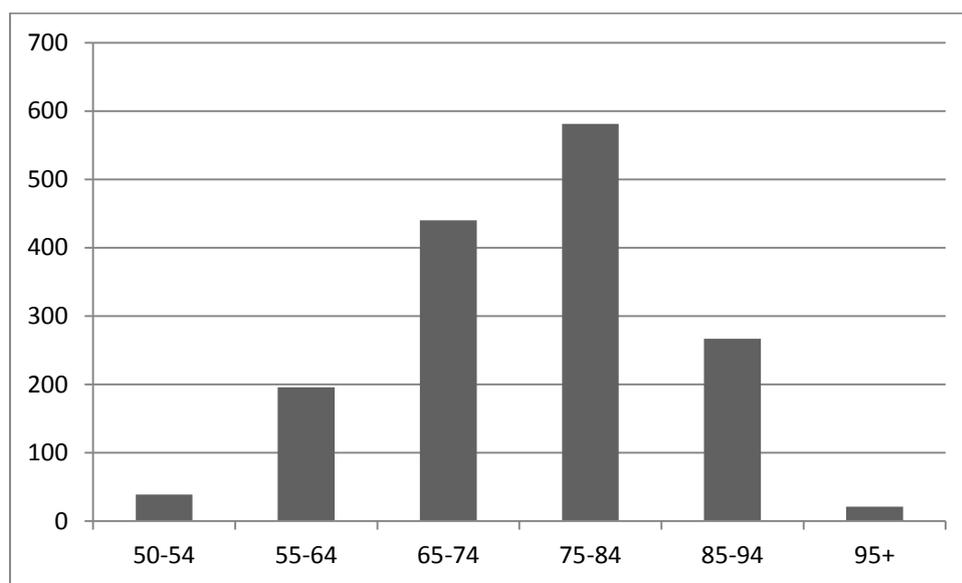
### ***Profile of participants recruited***

Here we outline the main characteristics of those 1572 older people who responded to Survey One, focusing on: age; gender; ethnicity; religion / belief; sexual orientation; self-reported long-term health conditions; disability; living arrangements; care responsibilities; highest level of formal educational qualifications; and occupational class (based on former occupation of those who are retired).

### *Gender and age*

The majority of the survey respondents (74.7%) were women, with just under a quarter being men.<sup>6</sup> The age of the participants ranged from 50 to 101 years, as shown in Figure 2, with the average (mean) age being 75.4 years. The average age of female respondents was slightly higher (75.5 years) than that of males (74.3 years).

**Figure 2: Age distribution of participants (n=1544)**



### *Ethnicity and Religions/belief*

Older people who completed the survey come from 16 different ethnic groups, although the majority from only two groups, with 90.5% White British and 4.1% Indian (n=1476). Table 5 in Appendix 2 shows a detailed breakdown of the ethnic background of the participants who completed the survey. These overall figures however disguise large differences in the ethnic background of respondents in the 11 areas where *fit for the future* was implemented, as the separate local area reports show.

Over three quarters (78%) of respondents identified themselves as a Christian and 12 per cent as having no religious belief. There were small proportions of Muslim (3%), Hindu (2%), Buddhist (1%); Sikh (1%) and other religion (3%). Table 6 (Appendix 2) provides a full breakdown.

### *Sexual Orientation*

The overwhelming majority of respondents (99%) stated they were heterosexual, with just 1% being LGBT (see Table 7, Appendix 2).

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<sup>6</sup> Gender: n=1485

### *Long term health conditions*

As ***fit for the future*** aimed to improve the physical and mental well-being of older people who were living with long-term health condition(s) or were at risk of developing a condition, it is important to map what type of health conditions participants live with. At the start of the intervention older people were asked specifically whether a GP or other health professional had diagnosed them with: respiratory conditions; arthritis; heart conditions; vascular conditions and stroke; cancer; diabetes; dementia; a mental health condition. They were also given the option to select 'other' health conditions. The most common long-term health condition reported amongst respondents was arthritis (52.4%), followed by heart conditions (28.5%), respiratory conditions (25.2%) and diabetes (18.3%), as shown in Table 5. Many respondents (43.9%) indicated that they had been diagnosed with 'other' health conditions, but the design of the questionnaire did not allow all of them to specify what this condition was.

**Table 5: Respondents reporting being diagnosed with a long-term health condition - percentages (n=1570)<sup>7</sup>**

<b>Long-term health condition</b>	<b>Percentage</b>
Arthritis	50.5
Heart conditions	27.8
Respiratory conditions	24.6
Diabetes	19.4
Vascular/ Stroke	16.4
Mental health problem	13.1
Cancer	9.5
Dementia	4.4
Other	43.8

Furthermore, many of the respondents reported living with multiple long term health conditions: 29.4 per cent reported two, 20.2 per cent three, 9.6 per cent four, and 3.9 per cent five or more long term health conditions (see Table 6). A small proportion (6.8 %) of respondents did not report being diagnosed with a long-term health condition.

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<sup>7</sup> The figures presented in this table do not add up to 100 per cent, as many participants reported living with multiple long-term health conditions.

**Table 6: Respondents diagnosed with multiple long-term health conditions, self-reported - percentages (n=1570)**

The number of long-term health conditions	Percentage
None	6.8
One	30.1
Two	29.4
Three	20.2
Four	9.6
Five or more	3.9
<b>Total</b>	<b>100.0</b>

### *Disability*

59 per cent of participants (565 of the 1076 responses to this question) considered themselves to live with a disability. Within this group, people mentioned several different disabilities, as shown in Table 7, the most frequently reported disability related to a physical impairment, with just over a third (36.7%) stating that they had some form of physical disability.

**Table 7: Respondents with different types of disability (n=561)<sup>8</sup>**

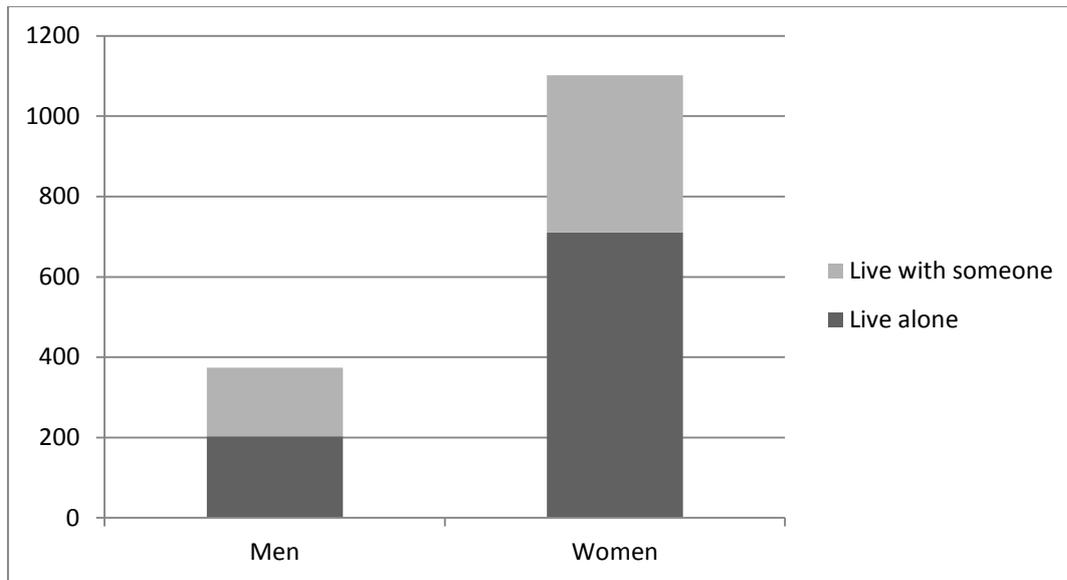
Disability	Percentage
Physical disability	36.7
Chronic illness	15.6
Deafness / serious hearing impairment	7.1
Blindness / serious visual impairment	6.4
Serious mental health condition	5.2
Other disability	4.5
Substantial learning difficulty	1.3
Substantial learning disability	0.7

### *Living arrangements*

Respondents were asked whether they lived alone or with one or more other person. The majority of the respondents (61.6%) lived alone (n=1563). There are, however, important differences between the living arrangements of male and female respondents, with a larger proportion of female respondents (64.5 %) than their male counterparts (54.3%) living alone (Figure 3), thus reflecting national trends (ONS, 2014).

<sup>8</sup> The percentages in Table 3.5 do not total 100%, as many respondents have more than one type of disability.

**Figure 3: Participants' living arrangements by gender (n=1476)**



#### *Caring responsibilities*

13.4 per cent of the respondents reported that they had caring responsibilities (n=1557). This is an important point to note given that all respondents themselves have a long term health condition. Moreover, this caring responsibility is shared by both male and female respondents, with 13.2 per cent of female respondents and 12.6 per cent of their male counterparts stating that they look after or support someone who is sick, disabled or frail elderly (n=1473).

#### *Educational qualifications and occupational class*

Nearly half of those who responded to information regarding their educational qualifications (44.4%) reported that they had no qualifications, with 29.4 having professional, other vocational or work-related qualifications. Just 6.4% held a first degree or higher (see Table 8, Appendix 2 for a full breakdown).

#### *Occupation/former occupations*

**Fit for the future** participants occupied or previously occupied a range of occupations (see Table 9, Appendix 2 shows), with Process, plant and machine operatives (17.5%), Administrative and secretarial occupations (16%), Sales and customer service operatives (14%), and Caring, leisure and other service occupations (13.9) being the key occupations mentioned. There were a small proportion of Managerial and professional occupations mentioned (8.1%), and just under 10 per cent reported no previous employment.

### *Comparison of **fit for the future** participants to population of England*

Respondents to the **fit for the future** survey (wave 1), when compared with the population of England (aged 45 and over) as a whole (see Appendix 3 for more details), were:

- More likely to be female (75% compared with 52%).
- More likely to be aged over 65 (84% compared with 39%).
- Less likely to be from a BME group but more likely to be from a religious minority.
- More likely to live alone and less likely to be a carer.
- Less likely to be overweight, to smoke or to drink and more likely to eat fruit/vegetables and to exercise.

### *Accessing participants*

Two stakeholders from different local authorities believed that **fit for the future** had provided a way to access people who might otherwise not be reached, encouraging them to participate in community events, some related to health and well-being. In so doing, **fit for the future** could be seen as having a beneficial effect in terms of widening participation. As one said:

***Fit for the future** has been another way of potentially reaching people who might not come to events – because of the one-on-one.*

And another said:

***Fit for the future** has been beneficial, it has brought in people who otherwise wouldn't have attended.*

### ***Services and activities offered***

Local Age UKs offered a variety of services and activities through **fit for the future**. Due to the individualised, tailored nature of the support, the types of services and/or activities which beneficiaries participated in varied quite considerably, both between areas and individuals. Thus, whilst many focused on group led activity, one-to-one interventions were also provided. Table 8 outlines a selection of services offered based on the activity logs submitted by the 11 participating local Age UKs. The activities listed in the table are broken down into the three main programme aims of: improving physical activity; healthy eating; and social engagement. The activities and services in this latter category aimed to improve participants' social networks to reduce isolation and thus improve their mental well-being. Due to the group led nature of many activities offered, those included in the other categories can also be classed as social engagement. As can be seen in Table 8 all local Age UKs ran a physical activity of some kind, and all ran some form of social engagement activity.

**Table 8: Breakdown of *fit for the future* activities offered**

Main programme aim	Activity or service offered	Number of local Age UKs offering activity or service
Improving Physical activity	<ul style="list-style-type: none"> <li>Exercise groups: Yoga; Zumba; Tai Chi; led walks; Trampolining; Aqua Mobility; Wii fit games; dancing (i.e. line, Latin); gym group; seated exercises; aerobics; 'staying steady'.</li> </ul>	11 (all)
	<ul style="list-style-type: none"> <li>Sports: Walking football; boccia; kurling; swimming.</li> </ul>	3
Healthy Eating	<ul style="list-style-type: none"> <li>Courses or classes on healthy eating and nutrition.</li> </ul>	6
	<ul style="list-style-type: none"> <li>Individual support around diet and healthy eating: food diaries; weigh ins; provision of cookery booklets.</li> </ul>	2
Social engagement	<ul style="list-style-type: none"> <li>Befriending service<sup>1</sup>: visits and telephone calls from Age UK staff and volunteers.</li> </ul>	2
	<ul style="list-style-type: none"> <li>Coffee mornings / Lunch clubs.</li> </ul>	5
	<ul style="list-style-type: none"> <li>Social and leisure: day trips; cinema; gardening; allotment project; book club; tea parties; singing, games and quizzes.</li> </ul>	7

<sup>1</sup> Also offered to Age UK clients who do not participate in *fit for the future*

Due to the tailored nature of the support plan, some activities were aimed at individuals, either to improve learning or provide additional support, such as quitting smoking advice sessions. Seven participating local Age UKs reported that they had offered one-to-one services as part of the *fit for the future* activities. Some local areas provided courses on using computers and the internet. While these services are 'one-to-one', they can also be viewed as contributing to increasing social engagement, as case study participants explained that they primarily used the internet to keep in touch with friends and family.

It has not always been possible to identify which of the activities were already taking place prior to the *fit for the future* programme, and which would have continued to operate had the programme not received funding. Thus the level of dead weight (i.e. the activity that would have taken place anyway, regardless of the programme) is somewhat difficult to identify.

***Delivery of the services: providing complex, community led, highly personalised services and support***

The types of services and activities, listed above, were offered with the aim of improving participants' well-being in the broadest, most holistic sense. The different ways in which this support has been provided and delivered are listed here:

*Signposting:* participant older people are given information about services available for them to access, this includes: a) information about local services provided by other organisations, such as the Breathe Easy Group and Ear Foundation leaflet (Nottingham and Nottinghamshire); and b) information produced by Age UK, such as the Healthy Eating Guide, Save Energy, Pay Less Guide, Home Safety Checker Guide, and Winter Wrapped Up Guide. The support / action plans devised for the participant older people indicate that this kind of signposting took place after the needs assessment, and thus only the relevant guides were given to the participants.

*Referrals to other services:* participant older people are also referred to other appropriate services, following their initial assessment in ***fit for the future***. Some of the services that they have been referred to include: Age UK Benefit Check; Age UK Debt Advice; Age UK Advice and Information Outreach; Green Doctor (a voluntary organisation making homes more energy efficient); Library at Home service; home care providers; Vision Consortium; local organisations which run groups for older people (bingo, lunch clubs); local charities organising home care services; Adult Social Care Services of local authorities; Fire Service (for safety check, fitting fire alarms).

*Provision of a broad range of activities:* local Age UKs and their partner organisations referred older people, based on the initial assessment, to a broad range of activities (either existing or newly developed), focusing on the main programme aims of increasing physical activity, social interaction, or healthy eating. In some cases older people were initially referred to a single group, and then participated in other ***fit for the future*** activities as their awareness of what was available increased. For example, one beneficiary got involved in physical exercise following initial classes to improve specific skills:

*I went first to do a computer course. ... The writing class just came after that. ... Zumba [came because] I was looking for an exercise class, [and it] is great fun.*  
(Sarah, Leeds)

A few local Age UKs ran groups which aimed to meet a variety of the main ***fit for the future*** objectives. Some added social elements to exercise classes, for example, by providing coffee and cakes and inviting participants for a chat after the exercise group. In the case of the 'Men in Sheds' group in West Cumbria, it was the opposite and the health element was added to the social activity. So whilst the main purpose of the group was to fix donated

bicycles and give them to schoolchildren in Gambia, according to the person who ran the group, they also talked about healthy eating and the importance of exercise in the breaks, encouraging the men to think about joining exercise classes. The participants, however, saw it as a social occasion and a hobby, rather than being related to overall health.

In one local Age UK area (Rotherham) a 'multi-purpose' approach was consciously adopted, aiming to engage older people in social, physical and healthy eating activities within the same sessions. Older people would take part in an exercise group, followed by discussions around healthy eating and games/quizzes, such as in the following example:

*[We do] exercise and we always do a quiz. Play games and dominoes because we have a couple of men who come and like cards and dominoes. Scrabble. (Sue Rotherham).*

This approach proved successful, as after Age UK stopped supporting the group, some continued to be run by the members independently, demonstrating how **fit for the future** successfully provided a starting point for organising a community group.

*Practical help:* some participants have been provided with practical help following their assessment, for example, Age UK staff / volunteers have made arrangements to: have a water metre fitted; get boilers and heaters repaired; get rebates from utility service providers; set up insurance for household items; and contacted the local authority to arrange for assisted refuse collection. A case study participant in East Cheshire, for example, was struggling to participate in social activities due to failing health, but benefitted from the tailored plan offered by **fit for the future** as he was assisted with home help, aids and adaptations, and with ICT, thus helping to ensure he could maintain his independence, as he puts it:

*[the worker] talks about the problems [I] have got, about the services that are available, he mentioned care and repair services to help with household's maintenance and repairs, and the help at home service run by Age UK...I have also had problems using my desktop computer because my sight is deteriorating, and he has arranged for someone to come and see me next week to see if something can be done (David, East Cheshire).*

*Personal support and encouragement:* many case study participants received regular phone calls from Age UK as a result of participating in the **fit for the future** programme. Age UK staff / volunteers also supported older people to improve their well-being, for example: they accompanied a case study interviewee (Tajinda) to exercise classes until she was confident enough to go independently; encouraged another case study interviewee (Peter) to go for a

short walk every day; encouraged another (Rachel) to join groups and attend activities out of her home rather than staying at home where she is visited and telephoned by Age UK staff and the volunteers of the befriending service. These examples refer to the 'holistic' nature of the programme and are returned to below.

*One-to-one advice:* as touched upon previously due to the tailored nature of the support/action plans, some Age UK staff and volunteers view supporting participants with complex needs as a gradual process, which essentially involves providing one-to-one support, or services not necessarily within the intended scope of the programme. This is most evident in the case studies of older people who were in poor health at the beginning of their engagement with the programme, whereby their support started with arranging personal and housekeeping services and reducing social isolation. These steps were thought to prepare the older person for going out more and becoming involved in activities designed to increase their physical activity.

### **Participant's expectations and experiences of *fit for the future***

The following discussion is drawn from the case studies and considers the main expectations of older people, and how the unique implementation of *fit for the future* has impacted on how they experienced the programme.

#### ***Older people's expectations of fit for the future***

Older people provided a number of reasons for initially taking part in *fit for the future* and therefore their expectations of the programme varied accordingly. Some had very few, if any, expectations at the outset, this being particularly true for those who were referred to the programme through a health professional, or who were approached directly by Age UK:

*I was thinking what I could do, and when I was down at the doctor's surgery one of the age UK gentlemen was sitting in the foyer. I started to talk to him and he started suggesting things. I thought I'd give it a try. (Linda, Nottingham)*

Others, including those who self-referred, had specific aspirations for their involvement in *fit for the future*, including a desire to lose weight, or increase their overall fitness:

*I was looking for exercise – I had been going to the gym but that came to an end. I invested some of my retirement payment and paid for a personal trainer for a whole year...but I couldn't really keep that up any more, and my trainer went private, so I was looking for something cheaper. And I wasn't so keen to do the gym without support. (Eve, Exeter)*

Regardless of the activities offered, the main consensus among older people interviewed was the importance of the social aspect of the programme, which was highly valued by many. Reasons for wishing to interact with others varied, with some wishing to combat loneliness and isolation, while others wanted to increase their confidence:

*It gets you out of the house. You have to do that because you can feel a bit lost at times. You feel more confident if I you are part of something. (Samantha, Hillingdon)*

Others expressed a wish to widen their social circle and make new friends:

*To meet new people – we hoped to get to talk to new people who live round this area. It's all about meeting people and a bit of a natter. As you get older it is harder to meet new people. (Adam, Rotherham)*

### ***How participants benefitted from the fit for the future implementation model***

Many of the older people relayed positive experiences about their involvement and engagement with ***fit for the future***. The evidence of the case studies with older people suggests that their experiences of the programme is dependent upon the extent to which the support provided is both personalised and holistic; and the accessibility of services and activities.

#### ***Personalised and holistic support***

Most of the case study participants, in all 11 locations, reported that they received complex, highly personalised support. It emerged from the case study interviews that Age UK staff and/or volunteers paid specific attention to ensuring that individual needs were at the centre of their provision. This related to general advice and assistance, such as a beneficiary who was offered help when discharged from hospital, and another who was given help with choosing a new care home for her husband (touched upon above). Alongside this broader level of help were examples of assistance which aimed to meet the more specific aims to the programme, such as facilitating participants to lose weight. In Exeter, the case study participants who wished to lose weight were provided with services tailored to their particular needs, as the following two examples show:

*[The Age UK support worker] looks at my food diary and asks me about the week and I'm completely honest with her even if I had one of my munchies and went off the diet. She accompanied me to the hospital dietician and suggested courses... She was very concerned that I get as much help as possible. She's very imaginative and is good at finding things that I would like... (Mary, Exeter).*

*I lost 2.5 stones under six months [the support worker] helped me keep to the diet and I need less insulin. She gave 1-to-1 support with the diet. (Cath, Exeter).*

Participants also referred to support to help them gain confidence in participating in group activities:

*She [the Age UK project worker] is very sweet, she came with me to the exercise class first time. It's hard to meet older people. She often calls and asks me how I am.*  
(Rabia, Hillingdon)

This therefore reflects an additional unexpected outcome, and highlights the holistic nature of the programme.<sup>9</sup>

#### *Accessibility of services and activities*

According to case study interviewees, some older people found **fit for the future** particularly attractive because the services were easy to access: in terms of time; location; transport options; fees; and composition of participants. These factors all come together and influence the decisions of individual participants. Some interviewees mentioned that **fit for the future** groups were run at times that best suited them, whereas 'standard' exercise classes in gyms or community centres were often started too late. One case study interviewee explained why she chose the Age UK 'Zumba Gold' class:

*I was looking for an exercise class but everything was so expensive. And ... most classes are in the evening [when] I'm tired.* (Sarah, Leeds)

The overall cost of accessing services was mentioned by many of the interviewees. They said that they were more likely to access the services if they were free of charge or relatively cheap. The cost that they were referring to include the fees they paid for the services, the room hire and the cost of transport to the venues. Some participants mentioned that the cost was often kept down through **fit for the future**, particularly if the venue was provided free of charge, which sometimes happened as a result of a special arrangement with the local authority. This suggests that the programme has enabled older people to access activities that they would not otherwise have been able to.

The location of the group sessions was particularly important for older people who were carers or who had limited mobility. An older couple in Rotherham, for example, have to use a car to go into the town centre from their sheltered accommodation as both have physical impairments. The husband (Adam) walks very slowly and his wife is in a wheelchair. The **fit for the future** group meets only a hundred meters from their bungalow, and has been their

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<sup>9</sup> These types of unplanned interventions are hard to formulate as targets and quantifiable outcomes of a specific programme, but they are very important for the participant and also take up the time of Age UK staff, and are thus important elements to consider.

main source of social contact apart, from their family, in the last couple of months. Together the low cost (including the low cost of travel) and convenient location contributed to an older person's decision to choose **fit for the future** services over mainstream exercise classes:

*You see, the good thing is that I can come here on the bus and that's free, so I have to pay only for the class and that's minimal. And the bus stop's just outside. I probably would have found something else, but it suited me to come here and I enjoyed coming here." (Adam, Rotherham)*

The types of other people accessing the activities and the extent to which they felt accepted by other group members was also particularly important to some participants. For example, one older person with facial palsy (along with an impaired sense of balance), felt embarrassed about her appearance, but gradually felt comfortable attending an exercise class as those in the walking and Zumba group that she attended were understanding and supportive. This meant that she continued to attend sessions, resulting in her health benefitting from regular exercise. Another respondent felt more comfortable joining the programme as she was approached by someone who shared her ethnicity, and also felt comfortable with joining a swimming class due to the presence of other Asian women in the group. This therefore highlights the importance of specific activities targeted at certain groups of older people.

The importance of the accessibility of activities is further reflected by the fact that, although many older people were positive about the timing and locality of activities offered in their respective areas, this was still an issue for some. For example, suitable times was particularly important for participants who are also carers, as they often have a very strict daily routine, limited by the availability of formal care services that they can draw on to enable them to go out and leave the person being cared for. Even those carers who have a relatively light care load may be restricted in terms of their ability to leave the home. For example, one respondent was interested in joining **fit for the future** exercise classes, but they were in the afternoon, when she visits her husband in a care home:

*They also offered an afternoon dance thing. Then they were doing this sitting down yoga, but that was in the afternoon, and I could not take up on those, and I told them about the situation. If it was in the morning that'd be great, or if it finishes by 3 o'clock and it's [here], it's not too bad, but most of them were 2-4 pm, so that's not good for me. (Kate, Nottinghamshire)*

## **Summary**

- Local Age UKs have adopted a variety of approaches to recruiting or referring older people to the programme.
- Most older people were referred to ***fit for the future*** from Age UK services, self-referral and by 'other' health professionals, but, overall, less so by GPs.
- All participating local Age UKs provided services relating to physical activity and social interaction. Eight ran services related to healthy eating, and seven offered one-to-one support services.
- Due to the individualised, tailored nature of the support provided, the types of services or activities beneficiaries took part in varied quite considerably, both between areas and amongst individuals.
- The different ways in which support has been provided and delivered includes: signposting; referrals; provision of a broad range of activities; practical help; personal support and encouragement; and one-to-one advice.
- Older people viewed the social aspect of the programme as valuable.
- An additional unexpected outcome was the holistic nature of the programme due to the highly personalised support offered as a result of its implementation model.
- Convenience and accessibility were important considerations, with many older people appreciating the flexibility in terms of the: time; location; transport options; fees; and composition of participants in the programme.

## 6. Impact on older people

This section examines the impact of *fit for the future* on the well-being of the older people taking part in the programme, focussing especially on the outcomes<sup>10</sup> included in Age UK's proposal to the Big Lottery Fund. It is broken down into six main subsections, these are outlined below:

- **Section 6a:** Discusses the methodology adopted, including data collection methods, the tests used and the profile of respondents. It also considers the survey results overall, showing how the variables measures should be treated as interconnected.
- **Section 6b:** Looks at mental well-being, focusing on the extent to which: older people feel more positive about themselves; feel less isolated and/or lonely; and feel more satisfied with their life.
- **Section 6c:** Concentrates on healthy eating, looking at the degree to which older people have increased their daily consumption of fruit and vegetables.
- **Section 6d:** Considers the extent to which older people have increased the amount of physical activity they do per week.
- **Section 6e:** Examines weight management, focusing specifically on BMI and waist circumference.
- **Section 6f:** Discusses the degree to which older people have reduced their average consumption of alcohol and cigarettes.
- **Section 6g:** Focuses on the management of long-term health conditions (LTCs), assessing the degree to which older people feel more supported to manage their LTCs; and feel more in control of their own care as relevant to their specific LTCs.
- **Section 6h:** Provides a summary of the key impacts of *fit for the future* on older people.

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<sup>10</sup> These outcomes are closely linked to the Public Health Outcomes Framework 2013-2016, for more details see Department of Health, 2013.

## **6a Methodological comments and overview**

The evidence provided in this section is drawn from the results of the self-completion survey carried out at three timepoints: the start of the intervention, three months after the start of the intervention and nine months after the start of the intervention. The analysis is based on responses from a sample of 1076 older people who completed the survey at all three timepoints and focuses on changes between the three timepoints. The statistical summary tables presented in this report include: frequency (with or without the corresponding percentage), mean (with the associated standard deviation) or median (with the associated interquartile range). The mean is the value that is commonly referred to as the 'arithmetic average' and the associated standard deviation (SD) is the measure of the scatter of individual values on either side of the mean - the higher the value of SD, the greater the scatter. The median is the value that divides the sample in two - with half of the values being smaller and half larger than the median value. The interquartile range is the corresponding measure of scatter: it represents the 'middle' 50 per cent of the values in the sample.

All statistical tests were conducted on the sample of respondents who provided data at all three timepoints (N=1076), however, for individual variables the number of valid responses is typically smaller than 1076, because of missing responses. When analysing local level data, tests of statistical significance were conducted only if there were at least 30 valid responses from a given area at all three timepoints, to ensure that the statistical tests are powerful.

The impact is evaluated in two steps: first we look at the number (proportion) of older people participating in *fit for the future* who achieved a positive outcome between the three timepoints, e. g. the proportion of older people who reported eating more fruit and vegetables or walking more. Then we analyse the magnitude of changes in outcomes and whether these changes are statistically significant. A statistically significant change is one where we can confidently regard the observed change as not simply occurring due to sampling error (i.e. it is a 'real change').

Data were analysed using IBM SPSS 21 and the level of statistical significance chosen for this report is  $p \leq 0.01$ , that is, a statistically significant change is indicated by a probability value that is less than or equal to 0.01. In other words, we are 99 per cent confident that the changes reported here (for example, a change in the number of minutes older people walk a day, or their BMI values) are not due to statistical error. A low cut off for significance of  $p \leq 0.01$  was chosen to restrict the probability of 'false positives' (Type 1 error). **Significant**

effects are indicated within the tables in this section by the † symbol<sup>11 12</sup>. It is important to note that when the sample size is large, very small changes may be statistically significant, and conversely, in a small sample even large changes may not be statistically significant. Different statistical tests were used for determining if an observed change is statistical significant (i.e. ‘real’) – the name of the test is given in the table summarising the findings and more detailed information about the tests, including the significance level, can be found in Appendix 4.

A few caveats about the data collected in the survey are in order here. As the survey was self-completed responses to some questions (weight, height or waist measurements) may be unreliable (Hill and Roberts, 1998). For example, several respondents reported different heights in Survey One, Two and Three. This is an important factor to note, because the value of BMI is very sensitive to height. To overcome the problem caused by different height measurements of the same respondent at different timepoints, the height reported in Survey One was used to calculate BMI values in all three waves of the survey. Many respondents did not provide data about their weight and waist circumference, reducing the number of cases where the change of weight, BMI and waist measurement could be calculated over the three timepoints of the survey.

### ***Overview of impact on older people***

When discussing the impact of ***fit for the future*** on individual participating older people, we analyse the level of the change, the statistical significance of the change and whether different groups of participants, for example men and women, or those living in different geographical localities have been affected differently by the intervention. Evidence from the case study interviews are reflected on to demonstrate the interwoven benefits to participants.

The World Health Organization defines health as “*a state of complete physical, mental and social wellbeing and not merely the absence of disease*” (WHO, 1948: 100), highlighting the complex relationship between these different functional domains in supporting optimal ageing. Indeed, older people participating in ***fit for the future*** often emphasised the connections between improved physical and mental well-being when they explained what the main benefits of the programme were for them, as the following quote illustrates:

*Zumba makes me happier because I enjoy it. ... It makes me breathe a bit harder.  
Meeting people that you know, having a chat, having a coffee.* (Sarah, Leeds)

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<sup>11</sup> It is important to note that we are unable to report with certainty that the observed changes are due to participation in ***fit for the future***, as they may have been influenced by other, non-related events.

<sup>12</sup> A more detailed explanation of the statistical summary tables is included in Appendix 4.

Gemma, who participated in chair-based exercise with Age UK Hillingdon gave more details when she talked about her group:

*It's very good and it's funny as well. We have bands and balls – we all laugh when we drop something. We can't all do everything but we work around it, laughing just generally having a good time. (Gemma, Hillingdon)*

The relationship between physical exercise and overall well-being also worked the other way round. Barbara joined a **fit for the future** group primarily to meet new people and improve her low moods, but she also start to feel the benefits of physical exercise, as she put it: *“because I'm feeling more fit, I can cope better”* (Barbara, Rotherham). Another participant based in Nottingham expressed the link between physical activity, the companionship of group members and her overall well-being by saying: *“I'm more active. I feel more relaxed. I don't think I'll be dead tomorrow”* (Linda, Nottingham).

Simon (Newcastle) explained that working on the Age UK allotment was good for his physical and mental well-being: *“gardening keeps my muscles in shape ... and in the garden you forget about everything, it's one of the few times when I can really relax.”* (Simon, Newcastle).

Table 9 provides a summary of the proportion of older people with a positive outcome observed for the main variables measured at all three timepoints. This table clearly demonstrates that older people participating in fit for the future experienced positive outcomes in their mental well-being, levels of physical activity and quality of diet. The magnitude of change in these outcomes is discussed in the proceeding sub-sections.

**Table 9: The proportion of older people with a positive outcome observed**

Outcome	Verification Method	% of older people with positive outcome Survey 1 - 3	% of older people with positive outcome Survey 1 - 2	% of older people with positive outcome Survey 2 - 3	Sample Size
Older people feel more positive about themselves.	7-item Warwick-Edinburgh Mental Well-being Scale	48.7 <sup>†</sup>	47.9 <sup>†</sup>	36.8	840
Older people feel less lonely.	Loneliness Survey Question	21.2*	17.9*	14.3	1008
Older people feel less isolated.	Isolation Survey Question	24.5 <sup>†</sup>	20.2 <sup>†</sup>	13.1	997
Older people are satisfied with their life	Life Satisfaction Score	38.4 <sup>†</sup>	38.1 <sup>†</sup>	29.2	976
Older people have increased the number of minutes of physical activity they do per week as per the Department of Health physical activity guidelines.	Walking Survey Question	44.9 <sup>†</sup>	40.4 <sup>†</sup>	33.9	955
	Hard breathing Survey Question	35.4 <sup>†</sup>	39.8 <sup>†</sup>	24.0	857
	Muscle Strengthening Activity Survey Question	32.3	36.5*	25.6	888
Older people have an improved body mass index (BMI).	BMI Survey Question	47.2 <sup>†</sup>	40.1	38.6	593
Older people have an improved waist circumference.	Waist Circumference Survey Question	39.5	32.5	28.8	271
Older people have reduced their average alcohol consumption per week.	Alcohol Consumption per week Survey Questions	31.8	27.7	28.6	220
Older people have reduced the number of cigarettes they smoke per day.	Cigarette Consumption per day Survey Questions	29.2	33.3	50.0	48
Older people have increased their daily consumption of fruit and vegetables.	Fruit & veg intake per day Survey Questions	38.8 <sup>†</sup>	39.9	24.4	989
Older people feel more supported to manage their LTCs.	Feel supported to manage LTC Survey Question	21.4	20.9	13.4	865
Older people feel more in control of their own care as relevant to their specific LTCs.	Feel in control of managing LTC Survey Question	21.4	21.1	13.0	828

<sup>†</sup>Statistically significant change at 1% level of significance (i.e. p<0.01); \*Statistically significant change at 5% level of significance (i.e. p<0.05)

## 6b. Impact on mental well-being

One of the greatest positive outcomes from the ‘original’ **fit as a fiddle** portfolio was reported to be a reduction in social isolation and loneliness and increased social connectedness (Ecorys, 2012). The positive mental well-being outcomes of **fit for the future** are similarly evident in both the survey data and qualitative case study interviews with older people; and included levels of social connectedness and satisfaction with life.

### *Satisfaction with life*

The 7-item Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was used in the surveys to directly measure mental well-being<sup>13</sup> with almost half of respondents reporting a statistically significant positive outcome by 3 months (that appears to remain at 9 months).

The overall change in the ‘average’ score between timepoints 1 and 3 is statistically significant, whereas older people felt more positive about themselves at the end of the intervention than at the start. More specifically, as shown in Table 10 there was a small but statistically significant increase in the mean score between timepoints 1 and 2, followed by slight and (statistically not significant) decrease between timepoints 2 and 3. This may therefore suggest that the main impact on mental well-being following participation in the programme took place in the first few months of involvement. However, we do not know how long the interventions lasted for (they may well have ended before the third survey was completed).

**Table 10: 7-item Warwick-Edinburgh Mental Well-being Scale - median (interquartile range)**

Survey One	Survey Two	Survey Three	n value	Statistically significant change*
27 (7.00)	27 (8.00)	27 (8.00)	840	Between timepoints 1-3 and 1-2

Statistical test: Repeated Measures Anova with Bonferroni adjustment for multiple comparisons between timepoints 1-3, 1-2 and 2-3.

\*p values and further details of the statistical test used are presented in Table 1 in Appendix 4

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<sup>13</sup> WEMWBS is a validated measure of mental well-being. Respondents are asked to rate their feelings over the previous two weeks from 1 (none of the time) to 5 (all of the time) on seven statements: ‘I’ve been feeling optimistic about the future’; ‘I’ve been feeling useful’; ‘I’ve been feeling relaxed’; ‘I’ve been dealing with problems well’; ‘I’ve been thinking clearly’; ‘I’ve been feeling close to other people’; and ‘I’ve been able to make up my own mind about things’. Ratings are summed up, producing a total score ranging from 7 to 35 for each respondent.

These results were not, however, consistent geographically.<sup>14</sup> Firstly, the average (median) values at the start of *fit for the future* varied a great deal by area from 24.0 in Cheshire East and 25.0 in Newcastle at one end of the spectrum to 29.0 in Nottingham and Nottinghamshire and 30.0 in Hillingdon. Secondly, the degree, and even the direction of change, also varied. Significant positive change was observed in: Blackburn with Darwen (timepoints 1-3); Exeter (timepoints 1-3); Lancashire (timepoints 1-3 and 1-2); and Rotherham (timepoints 1-3). A small, but statistically negative change was observed in Nottingham and Nottinghamshire (timepoints 2-3). The tables with local level data are presented in Annex 1.

There was also some variation in the results by ethnicity, as data presented in Table 11 below demonstrates. Asian British participants reported higher values on the mental well-being scales than those of other ethnicities at all three timepoints.

**Table 11: 7-item Warwick-Edinburgh Mental Well-being Scale by ethnicity - median (interquartile range)**

<b>Ethnicity</b>	<b>Survey One</b>	<b>Survey Two</b>	<b>Survey Three</b>	<b>n value</b>	<b>Statistically significant change*</b>
White British	27.00 (7.00)	27.00 (8.00)	27.00 (8.00)	728	Between timepoints 1-3 and 1-2
Asian British <sup>15</sup>	28.50 (9.00)	28.50 (8.00)	29.00 (5.25)	50	No
All other ethnic groups	26.50 (7.75)	27.00 (7.00)	25.50 (10.25)	20	No

Friedman test, pairwise comparisons between timepoints 1-3, 1-2 and 2-3.

\*p values and further details of the statistical test used are presented in Table 2 in Appendix 4

### *Satisfaction with life*

Respondents were asked to provide a rating of their overall satisfaction with life<sup>16</sup>, with almost 40% reporting a statistically significant positive outcome by 3months (that appears to remain at 9 months). At the start of the intervention the median value was 7, with 50 per cent of respondents indicating a value between 5 and 9 on the scale. Looking at the change over time, we find that there was a small positive change between timepoints 1 and 2, and no change was observed between timepoints 2 and 3, as shown in Table 12. Again this could suggest that involvement in the programme had a greater positive impact on satisfaction with life in the first few months, with the effects perhaps gradually wearing off over time,

<sup>14</sup> In the local level analysis all 840 valid cases were included – the distribution of data by areas could not be approximated as normal.

<sup>15</sup> Older people from Indian, Pakistani, Bangladeshi and other Asian British background.

<sup>16</sup> On a scale of 0-10 where 0 is 'extremely dissatisfied' and 10 is 'extremely satisfied'.

although we do not know how long the interventions lasted for (they may well have ended before the third survey was completed).

This average, however, hides a great deal of variation across the 11 areas where *fit for the future* was delivered. The average (median) values at the start of the programme ranged from 6.0 in Cheshire East, Exeter and Newcastle to 8.0 in Blackburn with Darwen, Hillingdon, Nottingham and Nottinghamshire, Rotherham and Warwickshire. Significant positive change satisfaction with life scores was observed in only three areas: Blackburn with Darwen, Cheshire East and Lancashire.

**Table 12: Satisfaction with life scale - median (interquartile range)**

Survey One	Survey Two	Survey Three	n value	Statistically significant change*
7 (4)	8 (3)	8 (3)	994	Between timepoints 1-3 and 1-2

Friedman test between timepoints 1-3, 1-2, 2-3.

\*p values are presented in Table 3 in Appendix 4

#### *Social networks: isolation and loneliness*

The surveys also focused on participants' social connectedness, measured by four questions selected from the Revised UCLA Loneliness scale (Hughes et al, 2004), which are also included in the English Longitudinal Survey of Ageing (ELSA).<sup>17</sup> The expectation was that, as a result of the intervention, older people feel less isolated and lonely, thus they feel a lack of companionship *less* often and feel isolated or left out *less* often, which is reflected in a negative change in the value of the indicators.

As expected, there was a negative change in the average (median) value of the indicator '*lack of companionship*' from 2 (referring to 'some of the time') at the first timepoint to 1 (referring to 'hardly ever / never') at the second timepoint. This was then maintained between timepoints 2 and 3, as shown in Table 13. However, the results of the statistical test indicate that the change was not statistically significant.

The median value of the indicator '*feeling isolated*' did not change over time, however, the statistical significance tests have revealed a significant decrease in the value of the '*feeling isolated*' indicator between timepoints 1-3 and 1-2 (see Table 13).<sup>18</sup> That is, older people felt

<sup>17</sup>The questions are: 'How often do you feel you lack companionship?'; 'How often do you feel isolated from others?'; 'How often do you feel left out?'; and 'How often do you feel in tune with the people around you?'. There were three response options to each question: 'hardly ever or never', 'some of the time', and 'often', represented by values 1-3, where 1 is 'hardly ever / never' and 3 is 'often'.

<sup>18</sup> In the case of median values a significant change may occur despite the corresponding median values remaining unchanged. Inspection of mean ranks (not shown in this report) indicates the direction and magnitude of the change. A

less isolated at the end of their participation in *fit for the future* than they did at the beginning.

The median value of the indicator *'feeling left out'* did not change over time, and the statistical significance test did not reveal a statistically significant change either, as shown in Table 13.

The final variable relating to social networks was based on a question asking participants how often they *'felt in tune with the people around them'*. Thus a positive change in the value of the indicator was expected as the outcome of participating in *fit for the future*. Indeed, there was a positive, but not statistically significant change, between timepoints 1 and 2, with a levelling off between timepoints 2 and 3, as shown in Table 13.

**Table 13: Change in the value of indicators measuring loneliness and isolation - median (interquartile range)**

Variable	Survey One	Survey Two	Survey Three	n value	Statistically significant change*
Lack of companionship	2(1)	1(1)	1(1)	1008	No
Feeling isolated	1 (1)	1 (1)	1 (1)	997	Between timepoints 1-3 and 1-2
Feeling left out	1 (1)	1 (1)	1 (1)	977	No
Feeling in tune with others around you	2 (1)	3 (1)	3 (1)	982	No

Friedman test between timepoints 1-3, 1-2 and 2-3.

\*p values are presented in Table 4 in Appendix 4

Focussing on the geographical areas where the programme was delivered, we find that older people felt they lacked companionship less often than the average at the start of *fit for the future* in: Blackburn with Darwen, Hillingdon, Nottingham and Nottinghamshire, Warwickshire and West-Cumbria. While there was not a statistically significant improvement in the 11 areas overall, there was one in Newcastle, between timepoints 1 and 3 (see Annex 1). It was also found that older people felt more isolated than the overall average at the start of the programme and also at timepoint 2 in: Exeter, Newcastle and Rotherham. Whereas there was a positive outcome in terms of reduced social isolation overall, there was no statistically significant outcome in any of the 11 areas (see annex 1).

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change across equal medians will normally be small, particularly, if the interquartile ranges are also unchanged.

The four measures of social connectedness shown in Table 13 were applied to assess if there were any differences based on gender. For women, it was found that there were positive changes overall in companionship, feeling left out, and feeling in tune, but that these were not statistically significant. However, a significant result was obtained for women being less isolated between the first and third, and first and second timepoints (see Table 14). No significant change was observed for men.

**Table 14: Change in the value of indicator measuring isolation, women - median (interquartile range)**

Variable	Survey One	Survey Two	Survey Three	n value	Statistically significant change
Feeling isolated	1(1)	1(1)	1(1)	720	Between timepoints 1-3 and 1-2.

Friedman test, pairwise comparisons between timepoints 1-3, 1-2 and 2-3.

\*p values are presented in Table 5 in Appendix 4

#### *Outcome by area*

Whilst the findings overall indicate that the main positive changes occurred within the initial months of the project, when individual geographical areas were isolated, for some, statistically significant positive changes are only observed between the first and 9 month timepoints (with significance not being reached between timepoints 1-2). For example Blackburn with Darwen, Cheshire East, Exeter, and Rotherham showed a statistically significant positive change in mental well-being at timepoints 1-3 only and Blackburn with Darwen, Cheshire East and Lancashire showed a significant positive change for satisfaction with life score across timepoints 1-3 only (for further information please refer to the Annex).

#### *Case study participants*

Numerous case study interviewees made positive comments about the role of the programme on their levels of 'social connectedness'. Indeed many said that although they were not actively seeking activities outside the home, they responded positively to the invitation from their local Age UK to get involved because they wanted to meet new people, as the following example illustrates:

*We ... just went across and they said we were going to chat and you know, do crafts and quizzes. I love quizzes, they keep your brain going and I do like crafts. ... So I just thought, it's something different, and also, meeting different people. See, I missed that. Because in my job I was travelling up and down the country, meeting different people every day, you do tend to miss it later. (Sue, Rotherham)*

Don in Exeter also felt that meeting new people and 'getting out' of the home were important benefits for him: *"I made a lot of friends and I get out regularly. [Without Age UK] I'd be just sitting at home and vegetating which is not the way to go, is it."* Similar feelings were expressed by another older man, who felt that through his work in the *Men in Sheds* group he could help others and have a new purpose in life: *"Without this I would be at home doing nothing. ... Yes, it's a purpose in life and helping other people as much as I can"* (George, West Cumbria). Another participant saw a direct relationship between increased social engagement and her increased confidence:

*It [the chair-based exercise group] gets you out of the house. You have to do that because you can feel a bit lost at times. You feel more confident if I you are part of something.* (Samantha, Hillingdon)

Some older old participants who lived in sheltered housing said that the **fit for the future** group was the only companionship they had on some days:

*Well, if it weren't for the [group], I'd be on my own 'til my daughter comes up... She doesn't come Monday and Tuesday, I'm sitting in. Unless we had them Tuesdays, afternoons, I'd be in all day, and I used to get fed up."* (Joan, Warwickshire)

For some interviewees the companionship of older people in similar circumstances was particularly important:

*It's given us more confidence. ... I've met a lot of new people ... and I realised that people have the same type of you know, same type of lifestyles, maybe lost their job or their partner but they went out there. We have a laugh and I feel better in myself.* (Sarah, West Cumbria)

For others, who were uncomfortable with groups, the befriending service was an important means to reducing loneliness, as Rebecca's example illustrates: *"I'm not a good mixer, I can't talk to a stranger. I like going out with my befriender – we go to garden centres, we've been to the coast, we go out"* (Rebecca, Newcastle).

For some older people it was the company of one particular *volunteer* or Age UK support worker that made the difference and had a very positive impact on their mental well-being by reducing their lack of companionship. Susan in Leeds lives with chronic pain and felt very low before she met her 'befriender', a university student, much younger than herself, who helped her in many ways:

*She helped me get out of the depression. She got me cooking - the first thing was beans on toast. Then I cooked an egg. Then we poached an egg. She got me going out, she made me walk to the [post] box, just up the road. ... We went to town together – that was the first time I've been on the bus – since [my condition deteriorated]. Step by step. She was excellent. (Susan, Leeds)*

Another interviewee emphasised that she preferred the companionship of a 'professional' befriender, because she did not want to 'burden' her family:

*That's why Age UK is an answer to my prayers. Because it is so much easier to ask someone who's paid to help you than ask a friend or someone in your family who's rushed off their feet. ... You can phone them up and pour your heart out and nobody's ever going to know about it. Whereas your family may think you are old and dotty. (Gemma, Hillingdon)*

A specific group of older people engaging with **fit for the future** who spoke about reduced isolation and loneliness as the main outcome of the programme was carers. This included older carers who had recently ceased caring due to the death of the person being cared for, and who were currently experiencing transition from an intensive and stressful time. Barbara only alluded to how difficult caring for her late husband had been, but her best friend explained that Barbara had lost a lot of weight, suffered from anxiety, and had also been "tied to the house" while caring for her husband who had suffered from Alzheimer's disease. She benefitted from joining a **fit for the future** group, in her friend's words: "She's more outgoing. She's out and about. ... She's got something to look forward to" (Barbara's friend, Rotherham). Joanna, who is the main carer of her husband, felt that going to the **fit for the future** group lifted her moods: "This group has been a lifeline. ... It has brought me a life, really, and some enthusiasm" (Joanna, Rotherham).

Another carer stopped going to a **fit for the future** exercise class because it did not fit in with her strict daily routine of visiting her husband in a nursing home. However, she felt that talking to an Age UK support worker over the telephone improved her mood:

*When [the support worker] from Age UK calls, she asks me how I am, what sort of exercise I get, everything in general really. ... I don't mind talking about it, it relieves my tension, and my daughter can't do it at the moment. It helps me to talk about things. (Kate, Nottingham and Nottinghamshire)*

Overall, the survey and qualitative data indicated that involvement in **fit for the future** had contributed toward positive outcomes in terms of improving mental well-being, mainly through the social interaction element that is embedded within the programme.

### 6c. Impact on healthy eating: attitudes and behaviour

We looked at the impacts on older people’s attitudes and behaviour in relation to healthy eating, assessing whether there was a change towards a more positive attitude<sup>19</sup>. Among participants providing a response at all three timepoints (n=1043) there was a change towards more positive attitudes, as shown by the increasing number of respondents agreeing with the statement ‘I think healthy eating is important for my health, and I am doing something about it at the moment’ and the decreasing number of those agreeing with the statement ‘I think healthy eating is important for my health, but I am not doing anything about it at the moment’ (see Table 14).

**Table 14: Changes in attitudes to healthy eating - percentages**

	Survey One	Survey Two	Survey Three	n value
‘I think healthy eating is important for my health, and I am doing something about it at the moment.’	79.3	88.1	88.1	1043
‘I think healthy eating is important for my health, but I am not doing anything about it at the moment.’	18.1	10.5	10.8	
‘I don’t think healthy eating is important for my health.’	2.6	1.3	1.1	

To examine whether these changes were ‘real’, we have run a test of statistical significance using the numerical values representing the different options respondents could choose.<sup>20</sup>

**Table 15: Changes in attitudes to healthy eating - median (interquartile range)**

Survey One	Survey Two	Survey Three	n value	Statistically significant change*
3 (0)	3 (0)	3 (0)	1043	Between timepoints 1-3 and 1-2.

Friedman test, comparisons between timepoints 1-3, 1-2 and 2-3.

\*p values are presented in Table 6 in Appendix 4

<sup>19</sup> Respondents were asked to choose one of the following: ‘I don’t think healthy eating is important for my health’, ‘I think healthy eating is important for my health, but I am not doing anything about it at the moment’ and ‘I think healthy eating is important for my health, and I am doing something about it at the moment’.

<sup>20</sup> The three options presented in Table 14 were represented by values ranging 1-3 in Table 15, with 3=‘I think healthy eating is important for my health, and I am doing something about it at the moment.’. An increase in the median value represents a positive change in attitudes.

The eating behaviour of participants was further explored by asking them how many portions of fruit and vegetables they eat on an average day and how often they eat a meal prepared and cooked from basic ingredients. There was a statistically significant increase in the average (mean) number of portions of fruit and vegetables older people reported eating per day, between surveys 1 and 2 and a statistically significant decrease between timepoints 2-3. Despite the fall in the number of portions after timepoint 2, the overall change for the programme as a whole (between timepoints 1 and 3) was positive and statistically significant, as shown in Table 16.

**Table 16: Number of portions of fruit and vegetables eaten per day - mean (standard deviation)**

Indicator	Central tendency	Survey One	Survey Two	Survey Three	n value	Statistically significant change*
Portions of fruit and vegetables	mean (SD)	3.32 (1.45)	3.70 (1.41)	3.58 (1.36)	959	Yes, between all timepoints.

Repeated Measures Anova, Bonferroni adjustment for multiple comparisons between timepoints 1-3, 1-2 and 2-3.

\*p values and details of the statistical test used are presented in Table 7 in Appendix 4

Some differences were found here by locality. For example, whilst the overall mean of the portions of fruit and vegetables eaten each day at the start of the programme was 3.32, this varied from 2.54 in Newcastle to 4.42 in Nottinghamshire. Further, whilst all areas bar Nottinghamshire recorded an increase in the portions of fruit and vegetables eaten, when the Friedman test was run for each area individually, a significant result across all three timepoints was not found for Exeter, Leeds, Newcastle or West Cumbria (this is considered further the Annex, where outcomes by area are assessed).

As the current recommendation is to eat at least five portions of fruit and vegetables a day, we have looked at the proportion of participants who reported doing so and found that the proportion rose from 25.3 per cent at the start of the programme to 30.4 per cent at timepoint 2 and then fell to 27.8 per cent between timepoints 2 and 3 (see Table 17). The increase between the start of the programme and timepoint 2 is statistically significant, however due the fall between timepoints 2 and 3, the overall increase between the start of the programme and timepoint 3 is not statistically significant.

**Table 17: Respondents reporting eating five or more portions of fruit and vegetables a day - percentage**

Survey One	Survey Two	Survey Three	n value	Statistically significant change*
25.34	30.45	27.84	272	Between timepoints 1-2.

Related samples Cochran's Q Test between timepoints 1-3, 1-2 and 2-3.

\*p values are presented in Table 8 in Appendix 4

Participants' behaviour relating to healthy eating was further explored in the surveys by asking them how often they ate a meal prepared and cooked from basic ingredients. Table 18 shows that a greater proportion of older people ate a meal prepared and cooked from basic ingredients more frequently in a week at the end of the programme than at the beginning.

**Table 18: Eating a meal prepared and cooked from basic ingredients per week - percentages<sup>21</sup>**

	Survey One	Survey Two	Survey Three	n value
Not more than once a week	16.5	14.2	14.5	1038
2-3 times a week	23.2	21.6	22.4	
4-6 times a week	22.7	24.7	24.1	
Every day	37.6	39.5	39.0	
<b>Total</b>	100.0	100.0	100.0	

To examine whether these changes were 'real', we have run a test of statistical significance using the numerical values representing the different options respondents could choose.<sup>22</sup> The data presented in Table 19 demonstrates that there was not as statistically significant change in the proportion of older people participating in *fit for the future* who ate a cooked meal more often at the end of the end of the programme than at the start of the intervention.

<sup>21</sup> The categories 'never', 'less than once a week' and 'once a week' are combined in this table.

<sup>22</sup> Respondents were asked to choose one of the following options: 'never', 'less than once a week', 'once a week', '2-3 times a week', '4-6 times a week' and 'daily', these are represented by values ranging 0-5. 'Don't know' responses were excluded from the analysis.

**Table 19: Eating a meal prepared and cooked from basic ingredients per week - median (interquartile range)**

Survey One	Survey Two	Survey Three	n value	Statistically significant change*
4 (2)	4 (2)	4 (2)	1038	No

Friedman test

\*p values and details of the statistical test used are presented in Table 9 in Appendix 4

### Case study participants

When we explored older people’s perceptions of the impact of the programme on healthy eating through the case studies, we discovered some interesting findings. Participants attending classes on nutrition / healthy eating highlighted that they gained new information and experiences about healthy eating in the groups, which motivated them to change their eating habits, as the following examples illustrate:

*There were two sessions on nutrition and fruits. I’ve never tasted kiwi fruit and now I have one every day for a start. I’ve never tried blueberries and I think they are nice, too. (Anne, Rotherham)*

*I’ve learnt a few new recipes on the course. Our favourite is the cheese and chive bread, everybody loves it. (Anthony, Nottingham)*

Sam started to cook for himself after his wife had passed away, but he mostly relied on paid household help. He really enjoyed the *Kitchen Kings* groups organised by Age UK Hillingdon:

*We made different dishes, [for example] soup [and] fish pie [and] there was a session using different spices. I went for 3 weeks, and I may go again when the course is run again. I tried to cook some of it at home – it didn’t come out right but since I cooked it was tasty (laughs). ... The soup is very handy to have in the freezer. (Sam, Hillingdon)*

Others said that the sessions made them remember foods they used to eat and like and allowed them to refresh their cooking skills:

*There are certain things that I became aware [of], things you let slip a little bit and it [the session] brought it back to the forefront. ... We had a thing the other day, all different fruit, and I thought, you know, I like all those, so why do I only buy*

*bananas, apples and pears, why not other types of fruit? So I started buying blueberries” (Sue, Rotherham).*

*I did go on a course with Age UK, to get into cooking for one. ... I learned how to do a lot of things that you forget, you know, when you have your family and you can't be bothered. ... I really enjoyed it. Well, actually, [my favourite] was the roasted vegetables..., I used to do them a long while ago. (Kate, Nottingham).*

However, these positive changes can easily be lost, when circumstances change and that continued support is sometimes needed, as the following example illustrates:

*I did change the way I cook until a couple of weeks ago, and then it just all went... I was worried about my husband and I was on the go all the time, so I just can't be bothered (Kate, Nottingham).*

So overall, the survey showed that participants were eating healthier as a result of getting involved with **fit for the future**, which was supported by case study interviewees. Further, whilst not statistically significant, the percentage of older people cooking a meal four times or more a week rose.

#### **6d. Impact on physical activity: attitudes and behaviour**

The programme's impact on physical activity has been explored by analysing change in related attitudes and behaviour. Participants were asked if they felt physical activity was important and whether they were doing something about it, and also to provide details on the amount of physical activity they did based on three measures: the number of minutes walking (per day); the number of minutes of activity that made them 'breathe somewhat harder than normal' (per week); and the number of minutes of muscle strengthening activity (per week). As shown in Table 20, attitudes and behaviour toward physical activity became more positive during the programme.

**Table 20: Changes in attitudes to physical activity - percentages**

	Survey One	Survey Two	Survey Three	n value
'I think physical activity is important for my health, and I am doing something about it at the moment'	63.5	76.3	71.3	1019
'I think physical activity is important for my health, but I am not doing anything about it at the moment'	33.9	22.7	27.7	
'I don't think physical activity is important for my health'	2.6	1.0	1.00	
<b>Total</b>	100.0	100.0	100.0	

To examine whether these changes were 'real', we ran a test of statistical significance using the numerical values representing the different options respondents could choose.<sup>23</sup> Table 21 shows that this improvement was statistically significant between the start of the programme and 3 months later.

Table 22 shows the changes reported in different types of physical activity including walking, breathing harder, and muscle strength activities. Initially, there was an increase in time spent doing all three types of activity, with the positive change being maintained or lost after the third month of the intervention.

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<sup>23</sup> Respondents were asked to choose one of the following options: 'I don't think physical activity is important for my health'; 'I think physical activity is important for my health, but I am not doing anything about it at the moment' and 'I think physical activity is important for my health, and I am doing something about it at the moment'; represented by values ranging 1-3.

**Table 21: Changes in physical activity levels - median (interquartile range)**

	Survey One	Survey Two	Survey Three	<i>n</i> value	Statistically significant change*
Changes in attitudes to physical activity	3 (1)	3 (0)	3 (2)	1019	Between timepoints 1-2.

Friedman test

\*p values and details of the statistical test used are presented in Table 10 in Appendix 4

**Table 22: Changes in physical activity levels - median (interquartile range)**

	Survey One	Survey Two	Survey Three	<i>n</i> value	Statistically significant change*
Minutes walking a day	30 (40)	40 (40)	40 (40)	955	Between timepoints 1-3 and 1-2.
Minutes of activity breathing harder per week	60 (120)	90 (130)	90 (135)	857	Between timepoints 1-3 and 1-2.
Minutes doing physical activity for strength per week	70 (112)	90 (135)	70 (110)	888	No

Friedman test between timepoints 1-3, 1-2 and 2-3.

\*p values are presented in Table 10 in Appendix 4

### *Walking*

As highlighted in Table 22 above, there was a statistically significant increase in the average (median) number of minutes walking (per day) reported by participants from 30 minutes at the start of the programme to 40 minutes three months later. Although no further improvements were reported another six months later, the level of physical activity was maintained, and thus the overall improvement between timepoints 1 and 3 was also statistically significant.

Tajinda started walking with a group organised by Age UK Blackburn and Darwen's Asian Heritage Project:

*We had three groups, slow, medium and fast walkers and two leaders for each group. It's fun. It wasn't just [a] walk, the group leader explained things, like plants, historical events that occurred. The group was open to everyone but mostly over 50s came. I was also trained as a walk leader. (Tajinda, Blackburn with Darwen)*

Walking as part of a group was the first type of organised physical activity Tajinda has been involved in, but since she started walking, she has also joined other groups organised by her local Age UK and now regularly does Tai Chi, aqua aerobics and Zumba, as she put it: *“One thing led to another. It probably took me about six months to get into all this – I started with the walking.”*

Similarly, Sarah started to go for short walks with the ‘55 Plus Group’, then she joined a dedicated walking group which in turn led to her becoming involved in cycling:

*[In the 55 Plus Club] sometimes we just sit and talk, sometimes [we] go for a walk. I also go for a walk with the Tuesday group. I went just to see what it’s like. We do about an hour’s walk. After a few weeks [the Age UK support worker] asked me if I wanted to try the cycling. (Sarah, West Cumbria)*

Walking was the main form of exercise that Peter did. He used to be a keen walker, but as his COPD became worse and he nearly lost his eyesight completely, he became almost completely inactive. He was encouraged by a **fit for the future** volunteer to start walking again:

*Age UK got me to start going out. They got one of the wardens to help me go out. I get a lot more exercise, they tell me to go out for walks, even if it’s just a short walk a day. Just to get you some fresh air. I go every day. (Peter, Leeds)*

*Exercise that makes you breathe somewhat harder than normal*

Table 22 shows that there was also a positive and statistically significant change in the level of activity that ‘makes you breathe somewhat harder than normal’ from an average (median) of 60 minutes per week at the start of the programme to 90 minutes at timepoint 2. As the level of activity was maintained later, the overall increase between timepoints 1 and 3 was also statistically significant.

Case study interviewees participated in a variety of cardio activities, including Zumba, ballroom and line dancing, swimming, aqua aerobics and cycling. Many older women reported that they enjoyed doing Zumba, as the following quote illustrates: *“I really enjoy dancing, it helps to use my brain and it is a cardio activity, and I need to coordinate steps”* Rose (Cheshire East).

Mark (Lancashire) benefitted from using cardio equipment in the gym sessions organised by the local Age UK. Mark used to be a keen runner and played football and rugby, but recently found out that this caused a lot of ‘wear and tear’ to his hips. In the gym he has access to machines which allow him to do more gentle forms of activity to maintain his fitness.

Swimming is the only form of activity that Mary can engage in currently, as her hips are worn due to osteoarthritis. The support worker at Age UK Exeter helped her to find a pool that was accessible to her (she uses a walker) and she greatly benefitted from the activity:

*[Swimming] helps me to lose weight, improves my mood, helps me to sleep better, and being in the water is fun. I take my daughter because I need help getting dressed, and we enjoy each other's company. (Mary, Exeter)*

Similarly, swimming was the only safe form of exercise for Cath, who experiences seizures and is susceptible to falls due to a head injury she sustained in an accident:

*The care company used to provide a second carer to take me swimming – I need one in the pool and one outside the pool - but because of the financial constraints they stopped providing that. Age UK really facilitated me to be able to go back swimming. I've always enjoyed swimming. ... It contributed to me feeling better and losing more weight than I would have only through dieting (Cath, Exeter).*

#### *Muscle-strengthening activity*

Table 22 shows that there was also some improvement in relation to muscle strengthening activity with participants reporting an average (median) of 70 minutes per week at the start of their involvement in the programme, increasing to 90 minutes three months later. This was followed, however, by a drop in the number of minutes to the original level at nine months after the start of the intervention. None of these changes were statistically significant.

Don worked with a personal trainer in a gym, as part of arrangement by Age UK Exeter to regain strength in his legs, which he lost due to a neurological problem:

*I'm working on getting the strength back in my leg. When I first started I could barely go up half a flight of steps and last week I walked up and down four times without stopping. I can get up from the chair (he demonstrates). He [the trainer]'s got me now to walk up and down the stairs and walking across the gym unaided – he's there if I need help. I'm slow but I can do it by myself. (Don, Exeter)*

Tina (Cheshire East) has osteoarthritis and lives with chronic pain. She has greatly benefitted from doing Tai Chi with Age UK:

*When I retired, at first I didn't do anything. Then I realised I had to do something physical. At first I didn't do anything. ... I hated school PE, I hate exercise, I have never liked it. But Tai Chi and Yoga and walking suit me to the core. It has to be something you like, otherwise you won't stick to it. ... I tried Tai Chi before in a*

*different place. It was a very big group and very cliquey. ... This group is very good – we use a fan, you have to deal with your feet and hands and the fan and your breathing – it's all a challenge.* (Tina, Cheshire East)

Chair-based exercise classes were organised by several local Age UK partners as part of **fit for the future**. Some younger interviewees felt that this type of activity was easy to do and beneficial, as Hanif explained: *“it's a one hour exercise. The instructor is very good – most of the exercise is quite easy and you can do it for an hour. It makes me more fit and makes my joints more mobile”* (Hanif, Hillingdon). For more frail older people the muscle strengthening outcome of this type of activity was also important, as the following quote from Andrea demonstrates: *“the keep fit group is very good, I like the company, and I've become more flexible and I enjoyed learning the exercises. It's also good for my strength”* (Andrea, Lancashire).

Overall, physical activities such as walking and breathing harder significantly increased, (though there was no assessed change in muscle strength activities) and case study participants reported positive changes to their health and social interaction due to taking part in physical activities through **fit for the future**.

## 6e. Weight management

Older people participating in *fit for the future* were asked to report their height, weight and waist circumference, which would enable us to follow any changes in their Body Mass Index and waist circumference. Unfortunately, many older people decided not to provide a response to these questions.

### BMI

BMI is the most commonly used indicator of a person's weight in relation to their height.<sup>24</sup> The average (median) value of BMI remained unchanged in the first three months of the programme (Table 23), and decreased by a small but not statistically significant amount between timepoint 2 and 3. Looking at the whole time period, the decrease in the value of BMI from timepoint 1 to timepoint 3 whilst small was statistically significant.

**Table 23: BMI -median (interquartile range)**

Survey One	Survey Two	Survey Three	n value	Statistically significant change*
26.45 (7.03)	26.45 (6.85)	26.19 (6.77)	593	Between timepoints 1-3.

Friedman test between timepoints 1-3, 1-2 and 2-3.

\*p values are presented in Table 11 in Appendix 4

The same test was run again for only those who were assessed as overweight based on their BMI scores at the start of *Fit for the Future*. This showed that their participation in the programme had enabled them to lose weight at timepoints two and three, with the change assessed as significant overall (Table 24).

**Table 24: BMI for overweight participants - median (interquartile range)**

Survey One	Survey Two	Survey Three	n value	Statistically significant change*
29.53 (5.23)	29.18 (5.33)	29.08 (5.35)	371	Between timepoints 1-3.

Friedman test between timepoints 1-3, 1-2 and 2-3.

\*p values are presented in Table 12 in Appendix 4

### Waist circumference

BMI is not sufficient as a single indicator of healthy body weight, as body shape is also relevant when assessing potential risks associated with excess weight. Body fat stored

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<sup>24</sup> BMI categories: BMI <18.5 underweight; 18.5-24.9 healthy range; BMI≥25 overweight; BMI≥30: obese. Source: NHS Choices, 2014.

around the abdomen increases the risk of developing type 2 diabetes and cardiovascular problems, compared to body fat around the hips and on the thighs.<sup>25</sup> Analysing the measurements of all participants, a small negative change in the average (mean) value of waist circumference was observed between timepoints 1 and 2, and then a slight increase between timepoints 2 and 3, with the mean value at 9 months after the start of the programme being lower than that at the start (Table 25). However, none of the changes were statistically significant.

**Table 25: Waist circumference in centimetres - mean (standard deviation)**

Survey One	Survey Two	Survey Three	n value	Statistically significant change*
93.20 (14.90)	92.08 (14.08)	92.30 (13.97)	269	No.

Repeated Measures Anova with Bonferroni adjustment for multiple comparisons, between timepoints 1-3, 1-2. \*p values and details of the statistical test used are presented in Table 13 in Appendix 4

#### Case study participants

The activities of Age UK Exeter focussed especially on weight loss through encouraging physical activity and healthier eating practices. Mary, who was obese at the start of the programme benefitted a great deal from the tailored, individual support:

*I had a great deal of support from Age UK and it's been the difference in me not losing weight and losing weight. ... I lost 3 stones, about 20 kilos. ... This is the first time that I've consistently lost weight due to the support and encouragement from [the support worker], knowing that I don't want to disappoint her. ... Age UK see me as a person, not only my weight – their whole attitude is very positive and supportive and they don't discriminate. (Mary, Exeter)*

David told us about how he benefitted from the weight loss support group:

*I used to weight 15 stone ... My GP told me I was borderline diabetic [type 2] ... Then I joined the 'Keep Fit' group. ... We just go down [to Age UK] – it's like a social gathering. We have a weigh in and we were asked to keep a food diary. We also got a pedometer. ... We also talked about food. ... When we are there we have a cup of tea and a little snack – some healthy food. ... I lost a stone – I don't need to eat as*

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<sup>25</sup> NHS recommendations for waist circumference as follows: for women, ideal: < 80cm (32"), high: 80 - 88cm (32" to 35"), very high: >88cm (35"). For men: ideal: < 94cm (37"), high: 94 - 102cm (37" to 40"), very high: >102cm (40").

*much as before because I don't do so much – especially after the knee replacement.*  
(David, Exeter)

Although Hanif in Hillingdon had started a diet before he got involved with **fit for the future**, the Age UK support worker also contributed to his developing healthier eating habits, as he explained:

*For a few months I stopped eating crisps and sweet things – no one told me but I wanted to lose weight. I eat some now but I cut down a lot. I eat better than before, I try to eat my five a day, more vegetables – it is to do with [Age UK advisor], partly.*  
(Hanif, Hillingdon)

Sarah and Eve were already on a diet when they got involved in **fit for the future**, but the increased level of physical activity was crucial in achieving their goals:

*I had to change it [the way I eat] before Age UK – I was putting too much weight on – the doctor told us to change as much as I can. ...I lost 10 pounds since I started to exercise [with Age UK].* (Sarah, West Cumbria)

*Then they decided to do an exercise diary – I did it for the whole week (a week in April 2014). I used a pedometer, it was easier than keeping time. ... That's when I went down a dress size – I went down to [size] 10.* (Eve, Exeter)

Overall, a statistically significant reduction in BMI was observed for overweight participants who took part in the programme and case study participants reported positive outcomes due to the weight loss support provided through **fit for the future**.

### 6f. Smoking and alcohol consumption

Reducing both the number, and amount of cigarettes smoked per day were among the aims of *fit for the future*. Of the 1049 older people who responded to the question about smoking, only 90 reported that they were smokers at the start of the intervention, and there was no statistically significant change in this number over time, as shown in Table 26. However, of the 401 respondents who reported consuming alcohol at the start of the intervention, this dropped to 370 at three months, and to 362 at 9 months, showing a statistically significant change between timepoints 1 and 3.

**Table 26: Number of respondents reporting smoking and drinking alcohol**

	Survey One	Survey Two	Survey Three	n value	Statistically significant change
Smoking	90	85	87	1049	No
Alcohol consumption	401	370	362	1035	Between timepoints 1-3.

Cochran Test timepoints 1-3, 1-2 and 2-3.

\*p values and details of the statistical test used are presented in Table 14 in Appendix 4

However, the actual amount of alcohol consumed over time by those who continued to drink was not assessed as statistically significant (see Table 27).

**Table 27: Amount of cigarettes and alcohol consumed -median (interquartile range)**

	Survey One	Survey Two	Survey Three	n value	Statistically significant change*
Number of cigarettes smoked (daily)	10 (9)	10 (10)	10 (7)	48	No
Units of alcohol (weekly)	5 (7)	5 (7)	5 (7)	220	No

Friedman test

\*p values and details of the statistical test used are presented in Table 15 in Appendix 4

#### Case study participants

Very few case study interviewees mentioned drinking alcohol apart from festive occasions. David became concerned with his drinking when his GP explained that cutting down on his consumption would help him lose weight, and thus, reduce his risk of developing type 2 diabetes:

*I used to drink a lot – I grew up with drink, it was normal to drink with colleagues and on holiday. Now I've reduced my intake to 22 units a week. (David, Exeter)*

Staff at Age UK Exeter told us that they tried to raise participants' awareness of the risks associated to regular alcohol consumption, for example by measuring how many alcohol units there are in a 'tot' of whisky they would drink while watching TV in the evening.

In summary the only statistically significant effect observed in terms of smoking cigarettes and alcohol consumption was the total number of older people who reported consuming alcohol, but of these, there was no real change in the units consumed in an average week.

### 6g. Managing long-term health conditions

This section focuses on whether and the extent to which older people felt more supported to manage their LTCs and felt more in control of their own care related to their specific LTCs.<sup>26</sup>

The four indicators used to explore older people’s feelings related to the management of their LTCs showed very similar values at all three timepoints of the survey (see Table 28). The average (median) values and the scatter around the medium did not change over time for any of the four indicators, and more importantly, the results of the tests of statistical significance did not indicate change.

**Table 28: Older people and the management of their long-term health conditions - median (interquartile range)**

Variable	Survey One	Survey Two	Survey Three	n value	Statistically significant change*
I am fully informed about issues relating to my long term health conditions	2 (1)	2 (1)	2 (1)	869	No.
I am fully involved in decisions regarding managing my long term health conditions	2 (1)	2 (1)	2 (1)	852	No.
I am fully supported in managing my long term health conditions	2 (1)	2 (1)	2 (1)	865	No.
I am fully in control of the care for my long term health conditions	2 (1)	2 (1)	2 (1)	828	No.

Friedman test.

\*p values and details of the statistical test used are presented in Table 16 in Appendix 4

### Preventing long-term health conditions

One of the overall aims of **fit for the future** was to prevent / delay the development of LTCs and thus to enable older people to remain independent and reduce the cost of LTCs to the health and social care system. One important aspect of this preventative work focussed on falls.

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<sup>26</sup> There were four separate questions related to the management of LTCs (see Table 28). Respondents could choose between five options: ‘strongly agree’, ‘agree’, ‘disagree’, ‘strongly disagree’ and ‘don’t know’. Don’t know answers were disregarded when calculating changes, other responses were coded from 1 to 4. A positive outcome in participants’ feelings about managing their LTC is indicated by a negative change in the value of the indicators.

Older people participating in *fit for the future* were asked if they had experienced a fall or loss of balance in the month before each wave of the survey. As data in Table 29 indicates, the proportion of older people who did not report a fall or loss of balance increased from 70.3 per cent at the start of the programme to 74.9 per cent at three months, then dropped to 71.9 per cent at 9 months after the start. None of these changes are statistically significant, however.

**Table 29: Older people reporting experiencing a fall or loss of balance - percentages**

	Survey One	Survey Two	Survey Three	n value	Statistically significant change*
Experienced a fall or loss of balance	29.7	25.1	28.1	999	No.
Did not experience a fall or loss of balance	70.3	74.9	71.9		
Total	100.0	100.0	100.0		

Related samples Cochran's Q test.

\*p values and details of the statistical test used are presented in Table 17 in Appendix 4

### ***Preventing unplanned visits to health professionals***

Older people participating in *fit for the future* were asked about the number of unplanned visits to GPs, hospitals and other health professionals. As the reported numbers were very small, we combined the three categories and analysed how the number of visits to health professionals changed over time. As can be seen in Table 30, a statistically significant change over time was not found.

**Table 30: Unplanned visits to health professionals - mean (Standard Deviation)**

Survey One	Survey Two	Survey Three	n value	Statistically significant change*
1 (1)	0 (1)	0 (1)	264	No

Friedman test.

\*p values and details of the statistical test used are presented in Table 18 in Appendix 4

### ***Case study participants***

Case study participants reported that involvement in *fit for the future* had led to a positive impact on their health conditions and balance. For example Elizabeth, who had had a fall before becoming involved in *fit for the future* benefitted from the gentle exercises designed to prevent falls:

*I still feel dizzy but perhaps less often – only one or two days a week. So I do need a bit of support [shows her walking stick]. She also reported increased flexibility: I*

*think I can move my neck a bit more than I could before. ... Some movements were painful before, but now it's easier (Elizabeth, West Cumbria).*

Samantha from Hillingdon reported that [the chair-based exercise] *“has some effect. ... It makes me more steady. I also learned to keep the light on at night, I'm not taking the risks I used to”* (Samantha, Hillingdon).

Don had a bad fall and was in hospital then in re-enablement in a residential setting before becoming involved in **fit for the future**. He worked with a personal trainer in a gym (organised by Age UK Exeter). He felt he had benefitted from the programme, had regained most of his confidence and was beginning to go out independently:

*I've always worked with a personal trainer – he classes me as one his successes. [What do you mean by success?] Getting up from the chair [demonstrates]. He's got me now to walk up and down the stairs and walking across the gym unaided – he's there if I need help – I'm slow but I can do it by myself. When we started he used to catch me but now I can correct myself, I'm better at balancing myself. So I'm obviously getting better.*

**Fit for the future** played a crucial part in speeding up Maureen's recovery after brain surgery. She lost her sense of balance and walked with difficulty, risking a fall with every step. The Age UK support worker helped her to find activities which improved her balance quickly, as Maureen explained: *“I've got to retrain my brain. I joined the Tai Chi group and [the support worker] suggested trampolining and archery. It helps with the hand – eye co-ordination. ... For some people it takes 3-4 years to learn to walk without a stick.”* For Maureen, however, this took less than a year.

Gentle exercise designed to improve balance and thus prevent falls helped older old people participating in the programme to remain independent, as the example of Glynis demonstrates:

*Well, as I say, ... if I wanted to get something out the cupboard, and that, and it was just above my [head], I couldn't lift it up, I used to do this [lifts one arm up with the other]. It was how I got my things out my cupboard, but now I can. I know there's certain things I still can't do, ... but the exercises have definitely helped me with my arm. (Glynis, Warwickshire)*

Finally, older people interviewed for case studies reported that increased physical activity helped them not only to lose weight (discussed above), but also to prevent or delay other certain health problems, as the following stories illustrate. Tajinda looked for opportunities to become more physically active after a routine medical check indicated that she was on

the way of developing type 2 diabetes and had high cholesterol levels. When she was interviewed a few months after she became involved in the programme she said:

*I've just had a check-up and my cholesterol is very good, and so is my blood sugar. Before, my blood pressure and my cholesterol was borderline, so they put me on a small dose of medication. But exercise helped me a lot and it makes me a happier person, I think. (Tajinda, Blackburn with Darwen)*

Sarah also reported health benefits of becoming more physically active: *"I feel more energetic and ... my blood pressure got better"* (Sarah, West Cumbria).

So whilst the survey data did not support it, case study participants were able to report positive effects on their long term health conditions as a result of getting involved in **fit for the future**.

#### **6h. Summary of impact on older people**

- Older people participating in *fit for the future* often emphasised the connections between improved physical and mental well-being when they explained what the main benefits of the programme were for them; with some case study participants reporting on the positive impact that the support of volunteers and staff at local Age UKs had in ensuring they reached health and fitness goals.
- Some of the main benefits differed based on either the local area, or the characteristics of respondents, such as those relating to gender and ethnicity.
- Older people participating in *fit for the future* benefited from improvements in mental well-being, levels of physical activity and diet; with improvements appearing to occur within the first 3 months of involvement, overall. There were almost no statistically significant changes between three and nine months, though without information on when involvement in projects ended it is difficult to conclude what this means.
- Overall, there was a statistically significant positive change in well-being, life satisfaction and social isolation across timepoints 1-2 and 1-3. In the initial 3 months almost half of respondents experienced an improvement in mental well-being, almost two-fifths in life satisfaction and almost a quarter in social connectedness (primarily social isolation). The magnitude of the average change was small but this was supported by interviews with older people, who reported that the programme had helped them feel less lonely and depressed and more confident through improving their levels of social interaction.
- Whilst the findings overall indicate that the main positive changes occurred within the initial months of the project, when individual areas were isolated, for some, statistically significant positive changes are only observed between the first and 9 month timepoints (with significance not being reached in the first 3 months).
- Participants reported having a more positive attitude toward healthy eating with almost 40% increasing their fruit and vegetable intake over 9 months. Case study participants attending classes on nutrition and healthy eating highlighted that they gained new information and experiences about healthy eating through group sessions, which motivated them to change their eating habits.
- Around 45% and 35% of participants experienced improvements in walking and physical activities that made them breath harder, with the average (median) increase being 10 minutes a day and 30 minutes a week respectively. There was no statistically significantly increase in the level of muscle strength activities. Case study participants reported positive changes to their health and social interaction due to taking part in physical activities through *fit for the future*.
- Around 45% of older people experienced a miniscule reduction in their BMI by three months.
- While case study participants reported improvement in their particular health conditions due to taking part in *fit for the future*, statistically significant changes relating to the

management or prevention of LTC conditions were not found; nor were reductions in falls or unplanned visits to health professionals.

- The case studies showed how positive changes can be lost when circumstances change, and that continued support may be needed.

## **7. Involving volunteers in *fit for the future***

As explained earlier in the report, volunteers play a central role in the delivery of the ***fit for the future*** programme. This section discusses the role that volunteers have played in more detail, outlining the profile of the volunteers that were involved, and providing an analysis of the impact of volunteering, both for volunteers themselves, and the programme overall. The findings reported in this section are based on a survey completed by volunteers across the 11 localities where ***fit for the future*** was implemented, as well as information provided by the qualitative interviews with stakeholders and older people. The data discussed in this section should be treated with some caution, particularly as the number of responses to the survey was low (n = 21).

### ***Profile and role of volunteers***

Of the survey respondents, 43 per cent (n=9) were over 50 and all bar three were female. Six of the 21 respondents were new to volunteering, and the number of weekly hours spent volunteering ranged from one to eight hours per week. A number of reasons were provided by the respondents for their desire to take part in the programme, the main ones being: to give back to the community; to build social networks; to gain skills and knowledge; and to increase employability. The success of the programme at engaging older volunteers was confirmed by some of the stakeholders interviewed. Volunteers carried out a range of roles for the ***fit for the future*** programme, which included:

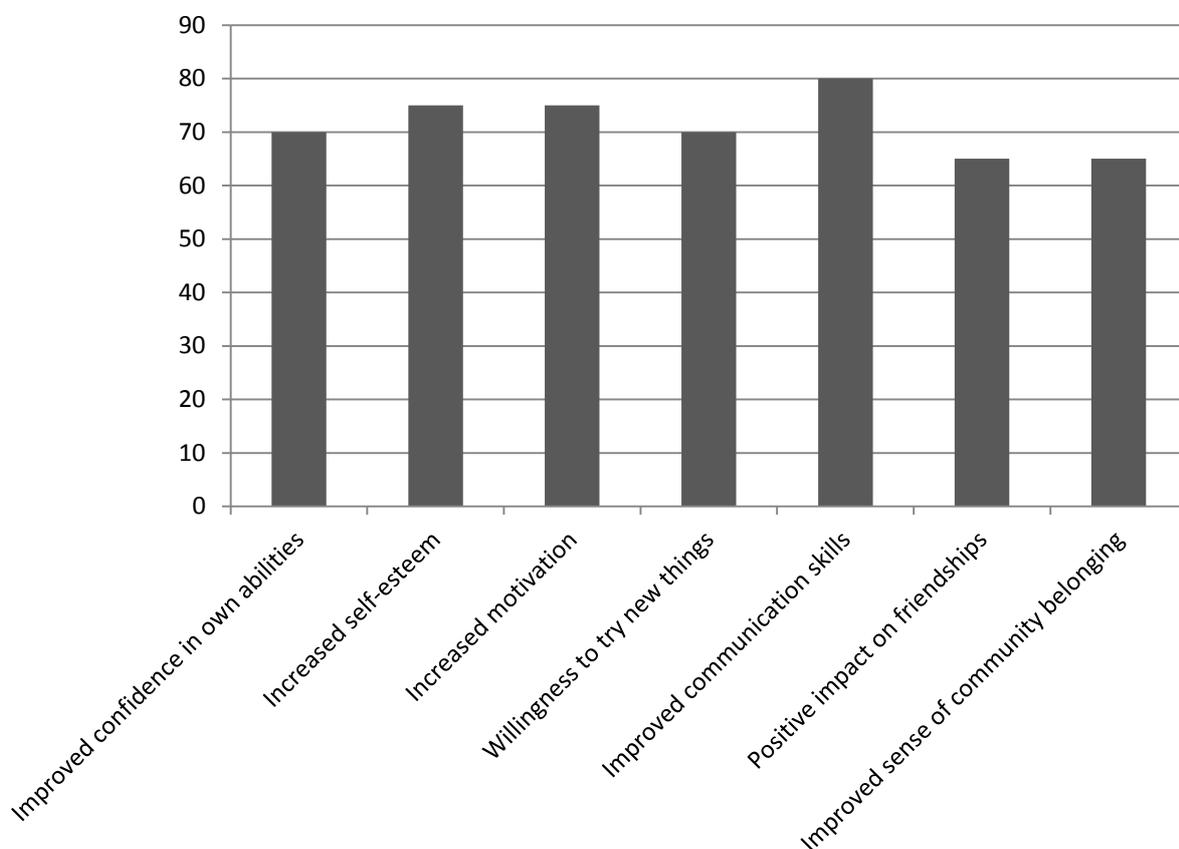
- Creative writing group coordinator
- Assistance with physiotherapy exercises
- Walk leader
- Swimming classes
- Treasurer
- Befriender
- Help to organise a local support and activity group
- Wii sessions
- Meditation and well-being tutor
- Leading a weekly arts and crafts group
- Teaching Tai Chi

This list of roles should not be viewed as exhaustive, as it is based on the small number of volunteers who took part in the survey. However, it does demonstrate the wide range of activities volunteers got involved with, ranging from social engagement activities, to physical exercise and support services.

### **Impact on the volunteers**

A high percentage of volunteers who completed the survey reported that they had learned new skills and gained in confidence, motivation and self-esteem as a result of participating in *fit for the future* (Figure 4). Volunteers also reported that they had experienced improvements in their health since getting involved in the programme, particularly in terms of their mental health. Indeed, almost half (48%) reported improvements to their mental wellbeing, with slightly less (35%) experiencing an increase in their physical health. Volunteers also reported other wider benefits. For example, 40% stated that volunteering for a local Age UK had improved their ability to secure paid employment, and just over a third said that it had provided them with a greater understanding of different cultures.

**Figure 4: Self-reported benefits for volunteers (percentage)**



The benefits of volunteering for *fit for the future* were also pointed out by some of the local Age UK partners who reported that volunteers who took part in the programme had found the experience to be worthwhile. One local Age UK partner representative, for example, said:

*[A volunteer] attends four of our different groups. She has embraced running the groups as a volunteer. She finds it very rewarding, she is sharing her skills. (Age UK, Leeds)*

An Adult Social Care worker also referred to the fact that creating volunteering opportunities had helped engage socially isolated adults in the community for which they worked.

### ***Impact of volunteering on the programme***

Although some of the activities were run by paid staff, some (including very successful ones) were being managed and sustained almost entirely by volunteers:

*The walking group has been very successful, it gets 15 to 20 every week...We give it a history theme... It's run by volunteers [it] doesn't need much staff input. (Local Age UK Partner)*

Older people themselves also reported valuing the support received from volunteers. Indeed, the following example, which refers to an older person who stopped going outside due to a lack of motivation and the effects of anxiety and depression, shows how the support provided by volunteers can help beneficiaries improve their wellbeing and make positive life changes:

*[The volunteer] helped me get out of the depression. She got me cooking...she got me going out – she made me walk ... just up the road. Step by step, she was excellent...I was her first client. She sent a card with my favourite chocolate bar enclosed]... I was so touched to get that card. (Susan, Leeds)*

### ***Challenges: as reported by stakeholders***

Although many of those involved in ***fit for the future*** stressed the importance of the role that volunteers have played in the programme, local Age UKs and other stakeholders in most of the 11 localities also referred to difficulties in recruiting volunteers to run ***fit for the future*** activities. Some local Age UK staff, in fact, reported that far less volunteers had been recruited than were required to meet the project's needs:

*We were supposed to recruit 20 volunteers, we had two or three maximum...this was a let-down, we had a worker on it... but she couldn't come up with a solution.(Local Age UK Partner).*

This was identified by one local Age UK partner as relating to the wider issue that capacity for services tends to outstrip the supply of volunteers available:

*We will always have a struggle with recruiting volunteers, as we have got more people that want our services than we have got capacity to deliver. (Local Age UK Partner)*

Stakeholders based in a few areas also referred to the short time frame that **fit for the future** was to be run for as being a barrier, particularly when the time for recruitment and the need to train volunteers were taken into account:

*The funding was only for a few weeks, and then you were relying on engaging volunteers after ten weeks or it would cease.* (Housing Services Officer)

Finally, resources were also mentioned by a few stakeholders as an important issue. One retired CEO of Healthwatch, for example, stated that **fit for the future** would for the most part require funding if it is to be sustained, *'volunteers are not free. They have to be managed, and trained.'*

### **Summary**

- Volunteers carried out varied roles and got involved with **fit for the future** for a variety of reasons, the main ones being: to give back to the community; build social networks; gain skills and knowledge and increase employability.
- Most volunteer survey respondents had learned new skills and gained in confidence, motivation and self-esteem as a result of participating in **fit for the future**.
- Almost half (48%) of volunteer survey respondents reported improvements to their mental wellbeing, with slightly less (35%) experiencing an increase in their physical health.
- Some activities were being managed and sustained almost entirely by volunteers.
- Some local Age UK partners reported difficulties recruiting sufficient volunteers to run **fit for the future** activities.
- Funding is required to sustain the work of volunteers, to ensure they are sufficiently trained and supported.

## 8. Partnership building

As a consequence of the way in which *fit for the future* was designed and delivered, the programme relied on the involvement of a wide range of stakeholders, including: Age UK staff and volunteers; local authority staff; health professionals; and representatives of other voluntary sector organisations. This section of the report examines the role and impact of partnership building through *fit for the future*. The findings are drawn from interviews with 56 stakeholders carried out at the start of the programme and subsequent interviews with 50 stakeholders (largely, but not entirely, the same people) conducted as the programme was drawing to a close. It looks, firstly, at the initial expectations of stakeholders in relation to *fit for the future* and its impact on partnership building. This is followed by a discussion of stakeholders' views on the outcomes (what actually happened) in relation to partnership working as the programme was implemented. Finally the section concludes by exploring the impact of the partnerships which were developed as a result of the programme.

### ***Expectations of partnership building***

Interviews with many of the stakeholders revealed that that their expectations for partnership building through their involvement and participation in *fit for the future* varied according to the type of organisation they represented. The expectations of each of the different partners are explored below, in turn.

#### *Age UK stakeholders (local partners and national officers)*

Age UK local partners, including Age UK project leads, who were responsible for the delivery of *fit for the future* in the 11 areas were largely eager to get involved in the programme, welcomed the prospects for partnership building, and were generally optimistic at the outset of the opportunities for this. This was tempered, in some cases, by a realism borne out by their experience of working in the voluntary and community sector (often for a number of years) that expectations are not always fully realised. Essentially, however, there were three key expectations of *fit for the future* in relation to partnership building amongst Age UK local stakeholders. These were that:

- Partnership was a *necessary element* to ensure successful delivery of *fit for the future*.
- Partnership would provide a way for Age UK to become an *integral part of the health care system*.
- Partnership was a mechanism that would allow a *wider audience* to be reached than had traditionally been the case with Age UK services, and would enable a more *holistic* form of support to be delivered to *fit for the future* participants.

Age UK National officers shared this overall optimism about the prospects for ***fit for the future***, wanting to build further on work already carried out by Age UK in the earlier ***fit as a fiddle***, which ran between 2007 and 2012 (ECORYS with Centre for Social Gerontology, 2012), secure local sources of funding for a continuation of the programme, and reach out to groups that did not traditionally access Age UK services. As one national officer said:

*We wanted to build on work already done but to work in a more specialised way, incorporating the dementia element and addressing different groups, and the idea of getting funding locally rather than them just relying on national funding.*

#### *Local authority stakeholders*

Eight of the 56 stakeholders interviewed were local authority representatives, largely, though not exclusively, local authority officers. They expressed, at the start of the ***fit for the future*** programme, a keenness to work in partnership with Age UK, seeing potential benefits arising from such partnership working, which can be summarised as:

- ***fit for the future*** would provide access to greater numbers of older people who could benefit from support.
- ***fit for the future*** would promote an increased uptake in participation in health and well-being activities among older people.
- ***fit for the future*** would result in the provision of an increased information flow, which would enable better signposting possibilities for the local authority.

One stakeholder noted that partnership working was already taking place, prior to ***fit for the future***, between the local authority that she represented and Age UK. Another speculated that there might be some duplication between the support work conducted by her local authority and the work being planned under the inchoate ***fit for the future*** programme.

#### *Health Professionals*

Ten health professionals representing NHS organisations or bodies working with the NHS were interviewed in seven out of the 11 areas where ***fit for the future*** was being delivered. These stakeholders were engaged in a variety of roles, ranging from: the delivery of health care itself (GP, community matron, occupational therapist, integrated care coordinating team); health support roles (public health nutritionist); through to more management-orientated roles (CCG service design and delivery manager, CCG locality manager, service design and innovation programme manager at an organisation supporting the NHS).

These stakeholders, largely, expressed considerable optimism about the potential benefits of partnership working that they believed would be initiated by ***fit for the future***. One said, for example:

*I saw it as a way of supporting our less complex cases on a long term basis and I hoped it would reach out to other patients, and they might not come back as a return referral.*

And another said:

*I'm a big fan of working together. I saw the opportunity to benefit the patients and to work more closely with other voluntary sector services. All ages should link in this collaborative way.*

Two stakeholders did express a note of caution, however, with one raising the issue that GPs might prove difficult to engage in the programme and another expressing concern as to whether recruitment targets would be easy to achieve. One said:

*My ambition is to make GPs aware, to say "this will help them", but you need to do it in a way that makes them think there is a benefit in it for patients. You need to stress the minimum effort that they need to put in.*

And the other said:

*I think **fit for the future** is quite positive...but you're always apprehensive, thinking will anyone sign up?*

*Voluntary and community sector representatives (other than Age UK)*

17 representatives of voluntary and community sector organisations outside of Age UK were interviewed and, in the initial interviews, they viewed **fit for the future** as a programme which would provide additional signposting opportunities, to which they could refer their clients. As one said, his expectation of **fit for the future** was:

*Just to provide more joined-up services in the borough and for eligible people. Inform us about it, we can refer on to it. It's our job to know what's going on so that we can pass on referrals.*

And another said:

*This is another service that we can put people in touch with.*

While it was acknowledged by many of these stakeholders that **fit for the future** would necessarily involve delivering through partnerships, their expectations of the programme's

role in relation to partnership working were mentioned by them only tangentially. As one stakeholder said:

*I would be expecting that all participating parties would be involved in an active way and consulted with, but that Age UK would lead it. It is a delicate balance, taking them with you and pushing them up the hill.*

Two of the 17 voluntary and community sector representatives spoken to on this issue commented that they were already working in partnership with Age UK generally (rather than specifically through **fit for the future**). One said, for example:

*We've always worked very closely with Age UK. If we don't know anywhere to signpost people, we'll ask them.*

### **Partnership Outcomes**

Having discussed the initial expectations of the stakeholders, we now examine stakeholders' viewpoints on the outcomes (i.e. what actually happened) in relation to partnership building as **fit for the future** was implemented.

The two waves of telephone interviews with stakeholders suggest that the largely optimistic expectations for the prospects for partnership building through **fit for the future** were sometimes, but not always, realised from the perspective of Age UK stakeholders. However, it is also important to note that the picture varied considerably across the 11 areas. The key themes relating to the partnership outcomes relate to: relationship development with health professionals (including involvement of GPs); building partnerships with local authorities; and partnerships involving voluntary and community sector representatives (other than Age UK).

#### *Relationship development with health care professionals*

From the many interviews carried out with stakeholders it appears that **fit for the future** enabled existing relationships with health professionals to be developed further. Although it appears that further work needs to be done here to develop meaningful partnerships with the health care sector and that engaging specifically with GPs was a challenge in some localities.

Local Age UK representatives in three areas reported that relationships between local Age UKs and other (health) organisations had been enhanced, contributing to partnership building. One said, for example:

*We did have a good relationship already with the CCG and local authority. **Fit for the future** was an opportunity for us to take that further, particularly working with GPs*

*and district nurses, but with us having a member of our staff working alongside them. This makes it much easier for us to engage.*

And another local Age UK representative said:

*Before **fit for the future**, we had a relationship with some GPs who referred. **Fit for the future** has enabled us to broaden this out wider.*

In another locality, it was noted by one local Age UK representative that a strong partnership that had been built there between the local Age UK and the occupational therapy team at a local hospital. Notably, however, this had not been the case with GPs in this area, with whom attempts to build a relationship that would produce referrals ‘didn’t turn into anything concrete’, according to the same interviewee. In another example of building relationships in this same area, a different Age UK local stakeholder told of how **fit for the future** had led the local Age UK to be a member of a working party exploring changes in health care delivery:

*We’re on two significant working parties on transformation in health, which we wouldn’t have been before.*

Importantly, these enhanced or new partnerships had contributed to enhancing the reputation of Age UK as a legitimate deliverer in the health care sector. Local Age UK representatives in four areas explicitly reported this as a benefit of **fit for the future**.

As one said:

*The benefits are the awareness that we’re here, and relationships across health and social care have improved. We’ve demonstrated that we’re effective and professional. The statutory sector is seen as more professional than the voluntary and community sector, and we’ve dispelled this.*

And another:

*Overall, it’s worked as we thought it would. It’s given us influence with the CCG and health.*

Another Age UK local stakeholder commented:

*The project has allowed us to showcase, show them what we could do to support people with long term conditions, and we’ve proven that the voluntary sector can do it, that’s a massive benefit.*

And, in the area referred to above where a partnership had been developed between a local hospital and the **fit for the future** team, the legitimacy of the local Age UK as health care deliverer was demonstrated by the fact that its staff received training in falls prevention from the hospital occupational therapy team. As one Age UK local stakeholder said:

*Our staff have had specific training around falls prevention.*

One of the national Age UK stakeholders also noted that in the three **fit for the future** areas which are now testing the GP navigation model, and which had benefited from a further time investment in networking and promoting the programme, “the GPs are now providing referrals there”.

Despite these fruitful relationships which were reported to have been developed with health care professionals through the programme, many of the stakeholders who were interviewed who represented the NHS and associated bodies appeared to perceive the relationships as stopping somewhat short of a ‘partnership’. One stakeholder said, for example:

*Our main relationship is with the Age UK coordinator; we’ve not had any meetings in which everyone has come together.*

Another stakeholder, once again saying that although there had been links and communication these amounted to less than what might be called a meaningful partnership, indicated that finding time to build relationships was an issue:

*The relationship is pretty good, the work by Age UK is really appreciated by our staff. It raised awareness in my team about Age UK and the work it does. Sometimes staffing has been an issue: having time to meet up and progress it, you don’t get the time in the day for service developments.*

Another said:

*I’ve not kept in touch as much as I should have. I’ve just assumed it would be OK when I’ve not heard from them.*

And in a later interview, the same stakeholder reaffirmed the position as she saw it, saying, probably somewhat euphemistically:

*There is work to be done to integrate the voluntary sector more [with the health care sector].*

Furthermore, in some of the 11 localities (where *fit for the future* had been implemented) there was concern that effective partnerships had not been built with primary care despite a number of attempts. Four Age UK project leads, for example, explicitly mentioned that effective relationships with GPs were not built, despite efforts to do this, as did other Age UK local representatives. In one area, the original plan was that GPs would provide the referrals for *fit for the future*. However, stakeholders in this area reported that this did not happen. The reasons for this, according to one Age UK representative, were that:

*GPs said that they didn't know they were part of the project; others say they're interested but don't feel that they should have any involvement as to how it is achieved.*

This local Age UK representative said that she had been asked to make a presentation by the CCG to 50 GPs to promote *fit for the future*, but then was given less than five minutes in which to do this.

Another local Age UK representative from a different area told a similar story of a lack of engagement by GPs:

*It has been difficult to engage with some, particularly GPs, but that's been across the board with Age UK nationally. I don't know if it's resistance, whether they're not interested or whether it's time. They haven't got time to look at social outcomes. When I went to give a presentation, some GPs were enthusiastic, others didn't seem interested.*

Yet another local Age UK representative, in another different area, also reported that there had been 'very little support or involvement with GPs'. For this stakeholder, the root of the lack of engagement with GPs and, indeed, the health care sector more generally, was a lack of publicity and marketing:

*There should have been a much bigger marketing campaign at a higher level. They ran some marketing at hospitals, but we needed a lot more. We needed to sell the product, and we didn't do enough.*

And another local Age UK representative, in a geographical area different from all those cited immediately above, expressed a similar view:

*It's been a burden to get primary care engaged.*

This issue of a lack of engagement - let alone partnership - with GPs was recognised by the Age UK National stakeholders as well. Asked about the biggest challenges to **fit for the future**, one said, for example:

*The biggest was getting the health commissioners, and the health sector locally, on board, and working with them, and getting referrals from GPs.*

A stakeholder from the voluntary and community sector outside of Age UK presented a similar viewpoint when asked about challenges:

*Engaging the medical profession at all levels – this is the challenge for any voluntary organisation seeking to do this work.*

And a stakeholder from the statutory sector (NHS), asked about challenges to implementing **fit for the future**, said:

*From my side, getting the GP practices involved, and getting the referrals from GPs. They struggle to keep it in mind, not just **fit for the future**, but other things.*

Another local authority stakeholder, when asked a similar question, provided a similar answer:

*99% of GPs are not interested in community-based activity; they're not interested in being bombarded by leaflets; they don't want to make referrals.*

Nevertheless, as previously discussed, some General Practices engaged with the **fit for the future** programme and made referrals and, in the case of one GP, championed the programme and the whole philosophy underpinning it, including the benefits of prevention and social interaction. As an Age UK local stakeholder, said when asked about challenges to the programme:

*Engaging with the CCGs and the surgeries. Some that we are working with has worked really well, but others are not engaging with us. It takes time to build these relationships.*

Another barrier to the building of partnerships, particularly with health professionals, according to one local Age UK stakeholder was the time that it took to negotiate the various layers of governance necessary before joint working could take place between the local Age UK and CCGs and GPs. This problem was exacerbated by the relatively short duration of **fit for the future** itself. As this stakeholder said:

*The main problem has been time, because the time is limited to 18 months - getting meetings with CCGs, they say “we’ll talk to GPs” and that might be five weeks before they come back, and then another four weeks to get to meet the GPs, and then it might be another four weeks to get past the PPG [patient participation group], and then if they query it, it might be another four weeks before there’s another meeting. Then, in one instance, they decided not to go ahead because they didn’t have the resources. There was an initiative involving the local care team which sounded, on paper, like it was doing the same as us, and the CCG said “that’s in place, and we’ll go with the one that we’ve got to go with” – but it wasn’t the same as ours.*

#### *Building partnerships with local authorities*

Overall, it appears as if **fit for the future** has made less impact in terms of building stronger partnerships with local authorities than with health professionals. Of eight local authority stakeholders interviewed, five indicated that the relationship between their local authority remained either unchanged, or had changed very little, as a result of **fit for the future**. One stakeholder said:

*Relationships between Age UK and us are just the same as they’ve always been.*

Another local authority stakeholder referred to how the relationship between the local authority and Age UK ‘is very good’, but that this was down not to **fit for the future** but to a different, more formalised, borough-wide partnership which involved the local authority, various NHS bodies including the local hospital and the ambulance trust, fire and rescue, the police, and the Department for Work and Pensions, as well as Age UK.

A further local authority stakeholder stated that she was ‘not aware of the relationship’ between Age UK and the local authority she represented:

*The only benefit is that **fit for the future** provides another referral source. It’s not on my radar.*

An Age UK local stakeholder corroborated the views of these local authority stakeholders, commenting of **fit for the future** and its impact on partnership building with the local authority in her area:

*It’s not been as much on the radar of the local authority as I would have wanted it to be, especially given that it could reduce the dependence of older people on the system. It’s not had the air play that I expected.*

Only two local authority stakeholders provided statements which indicated that there had been an enhancement of the relationship between Age UK and the relevant local authority because of **fit for the future**. One of these praised the information flow from **fit for the future**, saying that:

*We have communication with **fit for the future** steering group.*

Another, while noting that ‘not much had particularly worked with Age UK in the past’, believed that **fit for the future** had been a ‘very positive experience’, and that it had involved not just working with Age UK but with the health care sector too:

*Organising venues, marketing, looking at sustaining links with GPs and hospitals. Information is given to GPs and hospitals. We’re looking at flashing up material on the electric boards in GPs’ surgeries about **fit for the future**.*

In another instance, however, although the relationship between the local authority and Age UK had initially been strengthened by **fit for the future**, in more recent times communication seems to have broken down, and partnership is surely impossible without communication. According to the local authority stakeholder reporting this:

*Probably over the last few months, communication has been an issue. A number of meetings have been cancelled, and I have had no communication with **fit for the future**. I don’t know what the current status of their programme is. Communication has broken down on both sides.*

*Partnerships involving voluntary and community sector representatives (other than Age UK)*

Many of the voluntary and community sector stakeholders outside of Age UK were not well informed as to whether **fit for the future** had contributed to partnership building across different organisations. Some made vaguely positive comments about the benefits of partnership building *generally*, and some spoke of having a good relationship with Age UK itself which, in most cases where it was mentioned, had been in place for some time.

Another two, however, believed that they were not involved in any partnership work as part of the delivery of **fit for the future**. As one said:

*I’m not really involved in a partnership. They gave me information, and I planned the programme. I’m the only one there every week.*

Four stakeholders spoke explicitly about difficulties that they had encountered. One, for example, had been involved in **fit for the future** and invited to meetings early in the

programme, but in recent times had heard nothing further from the **fit for the future** team, and felt excluded without ever having been given a reason for that exclusion. This stakeholder commented:

*I was part of the partnership, but not now.*

Another stakeholder in the same geographical area expressed, independently, a similar sentiment:

*In some ways, I feel as if it is all one way. ...when we ask for things, like running a trip, we've not got a lot coming back from Age UK.*

Another stakeholder, in a different geographical area, had also experienced difficulties in the relationship, saying in the initial interview:

*Partnerships with Age UK - we are trying to sort that out, there are a few hiccoughs.*

And in the second interview:

*This is the tricky bit. My relationship with Age UK is not as good as I wanted it to be.*

### **Impact of partnership building**

Several stakeholders interviewed from the health and social care statutory sector, as well as from the voluntary and community sector, commented on the positive impact of the partnership building.

These positive impacts fell into two broad categories:

- The way in which partnerships through **fit for the future** had enhanced existing work and activities of participating organisations.
- The way in which partnerships through **fit for the future** had raised awareness among statutory agencies of the contribution the voluntary and community sector can make to health and social care delivery.

### *Enhancing the work of participating organisations*

Stakeholders identified two ways in which **fit for the future** had enhanced or improved the work of participating organisations: a) complementing and improving treatment for patients; and b) increased usage of community facilities.

a) Complementing and improving treatment for patients

The way that **fit for the future** was able to complement, or improve; treatment for patients took different forms in the three geographical areas where this was identified as a beneficial impact by stakeholders. In one case, in a hospital rehabilitation centre, a **fit for the future** group had been established for those in need of less intensive hospital treatment and, additionally, discharged patients were referred on to **fit for the future** for post-hospitalisation therapy. Both of these activities helped improve the service offered by the hospital rehabilitation centre, as well benefitting the patients themselves. Firstly, readmission rates to the centre were reduced and, secondly, staff time was freed so that more time could be spent on more complex cases. As one NHS stakeholder said:

*90% of people coming to the rehab centre achieve their goals. Some of those go to Age UK [**fit for the future**]. Less than half of them come back to be referred to the rehab centre. Before **fit for the future**, it was all of them who were being referred back.*

And another NHS stakeholder, from the same centre, said:

*We've set up a **fit for the future** group for people at risk of falls but who haven't actually fallen yet; they've started to do this with less complex cases. This allows us to spend more time with complex cases.*

The idea that medical treatment provided by the NHS has been complemented and enhanced by patients' participation in **fit for the future** was supported by another NHS stakeholder (in a different geographical area), albeit somewhat more anecdotally, who said:

*Some practices that have referred to **fit for the future** have definitely seen an impact on their patients.*

An Age UK local stakeholder supported this view saying (in a separate geographical area, different from the two above), again somewhat anecdotally:

*We get feedback from health and social care – people like community matrons – who say they have a reduced workload because of personalised support through **fit for the future**.*

b) Increased usage of community facilities

In one of the 11 **fit for the future** areas, much of the delivery of the programme took place in local authority run community centres. Prior to any link to **fit for the future**, these community centres had seen changes in the way they were run, no longer having wardens to organise events and, because of this and because of changes in funding arrangements,

usage of many of these community centres had been in decline. This meant that they faced the real possibility of closure as the local authority reviewed their viability, which would have resulted in a loss of a major community amenity. As one method of trying to avoid this, the local authority explored the possibility of different usages, engaging with Age UK to deliver **fit for the future**. A local authority stakeholder noted Age UK's pro-active approach following this engagement:

*Age UK have gone out and spoken to tenants, and started activities.*

The subsequent delivery of **fit for the future** sessions in these community centres increased usage by local residents sufficiently to avoid the risk of potential closure, providing a major assistance to the local authority in their objective to preserve these community centres as a resource for local communities. As the same stakeholder said:

*We have certainly seen an increase in usage across the five or six community centres that we've asked Age UK to be involved in. We would otherwise have seen community centres close due to lack of usage.*

**Fit for the future** therefore helped to maintain these centres in use as a facility for local communities.

*Raising awareness of the contribution the voluntary and community sector can make to health and social care delivery*

The second key way in which the partnership work developed as part of **fit for the future** can be seen to have had an impact is that, according to stakeholders, it has raised awareness of the contribution that the voluntary and community sector can make to health and social care delivery. A number of stakeholders referred to this factor explicitly in their interviews. One of these stakeholders, for example, saw **fit for the future** benefiting statutory agencies responsible for the delivery of health care as it provided a template on how the voluntary and community sector might become more strongly involved in such delivery. This is particularly important in era in which the voluntary and community sector is becoming more deeply involved in health and social care delivery overall. As this stakeholder said:

***Fit for the future** is valuable, because we are working on transforming community projects. It gives you ideas on how this can be done. It is critical that we work with third sector organisations, Age UK especially, as they have been in the area for so long. They know what works; they can help you. I involve Age UK much more now. I didn't know about them earlier. I now invite them to different projects that we're doing. We're doing a lot of work now with BCF [Better Care Fund], Age UK have*

*been involved in various meetings. You want them to be able to share their experience, scoping a project. Eighteen months ago I wouldn't have done it.*

And a further four stakeholders – one from the voluntary and community sector (other than Age UK), and three Age UK local stakeholders – each in different areas, expressed similar sentiments. One, a voluntary and community sector stakeholder, said, for example:

*The profile of **fit for the future** has been raised, especially amongst commissioners locally. It's mentioned at a lot of events by the powers that be. For example, it has helped to define our health and well-being strategy in relation to older people, especially in relation to social isolation and falls prevention.*

Another, Age UK local stakeholder, argued that:

*The health authority has become more aware of the project.*

And another, Age UK local stakeholder, commented on how CCGs in the city she works in are looking to involve the voluntary and health care sector more strongly in health and social care delivery, and that **fit for the future** was a potential model for this:

*A lot of CCGs are looking to a social prescribing model, so that it's not just about sending people to GPs and giving them medication, but sending them to the charitable sector to help manage their conditions.*

And another stakeholder, again from a local Age UK organisation, also argued that **fit for the future** had raised Age UK's profile as a deliverer of health care:

*It's meant that we've been able to get into primary care, which is of benefit to us. People have a much stronger understanding of what we do.*

This view that **fit for the future** had raised the awareness of statutory agencies of the contribution that Age UK can make to health and social care delivery was also shared by a national Age UK stakeholder, who said of the programme:

*There has been an impact, it has built the credibility [of Age UK's work in this direction] and the focus on prevention.*

### **Summary**

There was considerable optimism among stakeholders across the board at the start that **fit for the future** would initiate a considerable degree of partnership working and, through this, contribute to a successful delivery of the programme, facilitate wide participation, promote

a strong information flow to associated organisations, and enhance Age UK's role as an integral player in health and social care delivery. And, undoubtedly, relationships were strengthened across different organisations working to deliver health and social care. It does appear, however, that many of these relationships stopped short of anything that could justify the label 'partnership'. Relationships with GPs, for example, were, for the most part, stymied. Despite some successful collaborative work, little headway seems to have been made in partnership building with local authorities. It does appear from stakeholders, nevertheless, that relationships were developed significantly as a consequence of the programme in a number of geographical areas where ***fit for the future*** was being implemented, with a hospital and with other organisations, and that this had an impact in enhancing the reputation of Age UK as a legitimate deliverer in the health care sector.

The partnerships developed through ***Fit for the future*** had a positive impact through enhancing existing work and activities of participating organisations and by raising awareness among statutory agencies of the contribution the voluntary and community sector can make to health and social care delivery. In some geographical areas, ***fit for the future*** enhanced the work of statutory agencies by complementing and/or improving *treatment outcomes* for patients in a direct and identifiable way. In one area, ***fit for the future*** benefited a local authority (and, of course, concomitantly, local residents) through providing an increased usage of community facilities, thereby preventing closure of a community resource. Stakeholders in two areas believed that ***fit for the future*** had contributed to accessing participants for community events, and some stakeholders, especially though not exclusively Age UK stakeholders, argued that ***fit for the future*** had raised awareness among statutory agencies of the contribution that the voluntary and community sector can make to health and social care delivery.

## 9. Discussion and lessons learnt

This section considers what went well in *fit for the future* as well as any challenges that were encountered. It is based on the themes emerging from case study interviews with older people and stakeholders, including project leads at local Age UKs, and is broken down into a number of sub-sections including: referrals and partnerships; working with older people; engaging and recruiting volunteers; designing the research tools and assessing impact on the wider health and social care system.

### ***Referrals and partnerships***

- Referrals of ‘younger old’ people: Some local Age UKs expressed disappointment due to a lack of referrals of ‘younger old’ people, with suggestions that in the future similar programmes should concentrate on tailoring marketing toward this group. Again, working with health professionals, such as through ‘social prescribing’ was felt to be key to accessing older people at earlier stages of illness or disease.
- Number of referrals: Whilst some partner organisations benefitted from the increased number of referrals, others were unable to meet the increased demand for their services.
- Engaging health professionals: Whilst a few stakeholders reported a good relationship with health care professionals, many had struggled to engage GPs in their respective area. Yet health professionals could potentially have much to gain from involvement, as in the example of one health care professional who reported that referring early stage cases to local Age UKs had ensured the hospital she worked for could devote more resources to complex cases. Further, the case studies indicated that older people may respond more favourably if their local GP signposts them to activities and services. One local Age UK found that forming a good relationship with the local CCG had facilitated access. It was also suggested that increasing the timescales of the project would have given organisations more time to develop relationships with health professionals. For example, a few had found that GPs or CCGs were reluctant to devote time to setting up referral channels due to the short timeframe, and due to a concern that the programme may not be sustained longer term.

### ***Engaging older people***

- Involving older people with higher level needs than planned: The evidence from the case study interviews shows that some participants have not necessarily been able to engage with *fit for the future* in the same way or to the same degree as others. One of the main reasons for the different experiences that older people have had in relation to the programme can be attributed to the health of the participating older person. For instance, some participants were aware of the exercise classes available to them, but felt that these were beyond their abilities, and therefore they engaged with only the social activities. An older person from Blackburn and Darwen, for example, reported

improved well-being due to making new friends after participating in a social event (Knit and Natter), and she also benefitted from debt advice. However, she felt that the walking and swimming classes offered in the programme were too difficult for her, because of her arthritis, which contributed to her undergoing knee and hip surgeries. This example exemplifies the effectiveness of ***fit for the future*** in reducing isolation for many of the older people who participated.

- Gender: Gender is an important factor influencing how older people benefit from ***fit for the future***, particularly in terms of group dynamics. Older people interviewed for case studies, for example in Rotherham, explained that some men found it difficult to engage in groups where there were more women. Secondly, older men may be less willing to join health and well-being focussed programmes, which is why the ‘Men in Sheds’ group organised by Age UK West Cumbria under the umbrella of ***fit for the future*** may be successful, particularly as the declared aim of the group is to repair bicycles and not to socialise or discuss a healthier diet.

#### ***Engaging and recruiting volunteers***

- A few stakeholders believed that if the programme had run for a longer period, it would have provided more valuable time to engage volunteers.
- It was felt by one stakeholder that ***fit for the future*** relied perhaps too heavily on volunteers, underestimating the need for paid staff to ensure successful delivery of projects.
- One local Age UK felt that moving forward more emphasis needed to be placed on the specific characteristics of volunteers recruited. Due to the small scale of individual projects, this Local Age UK representative suggested that it was difficult to match volunteers with local populations in terms of faith, cultural and ethnic background.
- One local Age UK felt that volunteering opportunities need to be both ‘attractive’ and ‘flexible’ to fit in with the needs of a broad range of potential recruits. One CCG worker interviewed felt that to engage volunteers, it was also necessary to link with a wide range of organisations, such as universities and local charities that work with all age groups *“intergenerational work is important, it brings new energy”* (Age UK, Leeds).

#### ***Assessing impact on the wider health and social care system***

- As highlighted in Section 2, one of the aims of ***fit for the future*** was to delay or prevent the need for intensive and costly health and social care interventions. In Section 3 we presented research findings which suggest that eating a healthier diet and regular exercise could reduce or delay the onset of a range of chronic illnesses, and that reducing social isolation has been found to lessen demand for GPs and residential care. As ***fit for the future*** demonstrated positive significant change in portions of fruit and vegetables eaten, in some forms of exercise, and reducing social isolation, it is suggested that the programme may have contributed toward efficiencies and/or savings of this

nature (though the caveats to this assertion, provided in the methodological discussion in Section 6, should be borne in mind).

- Whilst we can infer from the findings, when collated with previous studies, that the ***fit for the future*** programme is likely to contribute to cost efficiencies and/or savings at a wider level, the data provided did not allow us to quantify these savings.

#### ***Designing the evaluation tools***

- Some local Age UK partners felt it would have been beneficial if they had been consulted and given an opportunity to provide input into the survey design.
- Some stakeholders felt that the broad difference in each of the 11 areas in terms of how the programme was being implemented meant it would be difficult to evaluate its effectiveness overall. It was suggested that a more 'consistent approach' is adopted in both the delivery and evaluation of future work of this kind.

## 10. Conclusions

This final section presents conclusions and recommendations based on the findings of this report, divided into two subsections; the first summarises those related to the programme's delivery, aims and objectives, with a focus on the participants and volunteers who took part; the second considers the programme's success in developing and sustaining effective partnerships.

### *Programme delivery, aims and objectives*

*Fit for the future* provided a unique delivery model which successfully engaged older people, volunteers and some local stakeholders, adding to the current evidence base around the benefits of adopting a holistic approach to improving the health and well-being of older people. It provided a wide range of activities and services, with older people appreciating the individualised, tailored nature of the support. Participants also valued the accessibility of the activities on offer, which was particularly important for older people who had caring responsibilities, or limited mobility. The qualitative data suggested that alongside improving physical fitness and literacy around nutrition, nearly all older people who took part benefited due to the social interaction element of the programme. The survey data also identified positive changes over time for a number of variables, including: mental well-being; satisfaction with life; feeling less isolated; healthy eating and increased consumption of fruit and vegetables; increased physical activity; and lower BMI scores. Positive benefits were also reported by volunteers in terms of their physical and mental health, confidence, skills, motivation and self-esteem.

However, whilst the uniqueness of the programme was in many ways accountable for particular successes, such as improving well-being due to its holistic nature, the resulting wide range of activities and services offered by each participating local Age UK meant that developing a consistent framework for comparison was difficult. Further, whilst volunteers reported positive outcomes as a result of getting involved in the programme, many local Age UKs had difficulties in recruiting sufficient numbers to run *fit for the future* activities.

#### *Recommendation 1:*

As one of the stated aims of the programme was to contribute toward reducing health care costs perhaps future programme evaluations of this kind should develop research tools which can better evidence measureable changes, such as the use of a control group, or perhaps focus the evaluation on a narrower set of factors, so that direct comparison between participating local Age UKs can be better compared.

#### *Recommendation 2:*

As a number of local Age UK partners reported struggling to enlist or retain volunteers, steps should be taken, moving forward, to look at ways to support organisations to develop

a volunteer pool. Targeted resources should also be considered so that local Age UKs are able to offer support and training to volunteers. It is also suggested that developing effective partnerships in local areas through promoting the service is pursued further (partnership working is considered further below).

### ***Partnership working***

Most stakeholder interviewees felt that ***fit for the future*** could facilitate more effective partnership working at the local level, with many viewing Age UK's role as playing a potentially integral part, particularly in forming partnerships with health and social care services. Some stakeholders reported that the system of referring older people to ***fit for the future*** had helped to raise awareness, facilitate participation and further enhance the profile of Age UK. It had also reportedly resulted in parts of the health and social care system becoming more 'joined up' in some areas, with district nurses, hospital and GPs signposting to the programme, with a few local Age UKs reporting that some GP practices had 'embraced' the programme.

However, many stakeholders felt that more needed to be done to ensure the development of meaningful, sustainable partnerships to help ensure effective integration between the health and voluntary sector, with many participating local Age UKs failing to establish a relationship with GPs in their respective areas. A further issue was that the programme in many cases failed to engage local authorities. The reasons for this are not clear, and would need further investigation, particularly as local authorities are now required to ensure well-being is placed at the centre of strategies relating to older people. Finally, it was found that whilst partnership working helped to facilitate awareness of ***fit for the future*** some older people reported that they had not had the purpose of it explained to them prior to getting involved.

#### ***Recommendation 3:***

Based on findings that older people may take referrals from health care professionals more seriously, and the reported benefits of partnership working, it is suggested moving forward that more consideration is given to how better links with the health care sector in particular, can be formed. One of the main assessed barriers for GPs was a reluctance to engage due to the short time frame of ***fit for the future***, yet tackling this will be difficult, unless longer term funding can be secured. It would be beneficial if a joint initiative with local CCGs could be facilitated, due to their links with primary care providers and remit of promoting social prescribing and a preventative approach.

#### ***Recommendation 4:***

Ensure that when partner organisations refer to services that older people are provided with more information at the outset, as some case study respondents reported not being sure what the programme entailed when initially agreeing to take part. It is suggested that

information detailing what the programme offers could be provided in a leaflet format, which could be placed in areas such as General Practices and Pharmacies.

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## Appendices

### Appendix 1: Statistical tests used in the report

Variables with normal distribution:

- Repeated Measures ANOVA, with Bonferroni adjustment for multiple comparisons: An ANOVA looks for differences between the means of the groups, when the means are very different; we say there is a greater degree of variation between the conditions. Bonferroni was used to correct for the number of pairwise tests that were carried out, thus reducing the chance of obtaining a type I error.

Variables without normal distribution:

- Friedman test: The Friedman is a non-parametric equivalent of the repeated-measures ANOVA. The test involves two steps – in the first step the null hypothesis of zero change over time is tested; in the second step pairwise comparisons are made.
- Related samples Cochran's Q test: This is similar to the Friedman test, but is applied to binary data (answers with two responses, such as 'yes', 'no').
- Sign test (extension project only): This tests whether two related samples are different, the differences between the groups are calculated and the direction of change is measured.

## Appendix 2: Profile of participants

**Table 1: The number of surveys by area**

Area of England	Survey 1	Survey 2	Survey 3
Blackburn with Darwen	130	102	100
Cheshire East	150	112	101
Exeter	110	93	84
Hillingdon	148	121	114
Lancashire	174	117	96
Leeds	120	85	81
Newcastle	150	102	89
Nottinghamshire	149	124	104
Rotherham	136	123	114
Warwickshire	152	110	96
West Cumbria	153	140	127
<b>Total</b>	<b>1572</b>	<b>1229</b>	<b>1106</b>

**Table 2: The number of older people who responded to all three waves of the survey**

Area of England	N
Blackburn with Darwen	98
Cheshire East	100
Exeter	83
Hillingdon	103
Lancashire	93
Leeds	80
Newcastle	88
Nottinghamshire	97
Rotherham	113
Warwickshire	94
West Cumbria	127
<b>Total</b>	<b>1076</b>

**Table 3: Details of case Study Interviewees**

<b>Area</b>	<b>Name</b>	<b>Gender</b>	<b>Age</b>
<b>Blackburn with Darwen</b>	Rachel	Female	84
	Marie	Female	79
	Maureen	Female	67
	Tajinda	Female	63
	Ed	Male	87
<b>Cheshire East</b>	Harry	Male	86
	David	Male	82
	Rose	Female	73
	Ben	Male	70
	Tina	Female	62
<b>Exeter</b>	David	Male	80
	Don	Male	75
	Eve	Female	63
	Mary	Female	59
	Cath	Female	54
<b>Hillingdon</b>	Sam	Male	87
	Samantha	Female	80
	Gemma	Female	73
	Hanif	Male	71
	Rabia	Female	69
<b>Lancashire</b>	Andrea	Female	94
	Hannah	Female	76
	James	Male	76
	Chris	Male	71
	Mark	Male	65
<b>Leeds</b>	Susan	Female	88
	Peter	Male	76
	Sarah	Female	75
	Hannah	Female	71
	Louise	Female	63
<b>Newcastle</b>	Simon	Male	57
	Rebecca	Female	95
	Annabel	Female	95
	Don	Male	79
	Matthew	Male	77
<b>Nottingham and Nottinghamshire</b>	Tom	Male	79
	Linda	Female	79
	Kate	Female	77
	Ron	Male	74
	Anthony	Male	73
<b>Rotherham</b>	Adam	Male	79
	Barbara	Female	76
	Joanna	Female	76
	Sue	Female	72
	Anne	Female	69
<b>Warwickshire</b>	Betty	Female	93
	Joan	Female	86

	Glynis	Female	77
	John	Male	77
	Margaret	Female	Unknown
<b>West Cumbria</b>	Margaret	Female	88
	Elizabeth	Female	87
	Stephen	Male	67
	George	Male	67
	Sarah	Female	57

**Table 4: Information about stakeholders**

<b>Area</b>	<b>Organisation</b>	<b>Area of expertise</b>
National	Age UK	Project manager, health and well-being projects
	Age UK	Project manager, <i>fit for the future</i>
Blackburn with Darwen	Age UK	Project Lead, <i>fit for the future</i>
	Local authority	Promoting self-care
	Local authority	Community tutoring
	Voluntary sector	Co-ordinating care for over 50s
	Voluntary sector	Raising awareness of Alzheimer's, and providing care for people with Alzheimer's
Cheshire East	Voluntary sector	Health promotion and healthy eating
	Age UK	Project Lead, <i>fit for the future</i>
	Local authority	Adult social care
Exeter	NHS	Community health
	Age UK	Project Lead, <i>fit for the future</i>
	Private sector	Exercise and fitness provision
	NHS	General Practice
Hillingdon	NHS (CCG)	Commissioning services for older people
	Age UK	Project Lead, <i>fit for the future</i>
	Age UK (but NHS-funded)	Navigator – primary care services
	Age UK	Falls prevention

	Local authority	Sheltered housing
	Local authority	Health promotion
	Self-employed contractor	Sports and exercise
Lancashire	Age UK	Project Lead, <b><i>fit for the future</i></b>
	Local authority	Sports development
	NHS	Care for people with long term health conditions
	Voluntary sector	Community sports
	Voluntary sector	Community sports
	Voluntary sector	Community sports
	Voluntary sector	Keep fit promotion
	Voluntary sector	Friendship promotion
Leeds	Age UK	Project Lead, <b><i>fit for the future</i></b>
	Local authority and voluntary organisation	Sports and exercise
	NHS (CCG)	Working with GPs to shape referral practices
	Voluntary sector	Carers' support
Newcastle	Age UK	Project Lead, <b><i>fit for the future</i></b>
	Age UK	Senior member of staff
	Age UK	Services for older people
	Voluntary sector	Supporting adult mental health needs
Nottingham and Nottinghamshire Rotherham	Age UK	Project Lead, <b><i>fit for the future</i></b>
	Age UK	Information and advice
	Local authority and voluntary organisation	Signposting to older people's services
	NHS	Nutrition
	Voluntary sector	Church hall venue for community organisations
	Age UK	Project Lead, <b><i>fit for the future</i></b>
	Local authority	Community centre management

	Local authority and CCG	Health and wellbeing; democratic representation
	Voluntary sector	Campaigning and influencing on behalf of older people
	Voluntary sector	Nationwide philanthropic organisation
	Voluntary sector	Co-ordinating voluntary services
Warwickshire	Age UK	Project Lead, <i>fit for the future</i>
	Age UK	Services for older people
	Private sector	Commissioning support to GPs
	Private sector	Housing
	Local authority	Public health
	Voluntary sector	Health watchdog
West Cumbria	Age UK	Project Lead, <i>fit for the future</i>
	Age UK	Senior member of staff
	Voluntary sector	Tenants and residents' association
	NHS	Mental health support
	NHS	Occupational Therapy
	NHS	Occupational Therapy

**Table 5: Ethnic background of participants, percentage (n=1476)**

Ethnic background	Percentage (%)
White British	90.5
Irish	1.4
Gypsy or Irish Traveller	0.1
Other White	0.5
Indian	4.1
Pakistani	1.0
Chinese	0.1
Other Asian	0.6
Mixed white and Black Caribbean	0.2
Mixed white and Black African	0.3
Mixed white and Asian	0.1
Other mixed background	0.1
Caribbean	0.5
Other Black, African, Caribbean	0.1
Arab	0.1

Any other ethnic background	0.2
<b>Total</b>	<b>100.0</b>

**Table 6: Religion or belief of participants, percentage (n=1317)**

Religion or belief	Percentage (%)
Christian	78.0
No religion	12.0
Muslim	3.0
Other religion	3.0
Hindu	2.0
Buddhist	1.0
Sikh	1.0
<b>Total</b>	<b>100.0</b>

**Table 7: Sexual orientation of participants, percentage (n=1176)**

Sexual orientation	Percentage (%)
Heterosexual	99.0
LGBT	1.0
<b>Total</b>	<b>100.0</b>

**Table 8: Educational qualifications, percentage (n=904)**

Educational qualifications	Percentage (%)
Degree or higher degree	6.4
HND, HNC, NVQ Level 4 or equivalent	3.9
A-levels, NVQ level 3 or equivalent	4.9
GCSE, O-levels, NVQ level 2 or equivalent	9.3
Professional qualifications	13.8
Other vocational / work-related qualifications	15.6
Foreign qualifications	1.8
No qualifications	44.4
<b>Total</b>	<b>100.0</b>

**Table 9: Occupations, percentage (n= 863)**

Occupations	Percentage (%)
Managers, directors and senior officials	1.3
Professional occupations	6.8
Associate professional and technical occupations	1.2
Administrative and secretarial occupations	16.0
Skilled trades occupations	10.2
Caring, leisure and other service occupations	13.9
Sales and customer service operatives	14.0
Process, plant and machine operatives	17.5
Elementary occupations	9.3
Outside the labour force	9.8
<b>Total</b>	<b>100.0</b>

### **Appendix 3: Age UK *'fit for the future'* – Survey (Round 1) Benchmarking Profile**

The aim of this profile is to use the Health Survey for England (HSE) (2013) microdata to understand how typical the Age UK survey respondents are compared with the population (aged 50+) of England as a whole. The following characteristics are covered:

- Age-sex (HSE has a 'single-year of age' variable so age groups will be matched to those used in the survey)

Then age-sex by:

- Ethnicity
- Religion
- Household size and type – do they live alone?
- Do they provide care
- Health status
- Wellbeing – some of the questions are asked in HSE
- BMI
- Weight, height and waist circumference
- Alcohol intake
- Smoking
- Fruit and vegetable consumption
- Exercise and activity

As part of the profiling it is possible to produce an estimate of the number of people in England who are similar to those in the first round of the Age UK survey.

## Appendix 4: Individual tables of statistical test results

**Table 1: 7-item Warwick-Edinburgh Mental Well-being Scale; mean (standard deviation)**

Survey One	Survey Two	Survey Three	n value	p value
26.91 (4.690)	27.64 (4.706)	27.44 (4.781)	778	.001†; <.001†; .330

Statistical test: Repeated Measures Anova with Bonferroni adjustment for multiple comparisons between timepoints 1-3, 1-2 and 2-3. There were 840 valid responses over the three time-points, but only those with WEMWBS>15 were included in the analysis to make the distribution of values more normal, which allowed us to perform a robust (parametric) test of statistical significance.

**Table 2: 7-item Warwick-Edinburgh Mental Well-being Scale by ethnicity; median (interquartile range)**

Ethnicity	Survey One	Survey Two	Survey Three	n value	p value
White British	27.00 (7.00)	27.00 (8.00)	27.00 (8.00)	728	<.001†; <.001†; 1.000
Asian British <sup>27</sup>	28.50 (9.00)	28.50 (8.00)	29.00 (5.25)	50	.383*
All other ethnic groups	26.50 (7.75)	27.00 (7.00)	25.50 (10.25)	20	.486*

Friedman test, pairwise comparisons between timepoints 1-3, 1-2 and 2-3.

\*Friedman test, multiple comparisons were not performed because the null hypothesis of no change over time was retained.

**Table 3: Satisfaction with life scale; median (interquartile range)**

Survey One	Survey Two	Survey Three	n value	p value
7 (4)	8 (3)	8 (3)	994	<.001†; <.001†; 1.000

Friedman test between time-points 1-3, 1-2, 2-3.

**Table 4: Change in the value of indicators measuring loneliness and isolation, median (interquartile range)**

Variable	Survey One	Survey Two	Survey Three	n value	p value
Lack of companionship	2(1)	1(1)	1(1)	1008	.027; .049; .526
Feeling isolated	1 (1)	1 (1)	1 (1)	997	.002†; .005†; 1.000
Feeling left out	1 (1)	1 (1)	1 (1)	977	.019; .090; 1.000
Feeling in tune with others around you	2 (1)	3 (1)	3 (1)	982	.183; .165; 1.000

<sup>27</sup> Older people from Indian, Pakistani, Bangladeshi and Other Asian background.

Friedman test between time points 1-3, 1-2 and 2-3.

**Table 5: Change in the value of indicator measuring isolation, women; median (interquartile range)**

Variable	Survey One	Survey Two	Survey Three	n value	p value
Feeling isolated	1(1)	1(1)	1(1)	720	.001†; .004†; 1.000

Friedman test, pairwise comparisons between timepoints 1-3, 1-2 and 2-3.

**Table 6: Changes in attitudes to healthy eating, median (interquartile range)**

Survey One	Survey Two	Survey Three	n value	p value
3 (0)	3 (0)	3 (0)	1043	.007†; .006†; 1.00

Friedman test, comparisons between time points 1-3, 1-2 and 2-3.

**Table 7: Number of portions of fruit and vegetables eaten per day, mean (standard deviation)**

Indicator	Central tendency	Survey One	Survey Two	Survey Three	n value	p value
Portions of fruit and vegetables	mean (SD)	3.32 (1.45)	3.70 (1.41)	3.58 (1.36)	959	<.001†; <.001†; .006†

Repeated Measures Anova, Bonferroni adjustment for multiple comparisons between timepoints 1-3, 1-2 and 2-3. Of the 989 valid responses 30 outliers were excluded – this allowed us to perform a robust (parametric) test of statistical significance.

**Table 8: Respondents reporting eating five or more portions of fruit and vegetables a day, percentage**

Survey One	Survey Two	Survey Three	n value	p value
25.34	30.45	27.84	959	.235; .001†; .200

Related samples Cochran’s Q Test between time-points 1-3, 1-2 and 2-3.

**Table 9: Eating a meal prepared and cooked from basic ingredients per week, median (interquartile range)**

Survey One	Survey Two	Survey Three	n value	p value
4 (2)	4 (2)	4 (2)	1038	.014

Friedman test, multiple comparisons were not performed because the overall test retained the null hypothesis of no change over time.

**Table 10: Changes in physical activity levels, median (interquartile range)**

	Survey One	Survey Two	Survey Three	<i>n</i> value	<i>p</i> value
Changes in attitudes to physical activity	3 (1)	3 (0)	3 (2)	1019	.011; <.001†; .077
Minutes walking a day	30 (40)	40 (40)	40 (40)	955	<.001†; <.001†; 1.000
Minutes of activity breathing harder per week	60 (120)	90 (130)	90 (135)	857	.006†; <.001†; .067
Minutes doing physical activity for strength per week	70 (112)	90 (135)	70 (110)	888	1.000; .015; .164

Friedman test between timepoints 1-3, 1-2 and 2-3.

**Table 11: BMI, median (interquartile range)**

Survey One	Survey Two	Survey Three	<i>n</i> value	<i>p</i> value
<b>26.45 (7.03)</b>	26.45 (6.85)	26.19 (6.77)	593	<.001†; .440; .054

Friedman test between timepoints 1-3, 1-2 and 2-3.

**Table 12: BMI for overweight participants, median (interquartile range)**

Survey One	Survey Two	Survey Three	<i>n</i> value	Statistically significant change*
<b>29.53 (5.23)</b>	29.18 (5.33)	29.08 (5.35)	371	0.38, <.001†, .020

Friedman test between timepoints 1-3, 1-2 and 2-3.

**Table 13: Waist circumference in centimetres, mean (standard deviation)**

Survey One	Survey Two	Survey Three	<i>n</i> value	<i>p</i> value
<b>93.20 (14.90)</b>	92.08 (14.08)	92.30 (13.97)	269	0.229; 0.083; 1.000

Repeated Measures Anova with Bonferroni adjustment for multiple comparisons, between timepoints 1-3, 1-2 and 2-3. Of 271 valid responses 2 outliers were excluded – this allowed us to perform a more robust (parametric) test of statistical significance.

**Table 14: Number of respondents reporting smoking and drinking alcohol**

	Survey One	Survey Two	Survey Three	<i>n</i> value	<i>p</i> value
Smoking	90	85	87	1049	.636*
Drinking alcohol	401	370	362	1035	.001†; .016; 1.000*

\*Cochran's Q test, multiple comparisons were not performed because the overall test retained the null hypothesis of no change over time.

\*Cochran's Q test, comparisons between timepoints 1-3, 1-2 and 2-3.

**Table 15: Amount of cigarettes and alcohol consumed, median (interquartile range)**

	Survey One	Survey Two	Survey Three	<i>n</i> value	<i>p</i> value
Number of cigarettes smoked (daily)	10 (9)	10 (10)	10 (7)	48	.036
Units of alcohol (weekly)	5 (7)	5 (7)	5 (7)	220	.679

Friedman test, multiple comparisons were not performed because the overall test retained the null hypothesis of no change over time.

**Table 16: Older people and the management of their long-term health conditions, median (interquartile range)**

Variable	Survey One	Survey Two	Survey Three	<i>n</i> value	<i>p</i> value
I am fully informed about issues relating to my long term health conditions	2 (1)	2 (1)	2 (1)	869	.016
I am fully involved in decisions regarding managing my long term health conditions	2 (1)	2 (1)	2 (1)	852	.118
I am fully supported in managing my long term health conditions	2 (1)	2 (1)	2 (1)	865	.015
I am fully in control of the care for my long term health conditions	2 (1)	2 (1)	2 (1)	828	.027

Friedman test, multiple comparisons were not performed because the null hypothesis of no change over time was retained.

**Table 17: Older people reporting experiencing a fall or loss of balance, percentages**

	Survey One	Survey Two	Survey Three	<i>n</i> value	<i>p</i> value
Experienced a fall or loss of balance	29.7	25.1	28.1	999	.014
Did not experience a fall or loss of balance	70.3	74.9	71.9		
Total	100.0	100.0	100.0		

Related samples Cochran's Q test. Pairwise comparisons between time-points were not performed, because the null hypothesis of no change over time was retained.

**Table 18: Unplanned visits to health professionals, median (interquartile range)**

Survey One	Survey Two	Survey Three	<i>n</i> value	<i>p</i> value
1 (1)	0 (1)	0 (1)	264	.295

Friedman test, multiple comparisons were not performed because the overall test retained the null hypothesis of no change over time.