British Heart Foundation

ACTIVE FOR LATER LIFE

Promoting physical activity with older people

BEATING HEART DISEASE TOGETHER

SECTION 4 – THE WORKING PAPERS

This section comprises a series of working papers which provide more detail on specific issues related to programme planning for those promoting physical activity with older people. They are not designed as definitive guides, but to highlight research and evidence and to raise important questions about the planning of local programmes for older people.

CONTENTS

INVOLVING OLDER PEOPLE IN PROGRAMME DEVELOPMENT

There is agreement that involving local communities and older people in developing strategies and action plans improves the quality and effectiveness of programmes (Nichols, 1999). This process of participation and involvement requires a closer collaboration with communities and those people who are able to provide insights into local issues and needs and the appropriateness and acceptability of policies, strategies and provision. Moreover, it is often argued that health care organisations and professionals rarely consider the views of users and that the user's perspective can differ significantly from that of the professional.

WHY COMMUNITY PARTICIPATION?

The arguments to support greater community participation include:

- poor utilisation of services because of a lack of community involvement
- the economic argument that all available resources should be utilised
- that health education is more effective when people are involved in actually doing things themselves
- the social justice argument that people should be involved in decisions that affect them (Rifkin, 2000).

Central to the concept of community participation are the key themes of community development, people's participation and empowerment.

DEFINITION OF TERMS

Difficulties can often arise from the use of the terms '**community**' and '**participation**'.

Community is often defined in terms of geography despite evidence that geography is often a weak factor in defining common interests. People living in the same area do not necessarily have the same interests or views; such groups are not homogeneous.

Participation. There is a need to distinguish between mobilisation (which may be described as getting people to do what professionals think best), and involvement (where people actively decide what they think is best and professionals contribute expertise and resources to implement this decision).

These problems have been summarised by Cohen and Uphoff (1980):

– Participation is not a single thing.

– Participation is not solely an end, but more than a means.

– Participation is not a panacea for community problems.

– Participation in development is not the same as participation in politics.

– Participation in development is, however, inescapably political.

Participation may also be seen as an intervention, or a product. Experience suggests that participation is best seen as an ongoing, adaptive and dynamic process.

LEVELS AND STAGES OF PARTICIPATION

The exact nature of community participation as a process has been described as a continuum that can extend from tokenism – where local representatives are chosen and asked about decisions but have no real input or power – to opportunities for older people to set their own agenda and mobilise to carry it out, in the absence of outside initiators and facilitators (Cornwall, 1996). See Table 4.

Table 4 – Levels of participation

Mode of participation	Involvement of older people	Relationship between action and people
Co-option	Token involvement. Representatives are chosen but have no real input or power.	On
Compliance	Tasks are assigned, with incentives. Outsiders decide the agenda and direct the process.	For
Consultation	Local opinions are asked. Outsiders analyse and decide on a course of action.	For/with
Co-operation	Older people work with outsiders to determine priorities. Responsibility for directing the process remains with outsiders.	With
Co-learning	Older people and outsiders share their knowledge to create new understanding, and work together to form action plans, with outsider facilitation.	With/by
Collective action	Older people set their own agenda and mobilise to carry it out in the absence of outside initiators and facilitators.	By

Source: Adapted from Cornwall (1996).

PARTICIPATORY RESEARCH METHODS

Participatory action research is research which involves all those concerned with the outcome in the entire research process from planning to evaluation. It focuses on the involvement of people who traditionally have been objects, not subjects of research and considers a major objective to be to empower them through this process.

Rapid appraisal methods are extensively used to understand health and social needs and as a basis for developing policy, strategy and services.

Community profiling is a term used to describe a participatory approach to planning which emphasises:

- the use of researchers drawn from the local community
- revisiting the community to confirm findings and to explore the implications of those findings for the local community and for service providers.

There is no single model for participatory action research but common elements include:

- working with local people to decide what information is needed
- working with local people to decide how to obtain the information
- deciding who should collect the information
- analysing the information
- checking findings with key informants and against local knowledge
- selecting priorities for action
- planning the actions and outcomes
- monitoring the plan
- evaluation.

(Health Education Authority, 1995)

Further reading

For a fuller discussion of participatory research methods see:

Improving Health through Community Participation – Concepts to Commitment
By Draper A and Hawdon D. Published by the Health Development Agency, London, 2000.

Participatory Approaches in Health Promotion and Health Planning – A Literature Review
By Rifkin SB, Lewando-Hundt G and Draper AK. Published by the Health Development Agency, London, 2000.

Findings from the Better Government for Older People Programme

Significant learning about the participation of older people has been achieved through the two-year action research programme developed by the Better Government for Older People Programme. The aim of the programme was to improve public services for older people by better meeting their needs, listening to their views, and encouraging and recognising their contribution. The key lessons from the programme are summarised below.

Listening to older people through consultation

What works?

- encouraging and valuing the contribution of participants
- seeking the views of local people on a wide range of issues
- seeking to involve a broad spectrum of people from the target population
- choosing appropriate consultation methods for the topic and the target group
- investing in consultation
- follow up consultations with feedback and action.
- setting in place mechanisms for ongoing consultation and involvement.

Engaging with older people

What works?

- support for existing groups to develop activities and widen membership
- community development support to widen engagement
- older people's advisory groups and forums to drive forward change
- funding to value older people's contribution
- developing staff capacity to fully engage with older people.

Better meeting the needs of older people through improved information

What works?

- co-ordinated 'person-based' information, face-to-face and by telephone
- outreach information and benefits sessions in community venues
- creative ways of targeting publicity to older people
- older people actively contributing to producing and giving information
- information technology, if used alongside older people and linked to appropriate training
- local flexibility for joint working between managers and front line staff.

FINDINGS FROM THE BETTER GOVERNMENT FOR OLDER PEOPLE PROGRAMME (CONTINUED)

BETTER MEETING THE NEEDS OF OLDER PEOPLE – THROUGH DELIVERING SERVICES DIFFERENTLY

What works?

- a range of services provides flexibility to meet individual needs
- help with mobility improves older people's independence
- older people can contribute to getting services right first time
- managers and front line staff need motivation and training for joint working.

THE CONTRIBUTION OF OLDER PEOPLE – ACTIVE AGEING

What works?

- accessible IT opportunities attract a lot of older people
- offering a range of opportunities appeals to diverse interests
- publicity and support services (eg, transport) enables participation
- small-scale, local projects have encouraged innovation and creativity
- involving older people in deciding priorities encourages participation.

TACKLING AGEISM AND PROMOTING POSITIVE IMAGES

What works?

- holding a local older people's event to promote positive images
- showing what older people contribute as active participants in their communities
- building partnerships with the local press to challenge media stereotypes
- introducing age diversity policies into local authorities' own employment practices.

COMMUNICATION STRATEGIES

A variety of strategies and methods can be used to improve communication and increase the involvement of older people. For example:

- maximising the opportunities provided by existing older people's forum groups
- creating older people's councils, panels or advisory groups
- using small group or face-to-face interviews and other group work techniques
- organising conferences and special 'listening' events
- using mobile teams, road shows and information services
- using peer mentor researchers and volunteers
- outreach work among specific community groups eg, elders from ethnic communities
- using new communication methods eg, drama and creative writing
- creating new communication channels eg, letter writing, an internet network or a telephone network.

Practical opportunities

Involving older people can be much more than asking for their ideas and making use of their experiences in programme design. There is ample evidence of the practical ways in which older people can (and should) become active participants in programme development including:

- promotion (as active Ambassadors) using local radio and media and visiting local groups and organisations
- becoming leaders, teachers and coaches to physical activity opportunities
- Senior Peer Mentors, encouraging and motivating others to take the first steps into physical activity
- Physical Activity Buddies who accompany a friend to regular activity
- becoming actively involved in programme evaluation.

SUMMARY

- **make sure that older people have their say and are listened to**
- **older people have a wealth of experience to share**
- **listening to older people demands a significant investment of resources and time**
- **perhaps the most critical issue is the extent to which agencies can turn listening into action**
- **older people should be involved in the planning, promotion, practical implementation and evaluation of any programme.**

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An important question for those involved in promoting physical activity with older people is how older people can best be encouraged to incorporate more physical activity into their lives. In order to do this we must understand why older people do and do not participate in physical activity and identify some of the mechanisms and triggers that may initiate the adoption of physically active lifestyles, even in the later years.

CHANGING BEHAVIOUR

A number of theories and models have been developed which attempt to explain health behaviour change. (A summary of these models can be found in Dishman, 1994 and Sport England 2006)

The models share a number of common features which appear to influence behaviour change. These include:

- the value an individual places on the outcome
- the individual's belief about their ability to control their behaviour (self-efficacy)
- the need for re-enforcement and support.

However, these models may place too much emphasis on the individual's motivation to change, and ignore the impact of the wider environment on change. As the environment provides a strong moderating effect on individual behaviour, the importance of policy and environmental strategies to complement interventions focusing on individual change cannot be overstated. For example, limited access to safe walking routes may be a barrier to participation even when someone is keen to increase their level of walking.

IDENTIFYING BARRIERS

There is a wide range of barriers to physical activity for the older person. These barriers can be intrinsic (internal) and extrinsic (external).

Intrinsic barriers are those that relate to the individual's beliefs, motives and experiences concerning physical activity. These are most likely to be addressed by those who work directly with older people in providing counselling, advice, motivation, education and programme planning – for example, a peer mentor, exercise teacher, health visitor or GP.	**Extrinsic barriers** are those that relate to the broader physical activity environment, the attitudes of others and the types of opportunities that are available. These barriers are more likely to be addressed by those responsible for policy and strategic developments.

Programme barriers

Jones and Rose (2005) have also highlighted the importance of **programme barriers** that older people face which identify the location, timing, quality of the physical activity or exercise programme (too hard or too difficult) and the interpersonal skills of the leader or teacher. Evidence suggests that effective strategies to support individual behaviour change are influenced as much by the qualities and inter-personal skills of the helper working with the people (eg, a peer mentor, practice nurse or exercise teacher) as the theoretical model or intervention style used (Hunt and Hillsdon, 1996).

Whilst many of the barriers identified above will be evident among participants in a variety of physical activity programmes, planners must also take account of specific programming and class design issues as also being a potential source of barriers or even participation drop out.

A practical way of extending thinking relating to all the barriers connected with physical activity and exercise might be to consider a broader model which includes the experience of the exercise programme and individual sessions.

Intrinsic – Personal factors	Programme factors	Environmental factors
Poor self image, self efficacy. No history of positive experience of exercise.	Inconvenient time. Location and transport. Boredom. Exercising alone. Poor instruction. Too easy, too hard.	Lack of family/partner support. Social support. Weather/season. Medical problems.

INDIVIDUAL DIFFERENCES

Older people are not a homogeneous group and among the older population there are significant individual differences in attitudes to, motivation towards, and barriers to physical activity.

Intrinsic barriers might include:

Earlier experiences. Earlier experiences may have positively and negatively shaped attitudes towards health, old age and physical activity eg, school sport.

Cultural or religious reasons. Although there are no cultural or religious reasons prohibiting people from ethnic communities from taking part in physical activity, ethnic origin and culture can influence the mode of participation and the type of facilities required.

Gender. Men and women have different attitudes towards physical activity and their health, particularly after retirement.

Self-image. Many older people see getting older, a decline in capacity, and increasing disability as the inevitable consequences of ageing.

Time barriers. Different roles and interests at different stages in later life (eg, looking after grandchildren, travel, volunteering) may mean that disposable or free time changes or may decrease over time.

Perception of physical activity. The individual's perception of physical activity is formed by a combination of intrinsic barriers and key beliefs (for example a belief that exercise might be dangerous).

Don't mention the E word. For some older people Exercise is about hard work, possibly over-exertion and pain – physical activity may be a more appropriate term.

Recommendations for overcoming intrinsic barriers

Change perceptions of what it means to be physically active. Everyday and moderate physical activity is beneficial, small changes in behaviour can make a difference, examine cultural beliefs and values.

Provide education, advice and information. How to get started, how to find out what is available locally and how to exercise safely.

Provide re-assurance, concerning over-exertion and injury, following illness and the advance of frailty. It's never too late to start.

Enhance self-efficacy. Provide opportunities to try out new activities and behaviour. Provide opportunities for early success which include establishing the pattern of exercise behaviour within the individual lifestyle.

Provide information and opportunities around life events. Provide guidance at the time of retirement from work via pre-retirement programmes and medical professionals. Provide guidance at the onset of illness or disease, via physiotherapy or rehabilitation programmes.

Emphasise the non-health benefits. Highlight the social benefits of physical activity. Stress personal goals and targets – for example maintaining mobility and independence, playing with grandchildren.

Provide support. Maintain contact at times of lapse and relapse, using peer mentoring and buddy systems and family and carer support. (Finch, 1997)

Programme barriers and solutions

Immediate access to opportunities. Ensure the proximity of opportunities and facilities to the living environment with good transport links.

Timing of activities and counter-attractions, eg, clashes with caring responsibilities, bingo or bridge club.

Skills and qualities of teacher or instructor, eg, ability to relate to and communicate appropriately with older people, task setting at an individual level.

Provide support. Maintain contact at times of lapse and relapse, using peer mentoring and buddy systems and ensure family and carer support.

Appropriate induction and assessment of individual needs. Health check, providing reassurance about a safe start, concerns re over-exertions, advice about clothing, water.

Exit strategies – ***to another programme to sustain participation***. Particularly in the case of come and try in activities or short term rehabilitation classes, or to try a new interest or progress to a more suitable level.

Opportunities for socialisation. To ensure a strong sense of togetherness and community amongst participants to classes.

Overcoming extrinsic barriers

Recommendations that would help with the development of 'activity-friendly environments' for older people include the following (Stewart, 2000):

Physical environment

Increase the number and breadth of physical activity classes and facilities for older people.

Improve the physical environment to facilitate more walking and cycling.

Improve transport options, especially in areas where this is a problem.

Improve the safety of neighbourhoods where fear of crime is an issue.

Social and cultural environments

Provide community events that promote physical activity for older people.

Enhance public education to change norms, values and beliefs about the value of physical activity for people over the age of 50.

Establish walking groups and buddy systems to provide support for others.

The influence of significant others

In addition to the influence of the GP, the attitudes of family, peers, friends and carers (both family and professional) are powerful motivators – "thinking that others think I should be doing this". (Yardley et al 2005)

Organisations and institutions

Encourage GPs and other providers to assess physical activity levels and recommend increased physical activity to all their older patients.

Provide GPs and other health care providers with appropriate materials to help them assess and counsel patients over 50 about physical activity.

Raise awareness among professionals, including managers of older people's services (eg, residential and care settings), and leisure and recreation providers.

Develop collaboration among local businesses to create walking maps or sponsor benches along walking routes.

Media and communications

Provide information and materials on physical activity in languages and formats designed to reach all older population segments.

Identify the best channels for communicating this information to lower income and minority groups in the community.

Provide information on opportunities for exercise in the community that are appropriate for adults aged 50 and older.

Design specific informational cues for public places eg, using the stairs.

Positive images of older people

Redress the balance of media images and promote positive role models, for example by:

– using positive non-stereotypical images of older people

– using physically active role models from within the target group – 'people like us'

– using appropriate 'activity ambassadors'.

THE EVIDENCE ABOUT FALLS PREVENTION – BARRIERS AND MOTIVATION

More specific work has recently been undertaken to look at the barriers that older people face when encouraged to take part in falls prevention exercise classes that identify strength and balance exercises as key components (Yardley et al 2005). Qualitative studies revealed the following information:

PERCEIVED POSITIVE FACTORS AND BENEFITS

- noticeable benefit/improvement (restoring/ maintaining fitness and functioning, better health – blood pressure, dizziness, diabetes)
- feel and look good (less stiff, less pain, more mobile, strong, energetic, better balance and mood, weight loss)
- able to do more things (walk, do without stick, climb stairs, travel, go out alone, ride bike, go shopping, ADLs)
- maintaining and increasing independence
- social contact (bond formed through prolonged contact with group)
- confidence/pride in achievement (general increase in self-confidence, approval of family/ friends/doctor)
- enjoy the activity (get out of house, use equipment).

NEGATIVE FACTORS

- health problems (actual and perceived interference)
- no observed positive effects when tried programme
- not liking social contacts in classes (peers or leader!)
- unpleasant experiences (fatigue, pain etc.) or not enjoyable
- low motivation or perceived relevance
- other priorities (caring for dependents, holidays, other appointments, housework).

WHAT ARE THE KEY MOTIVATIONS FOR OLDER PEOPLE TO TAKE UP STRENGTH AND BALANCE TRAINING EXERCISES?

1. thinking you are the kind of person who should do these activities
2. thinking other people think you should do these exercises
3. believing that these activities would be enjoyable
4. concern about the risk of a future fall
5. NOT having recent falls, or risk factors for falls.

RESISTANCE TO FALLS ADVICE AND INTERVENTIONS

Question – Many older people are resistant to advice about preventing falls. Why is this?

Advice may be disregarded for a number of reasons:

- some consider it relevant only to people older and frailer than themselves – a view held by many over-75s who had fallen recently
- some people reject the idea that they are at risk, either because they are genuinely confident (sometimes overconfident) of their capabilities, or because they feel that to accept that they are 'at risk' may stigmatise them as old and frail
- some people who have fallen do not accept that they are likely to do so again (and could therefore benefit from advice) because they attribute their falls to momentary
- inattention or illness rather than to a persisting vulnerability
- other people accept that they are at risk of falling but feel nothing can be done about it and that it is an inevitable part of ageing
- others accept that they are at risk and that falls prevention measures may work, but think the downside of taking the measures would outweigh the potential benefits.

Question – What is the best way to persuade people to buy into advice on preventing falls?

Rather than focusing on the risk of falls – the very mention of which can be anathema to older people – and the possible consequences, it is always better to start by stressing the benefits of improving strength and balance.

- strength and balance training is a key intervention to reduce the risk of falling. Training can be given for this at home, in the community or in hospital
- activity carried out to improve balance is likely to be seen as socially acceptable and relevant by a wide range of older people, whereas hazard reduction, which many older people take to mean restricting activity, is not.

Question – Does it help to target people according to their age, risk of falling or fear of falling?

Targeting people in this way is unlikely to be effective, but it is a good idea to tailor the advice you are giving to the situation and to the capabilities of the individual.

- people are more likely to make use of information and opportunities (for example, to do balance training) if they can personally choose the advice and activities that will suit their particular abilities, needs, priorities and lifestyle. Also, it should be acknowledged that the recipient may have valid reasons for rejecting the advice.

Question – What sort of advice tends to be best received?

Many older people are receptive to messages about the positive benefits of exercises that improve balance and mobility, including health, strength, confidence and enjoyment.

- they are likely to welcome support and encouragement to help them make this kind of exercise an enjoyable, habitual part of daily life, especially if they are given explanations for the advice offered.

From "Don't mention the F Word" (Help the Aged – Preventing Falls). Advice to practitioners on communicating falls prevention messages to older people.

Building support strategies into your programme

Making the change and adopting physical activity as a regular lifestyle choice provides many challenges for the older person. Whatever the intervention, whether it is designed to assist the individual, a family or a larger group, **support** has been identified as a critical component of successful behaviour change (NICE 2006). Support can provide further information, advice and guidance, a companion to accompany a beginner to a new class or group, and motivation and understanding if things go wrong.

Review-level evidence suggests that interventions that used telephone support and follow-up are also associated with long-term behaviour change. (Health Development Agency 2005)

Interventions that provide support and follow-up are also associated with changes in physical activity and include:

- telephone and written contact and support
- computer-generated feedback and messages
- informal group meetings and events
- use of exercise log books. (NICE 2006)

GETTING STARTED – THE INDUCTION PROCESS

For new participants, joining a class or group may be the first such experience for some considerable time if not completely new. It may also be a daunting experience. Induction sessions will be helpful in overcoming concerns, and by providing information and re-assurance about the level of physical activity, clothing, safety and that the programme is designed to meet individual needs and goals.

Induction sessions prior to joining the group should include an explanation of:

- the aims of the sessions
- the exercises and equipment to be used
- safe and comfortable clothing for the session
- the importance of working at one's own pace, appreciating the different levels of function and ability within the group and the individual nature of progression
- the reasons for graded sessions and the benefits of progressing slowly
- when exercise should be stopped and when it can continue
- the safety precautions to take when exercising outside the session
- strategies for improving compliance
- strategies for accessing the session eg, transport.

Goal setting and achievement

Individual goal or target setting is also known to increase motivation and should consider the following:

1. Expectations

Has any individual screening, initial assessment or discussiontaken place?

What do participants want to achieve?

Most will identify independent living as being important, but what are the steps towards this?

2. Encourage participants to set own goals

Smart or simple, realistic and behavioural.

"I will come to the exercise class three times in a month" – "I will lose weight".

"Increase my strength?" "How will I know if I've achieved it?".

Short term and long term, both are important.

Early and short term goals must be achieved to increase self-efficacy and confidence.

3. Monitor and provide feedback

Focus on early successes as well as struggles.

Frequent review and adjustment.

How are goals or progress monitored (pedometer?).

4. Reward and incentives

Re-enforcement has a far greater effect than punishment.

Encourage self reward.

Encourage recognition and achievement by group (return by newcomer or absentee).

Very important in early stages to increase in confidence and self-efficacy.

5. Problem solving to overcome obstacles

Participants should be assisted to provide own solutions, not instructor, or how can we solve this together?

Participants are more likely to act on own solutions.

6. Promote long term adherence

6 months is accepted as maintenance behaviour so develop strategies to avoid and overcome lapses and relapses. (Lapse is missing a session or two – Relapse returning to sedentary behaviour).

Avoid all or nothing measurement of success.

STRATEGIES TO SUPPORT PARTICIPATION AND IMPROVE ADHERENCE

Frequently identified strategies to improve compliance and confidence include:

- Providing opportunities to socialise to increase enjoyment and improve effectiveness. Strategies such as after the session get-togethers and Exercise Buddying appear to work well to assist compliance among older people
- Going that extra mile i.e. being conscientious in taking a register and following up absences and accidents no matter how minor. Arranging a rota to visit someone who is ill is an important part of the process of assisting people to feel part of the group
- Ensuring support staff or appropriate senior peers are available prior to, and after the sessions, will assist participants to share any limitations or worries. It also facilitates safer, more independent participation
- Being open to the diverse ways individuals may have of achieving their goals and reflecting by this varying the exercise opportunity is also important. Creating a safe, welcoming, well structured yet adaptable environment which encourages individuality and independence improves compliance. Support from friends and family is essential
- Educational talks/events on a wide variety of health, lifestyle and physical activity topics are also popular and motivating.

Home based exercise

Realistically, older, less functionally independent individuals will only attend a supervised session once a week.

A structured, concise, goal oriented, home exercise programme which incorporates exercises practiced in a supervised session, has been shown to effect training and is a useful supplement to the weekly exercise session in reaching frequency targets. (Campbell 1998).

Participants should be encouraged to follow the same guidelines as for the supervised sessions eg not exercising when unwell, always warming up and winding down afterwards, working moderately and discontinuing the exercise if symptoms of pain occur.

A number of reviews of effectiveness have cited walking from home as an effective intervention.

The best source of information...

Older people are a heterogeneous group and no single approach will guarantee success.

The best sources of information on the barriers faced by older people are older people themselves. Consulting with and talking to individuals and groups of older people concerning their own beliefs and attitudes, and the specific barriers they face, will help in the planning of programmes. Older people will also be able to suggest solutions for overcoming these barriers.

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WORKING PAPER 3

POPULATION WIDE INTERVENTIONS – RECOMMENDATIONS FOR PRACTICE

INTRODUCTION

This working paper highlights one area drawn from the Guidelines on Promoting Physical Activity with Older People drafted by the British Heart Foundation National Centre for Physical Activity and Health.

The guidelines were drawn from recent published reviews of effectiveness of physical activity interventions together with other published articles and guidelines in addition to learning from current professional experiences eg, the Local Exercise Action Pilot programmes.

In summarising the learning from these sources of evidence, the guidance highlights recommendations and **components of good practice** that can be used in planning interventions at three levels:

- **Population wide interventions** eg, environmental and policy interventions, campaigning and promotion.
- **Community/locality based interventions** eg, facility-based programmes, area-based physical activity projects and activity/participation events.

Click here to go to Working paper 4 – Community based interventions.

- **One-to-one interventions,** eg, lifestyle counselling and advice.

Click here to go to Working paper 5 – One-to-one interventions.

In addition, the guidelines offer an outline of best practice in:

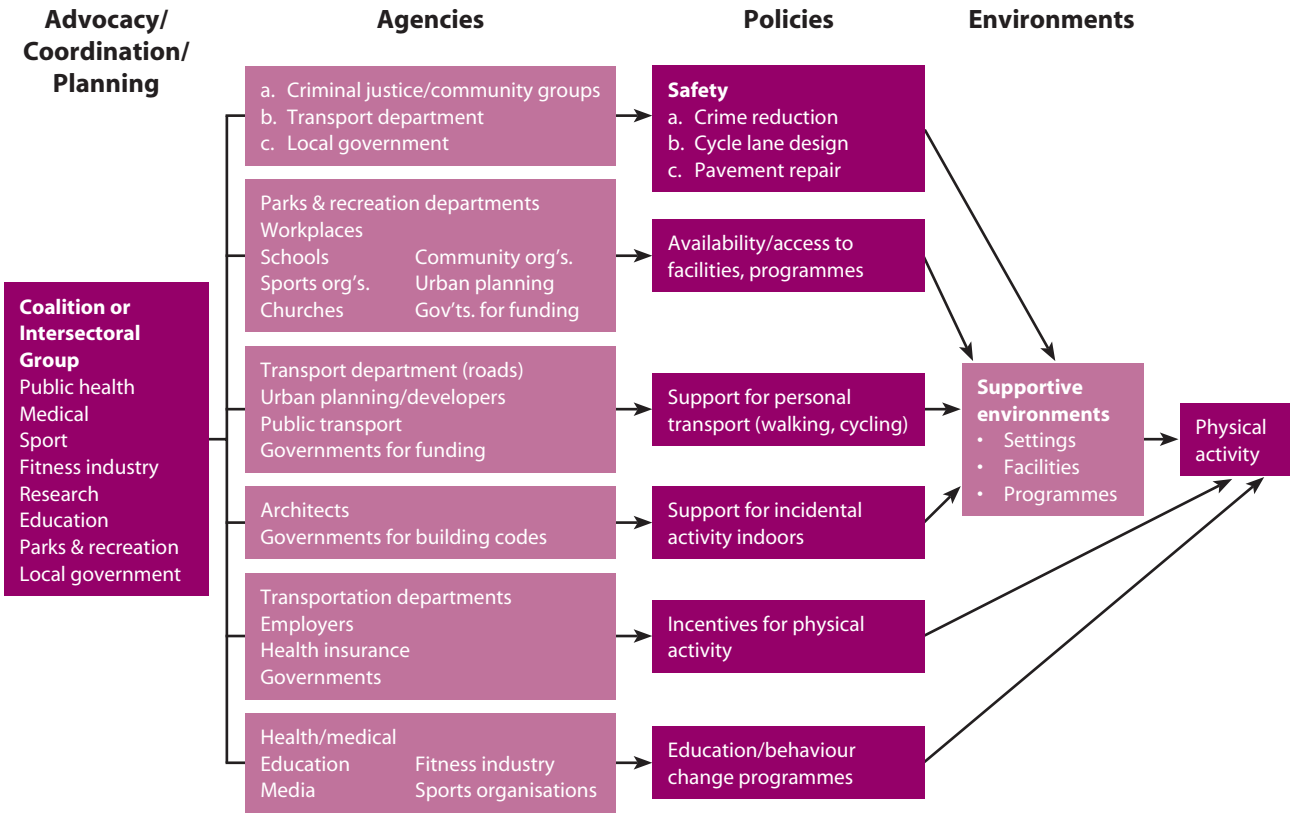
- **Physical activity and exercise programme planning** eg, for those leading and instructing groups involved in a range of activities eg, walking, tai chi, music and movement classes and chair based exercise.

Click here to go to Working paper 9 – Effective programming.

Community wide interventions

These recommendations relate to a range of community and population wide interventions, including environmental eg, building design, urban environment, natural environment, policy and transport, that are associated with promoting physical activity among older people. They relate to what is often described as social ecological models of health promotion (Sallis et al 1998) which examine the interaction and influence of physical and socio-cultural environments on health. The general thesis suggests that the environment can both restrict and encourage individual and population behaviours by promoting and demanding certain actions. In short, an individual, older person can make a decision to take up physical activity, but unless (s)he lives in a supportive environment, (eg, safe streets and well maintained pavements) the translation of that decision into action is much less likely.

Sociological model of healthy ageing (Sallis et 1998)



There is a lack of research into environmental and policy interventions to promote physical activity, although NICE are currently undertaking a review of five areas (transport, urban environment, natural environment, policy and building design) and are expected to published findings in the Spring of 2007.

Reviews of multiple studies indicate that a variety of environmental variables are associated with physical activity in children and adults (and possibly by inference also related to older people). However, the evidence suggests an association or correlation between such environmental factors and physical activity rather than high level evidence.

Consequently these recommendations provide general principles as well as guidelines. They relate to:

- the provision of transport
- the quality of the urban environment
- access to the natural environment
- the impact of building design
- the development of supportive policy
- the use of campaigns and communication activities.

These interventions have the potential to affect large numbers of older people. The creation of physical activity friendly and conducive environments (eg, safe walking routes) for older people will also benefit residents of all ages increase similar opportunities for other populations groups. Design strategies informed by the needs of older people can also serve as general principles of good community design.

1. The provision of transport

The provision of appropriate and reliable transport has long been identified as a key component of planning for older people's programming. While car usage is extending into the later years, many older people prefer to use public transport.

What do we know that works?

Physical activity participation among older people is likely to be improved by:

Improved transport options, especially in communities where this is a problem. (U.S Department of Health and Human Services).

Access to public transport including appropriate time-tabling and the provision of bus shelters remains a critical factor in providing access to facilities and programmes for older people. (ICMAA)

Accessible walking and cycling opportunities which remain the most popular activities for older people and are also the most accessible in terms of convenience and location. Promoting "active" or non-motorised transportation, supported by the development of safe, purposeful and practical routes for walking and cycling is a priority for increasing regular physical activity among older people.

Accompanied (eg, buddy and led) walks may increase motivation and social support for walking, particularly among new and less confident participants.

2. Urban environment

Neighbourhood design – What do we know that works?

Physical activity participation among older people is likely to be improved by:

Good quality (eg, level, non-slip) surfaces , maintenance (eg, repairs and snow clearance) and placement of pavements and pedestrian road crossings.

Minimising crossing distances and increasing the amount of time allowed for road crossing are of central importance to the older population. Road crossings can pose significant obstacles to older pedestrians who move at slower speeds than the average younger, healthier pedestrian. (Many older people are unable to walk at the speeds required (2.8 feet per second) to cross roads at pedestrian road crossing). Some older people may also have difficulty in seeing and judging traffic signals and oncoming traffic.

Accessible and nearby local services (eg, shops, chemist, library, post office, newsagent), improvement of the aesthetic appeal of the neighbourhood (eg, absence of rubbish, vandalism and graffiti), appropriate lighting and the convenience of water and toilets.

Accessible shopping malls and precincts and walking trails are also associated with increased walking among older people.

Increasing the number and breadth of physical activity classes and facilities of older adults, particularly in neighbourhoods with the least number.

Improving the safety of neighbourhoods where fear of crime is an issue.

The presence of strategies to reduce crime and perception/risk of danger (Safety training, "eyes of the community", neighbourhood watch) that will increase motivation to walk and cycle among older people.

Strategies to increase neighbourhood and social cohesion (eg, mutual trust, shared values, solidarity among neighbours) which are significantly associated with increased levels of physical activity among older people.

POPULATION WIDE INTERVENTIONS – RECOMMENDATIONS FOR PRACTICE (CONTINUED)

Natural environment

What do we know works?

Physical activity participation among older people is likely to be improved by:

Improved physical environments that facilitate more walking and cycling (US Dept of Health and Human Services) eg, parks, are more likely to stimulate opportunities for physical activity if they are aesthetically pleasing (tree lined walking paths) and benches (with backs and in shade) are provided for opportunities for 'pit stops' and rest, and reduced perceptions that parks are places for organised rather than informal activities.

Regular maintenance of pavements and roads eg, clearing of snow and ice to maintain opportunities for walking and cycling at all times of the year.

Policy development

These can be divided into legislative, regulatory (formal/legal government actions) or policy making (organisational statements/rules) actions that have the potential to affect physical activity for older people.

What do we know that works?

Physical activity participation among older people is likely to be improved by:

The enforcement of traffic laws and regulations (speed limits, traffic patterns and pedestrian rights of way) which will ensure greater safety among older walkers and cyclists.

The enforcement of community safety and crime reduction policies.

A range of sporting and recreation organisations eg, governing bodies of sport should be in the position to develop policies which promote physical activity for older people.

Residential, supported housing and care organisations who develop policies which promote physical activity for older people.

Building design

What do we know that works?

Physical activity participation among older people is likely to be improved by:

Improved visibility of stairs in workplaces and other public buildings, improvements in building design and technology (eg, wheelchair access, ramps, lifts, signing, automatic doors which lead to increased access to buildings). However such technology has also reduced the need for physical activity (eg, stair climbing).

Increased secure cycle storage spaces in workplaces and other public buildings.

An increase in the number and breadth of walking, recreational spaces and exercise facilities/gyms in residential and care settings.

POPULATION WIDE INTERVENTIONS – RECOMMENDATIONS FOR PRACTICE (CONTINUED)

Campaigning and communicating information

What do we know that works?

Physical activity participation among older people is likely to be improved by:

Information and materials on physical activity in languages and formats designed to reach all adult population segments (eg, low reading levels, culturally appropriate).

The use of optimal channels for communicating this information to lower income and minority segments of the older community.

Information is provided about exercise opportunities and resources in the community that are appropriate of adults aged 50 and over.

Specific informational cues in public places (eg, using the stairs).

Enhanced public education that attempts to change norms, values and beliefs about the value of physical activity for persons 50 and over.

Click here to go to Working paper 8 – Promoting and marketing physical activity with older people.

Supportive environment

What do we know that works?

Physical activity participation among older people is likely to be improved by:

An increase in the number of older people friendly physical activity settings, facilities and programmes.

An increase in the public and media profile of active older people.

An increase in the use of active older role models "someone like me" as motivators, leaders and instructors working with older people.

The education of significant others (eg, family, friends and peers) on the importance of physical activity for all older people.

The education of health and other professionals (eg, GPs and practice nurses, exercise and sports professionals, care and residential managers and workers) on the importance of physical activity for older people.

Summary

Many of these recommendations require long term development and will engage those promoting physical activity in new forms of partnerships with a range of local organisations. The importance of physical activity enhancing environments cannot be understated as they have the potential to make active living an easier choice and many of these can impact not just upon the older population, but everyone in the local community.

References

The full references for this working paper are contained in the BHF National Centre For Physical Activity and Health Guidelines on Physical Activity for Older People. They have been omitted from this paper to permit ease of reading.

WORKING PAPER 4

COMMUNITY AND LOCALITY BASED PROGRAMMES – RECOMMENDATIONS FOR PRACTICE

Introduction

This working paper highlights one area drawn from the Guidelines on Promoting Physical Activity with Older People drafted by the British Heart Foundation National Centre for Physical Activity and Health.

The guidelines were drawn from recent published reviews of effectiveness of physical activity interventions together with other published articles and guidelines in addition to learning from current professional experiences (eg, the Local Exercise Action Pilot programmes (DOH 2006)).

In summarising the learning from these sources of evidence, the guidance highlights recommendations and ***components of good practice*** that can be used to planning interventions at three levels:

- **Population wide interventions,** eg, environmental and policy interventions, campaigning and promotion.

Click here to go to Working paper 3 – Population wide interventions.

- **Community/locality based interventions,** eg, facility-based programmes, area-based physical activity projects and activity/participation events.
- **One-to-one interventions, eg, lifestyle counselling and advice.**

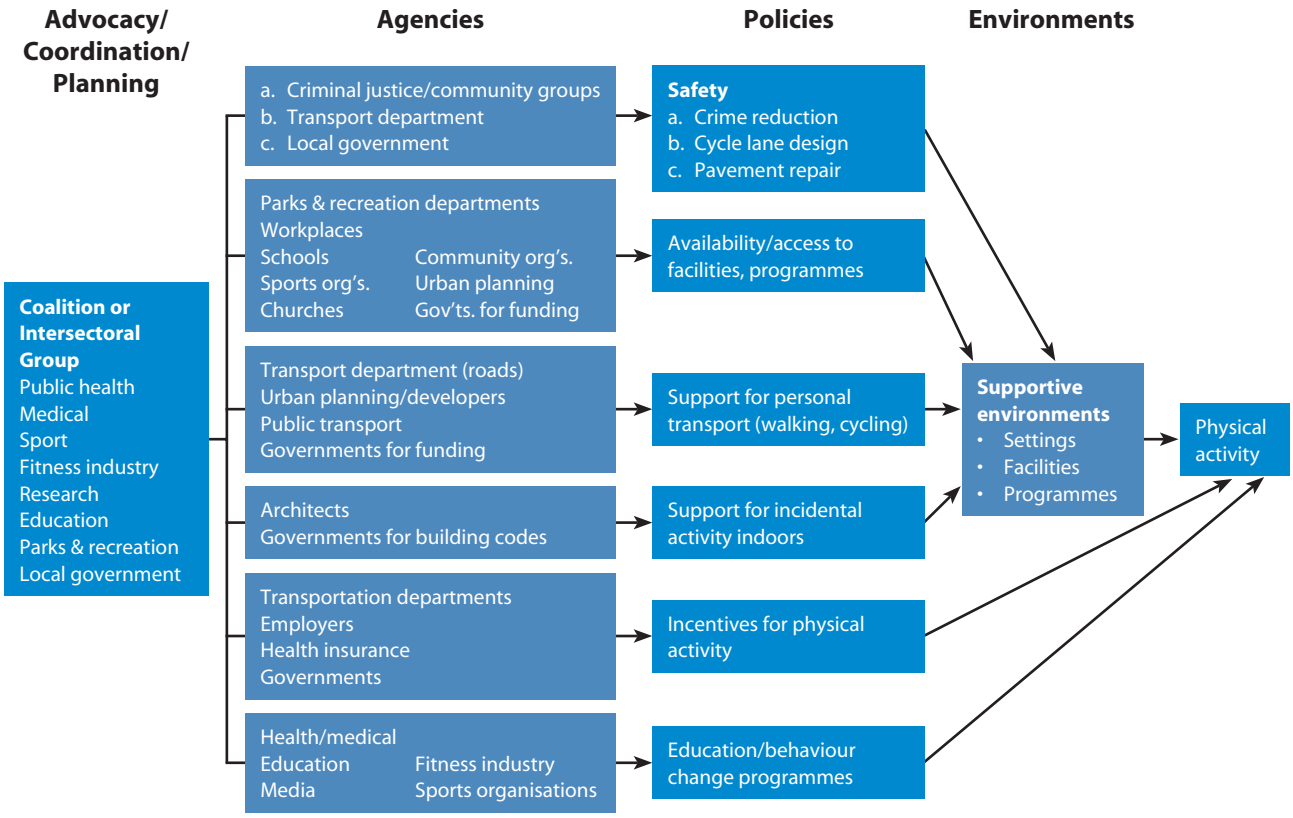
Click here to go to Working paper 5 – One-to-one interventions.

In addition, the guidelines offer an outline of best practice in:

- **Physical activity and exercise programme planning** eg, for those leading and instructing groups involved in a range of activities eg, walking, tai chi, music and movement classes and chair based exercise.

Click here to go to Working paper 9 – Effective programming.

Sociological model of healthy ageing (Sallis et 1998)



Community and locality based physical activity programmes for older people may take many forms ranging from the introduction of a city wide walking programme to the establishing of a village based peer health mentor or leadership programme. Most commonly they target new participants and are often (though not always) time limited and also draw upon the skills of a number of local partner organisations. From design to completion, there are a number of key components essential to success and this working paper highlights evidence of best practice.

Key components

1. Allow sufficient time for programme design and planning.
2. Develop the partnership.
3. Engage and involve participant groups.
4. Undertake a thorough audit.
5. Develop a marketing and promotion strategy.
6. Ensure choices are available.
7. Build support strategies.
8. Plan exit strategies from intervention.
9. Undertake monitoring and support through change.
10. Plan for evaluation and data collection.
11. Plan for programme sustainability.

Allow sufficient time for programme design and planning

Physical activity interventions, particularly those trying to reach an audience that may be reluctant to engage in physical activity, can take significant time to develop and become established.

In identifying the aims and purpose of a programme, it is essential to recognise the influence of policy and strategic levers, particularly those associated with programme partners.

Develop the partnership

Develop a partnership infrastructure and collaborative working. Most interventions have benefited from partnership working with a number of agencies. Particular benefits realised so far include joint and additional resources in the form of funding, facilities and equipment, and being able to access different skills and expertise. Partnership working extends the network and contacts of the lead organisation, enabling them to reach and engage with more participants from a variety of identified target groups.

The development of such partnerships also requires regular communication with steering and advisory groups and stakeholders – ensuring that there is clarity among all concerned concerning roles and responsibilities.

Engage and involve participant groups

Engage and involve participants and community groups in needs analysis, planning every aspect of programme development. Consultation with users from the intended target audience and with related community groups helps to identify needs and develop understanding of the barriers to participation. It also helps ensure that the nature of the intervention is appropriate for the intended audience. Actively engaging participants in the development, delivery and ongoing improvement of the intervention also ensures that it remains user focused.

Undertake a thorough audit

Review the knowledge and skills required at the planning stage and address gaps and weaknesses. Most physical activity interventions require a broad mix of knowledge and skills which will rarely be found in one project manager. Skills needed relate to engaging and maintaining the involvement of the target audience, as well as managing and delivering the project. Initiatives that target people with specific health problems may require specialist knowledge and expertise. Evaluating the project outcomes also requires a particular skill set, as does obtaining research ethics clearance.

Experience suggests that there will be the need to build additional capacity and skill sets through training and infrastructure development. These might include learning related to safety and risk assessment, promotion and marketing and evaluation skills.

Develop a marketing and promotion strategy

A marketing and promotion strategy should be built around the key questions of who are we trying to target, who is our intended audience? What is the message that we are trying to communicate? What communication channels and technologies should we use?

Marketing messages should be built around the needs, beliefs and expectations of the intended audience and their perceptions of the benefits of a healthy lifestyle.

Promotional messages must assume that older people know the benefits of physical activity, but for some reason they haven't taken advantage of that message. The message must be about inspiring people, persuading them to get off the couch without alienating them.

The message should feature ordinary people doing ordinary things. Older people respond best to promotional materials when they can identify with the people and the activities in the materials; they prefer to see "people like us", or someone they would like to have as a friend.

Click here to go to Working paper 8 – Marketing and promoting physical activity to the older person.

Ensure choices are available

A range of intervention strategies and choices of activity is associated with increases in physical activity with no one approach consistently and significantly superior.

A range of physical activity programmes should be developed that target adults aged 50 and over. These should include a combination of individual and group approaches using either group-based or home-based exercise sessions with support and follow-up.

Interventions that use individual-based or group-based behavioural or cognitive approaches with a combination of group- and home-based exercise sessions are equally effective in producing changes in physical activity.

Build support strategies

Making the change and adopting physical activity as a regular lifestyle choice provides many challenges for the older person. Whatever the intervention, whether designed to assist the individual, a family or a larger group, support has been identified as a critical component of successful change. Support can provide further information, advice and guidance, a companion to accompany a beginner to a new class or group as well as motivation and understanding if things go wrong.

Review-level evidence suggests that interventions that used telephone support and follow-up are also associated with long-term behaviour change.

Interventions that provide support and follow-up are also associated with changes in physical activity and include:-

- telephone and written contact and support
- computer-generated feedback and messages
- informal group meetings and events
- use of exercise log books.

Exit strategies from intervention

Have planned exit routes in place for participants at the start of the intervention. Once participants have been engaged in physical activity through a specific intervention, such as an exercise class or motivational interviewing and referral from a health practitioner, there is a need to have in place exit programmes/support and options available and agreed with other partners. Such opportunities accommodate a desire for a change in activity or a new interest as well as providing continuity and progression to an activity at a more appropriate level where desired. The opportunity to access choices is also identified as a component of effective practice.

Monitoring and support through change

Ensure that there are systems in place to monitor the progress of a programme. These will help partners review the progress of a programme and respond to changes and setbacks, eg, changes in roles or personnel. They will also identify additional training and capacity building that may be required as a programme matures.

Planning for evaluation and data collection

Establish how the success of the intervention will be measured at the outset, and identify existing mechanisms or put in place the necessary monitoring and evaluation framework. Physical activity programmes for older people are planned and implemented by a range of different partner organizations, eg, a charity, a health promotion agency, a local authority department and an older people's group. Although working together, there may be different points of view about what is important about the project, and this will influence how they view the purpose of the evaluation and what they want to find out from it.

Many interventions rely on data capture from participants to demonstrate success which can be difficult and time consuming. Depending on the measures of success selected and the robustness of the data required, additional expertise may need to be brought in to set up or manage the monitoring and evaluation process.

There is a need to distinguish between formative evaluation, designed to improve future programme development, and summative evaluation, designed to evaluate the effectiveness of the programme.

There is a difference between evaluation and research. Research is expensive, will require additional expertise and probably not required for most programmes.

Avoid research and evaluation methods that may become intrusive; participants may worry about having data recorded about their activities.

Programme sustainability

Develop a guide to survival. Ensure that there is sufficient time given over to strengthening programmes and finding exit routes so that they can make the change from pilot to mainstream provision and services. This may include:

- developing and communicating understanding and recognition among programme stakeholders
- communicating evaluation findings with programme partners and stakeholders
- positioning for new opportunities for further programme development with new partner agencies
- understanding the nature of each other's planning processes and strategic fit to policies
- ensuring continuity of leadership, and why programmes stop when someone leaves – do people make things happen, not the agenda?

References

The full references for this working paper are contained in the BHF National Centre For Physical Activity and Health Guidelines on Physical Activity for Older People. They have been omitted from this paper to permit ease of reading.

WORKING PAPER 5

ONE-TO-ONE INTERVENTIONS – RECOMMENDATIONS FOR PRACTICE

Introduction

This working paper highlights one area drawn from the Guidelines on Promoting Physical Activity with Older People drafted by the British Heart Foundation National Centre for Physical Activity and Health.

The guidelines were drawn from recent published reviews of effectiveness of physical activity interventions together with other published articles and guidelines in addition to learning from current professional experiences eg, the Local Exercise Action Pilot programmes.

In summarising the learning from these sources of evidence, the guidance highlights recommendations and **components of good practice** that can be used in planning interventions at three levels:

- **Population wide interventions,** eg, environmental and policy interventions, campaigning and promotion.

Click here to go to Working paper 3.

- **Community/locality based interventions,** eg, facility-based programmes, area-based physical activity projects and activity/participation events.

Click here to go to Working paper 4.

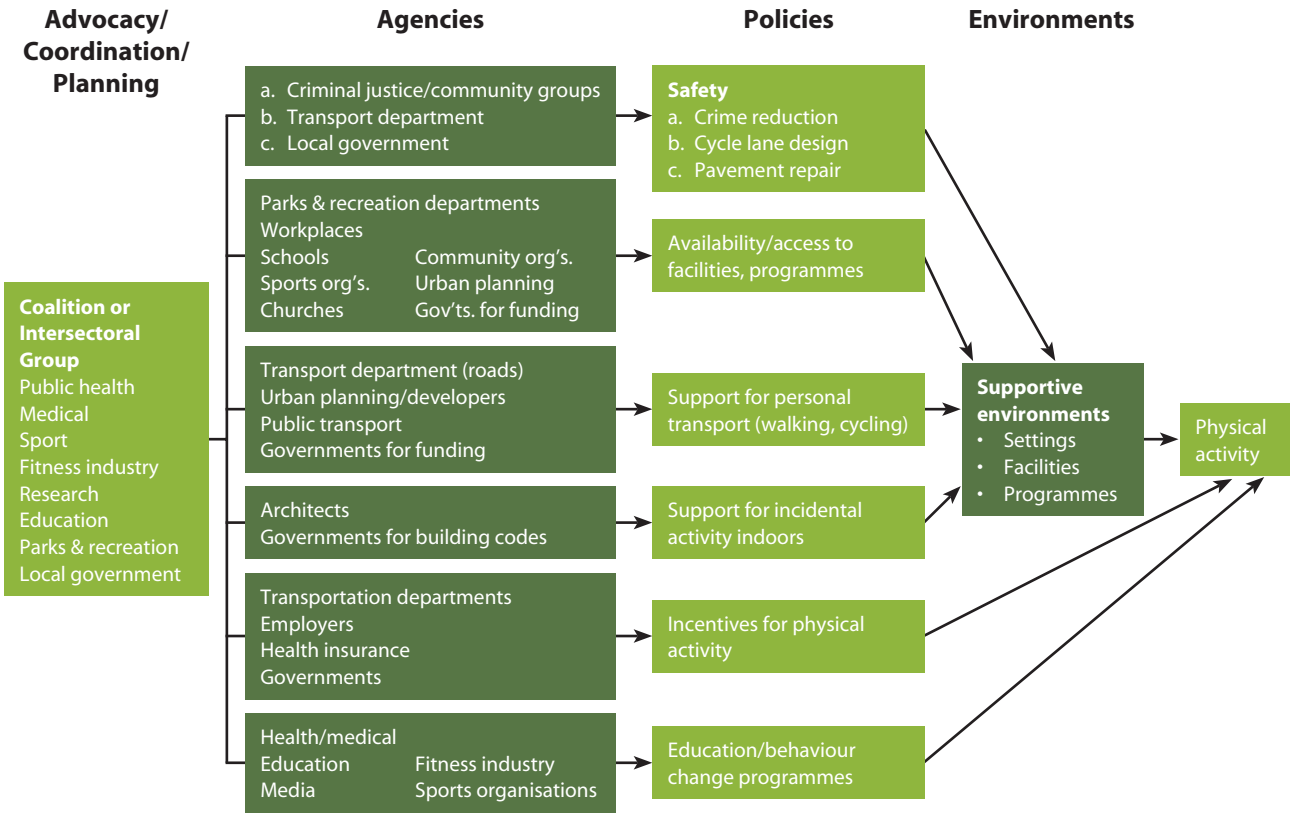
- **One-to-one interventions,** eg, lifestyle counselling and advice.

In addition, the guidelines offer an outline of best practice in:

- **Physical activity and exercise programme planning,** eg, for those leading and instructing groups involved in a range of activities eg, walking, tai chi, music and movement classes and chair based exercise.

Click here to go to Working paper 9.

Sociological model of healthy ageing (Sallis et 1998)



Introduction

There are many different opportunities for an intervention where advice may be helpful eg, different life stages and 'triggers' events. For the older person, these may include:

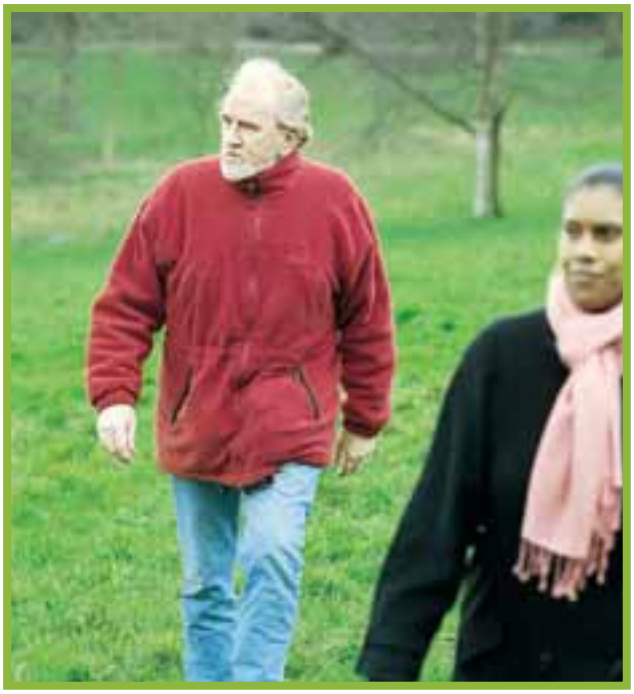
Retirement, empty nesting as the children leave home, moving house, moving into a residential, care or nursing setting, the onset of illness or disease associated with ageing, such as arthritis or type 2 diabetes, a specific acute event, such as a heart attack or accidental fall as well as opportunities provided through primary care.

A range of people may be in a position to provide such advice for a range of reasons eg, practice nurses and GPs, senior health mentors on befriending schemes, providers of day care centres, managers of sheltered and supported living schemes, health and care professionals in residential care and nursing homes, and community health practitioners such as community physiotherapists or community nurses.

Advice may be offered in a variety of ways including:

Planned and structured counselling and lifestyle advice programmes, referrals and recommendations provided within a health or care setting and informal visiting and befriending schemes.

One-to-one interventions – with older people



Recommendations for practice – summary

Use of a health educator and an extended consultation time.

Assessment of problem areas.

Recognition of readiness to change.

Goals agreed by both the older person and the professional.

Identification and recognition of social and environmental barriers.

A tailored action plan which specifies activity.

A choice and range of accessible local activities including lifestyle activities.

Supplementary educational materials.

Systematic follow-up and support over a period of time.

Detail of components of good practice for one-to-one interventions with older people

1. **Employ the use of a health educator and use an extended consultation time.**

   GPs are seen as authoritative sources of information by older people and advice from a GP (both negative and positive) is seen as being significant and important.

   Primary care interventions involving brief counselling in the general adult population do promote modest short-term increases in physical activity, including those incorporating physical activity specific advice, those tailored to patient characteristics and preferences, and the provision of supplementary materials. Short-term improvements can also be achieved by other professionals, including nurses and other health educators.

   Long-term increases in physical activity are not guaranteed from primary health care interventions among adults. Although GPs see a large number of older people, a number of factors mean that they might not have time or the opportunity to promote physical activity among older people:

   GPs are under increasing pressure to see large numbers of patients in time-limited opportunities for advice and intervention.

   They have to follow an increasing number of specific disease-based protocols and guidelines.

   Studies suggest that older people see 'someone like us' – someone of a similar age, an 'ordinary' person and perhaps someone of the same sex – as being the sort of person who should promote physical activity. The person should also have an understanding of the barriers and problems that physical activity could present to older people.

2. **Use extended consultation time.**

   There is evidence that brief counselling interventions are effective with adult populations.

   It has been suggested that more intensive interventions may be required due to the potentially long-standing sedentary behaviour of older people, the added barriers to physical activity specific to older people, and the greater prevalence of specific conditions and diseases among this group.

   Successful interventions have involved an initial 20-40 minute face-to-face session with a health educator.

ONE-TO-ONE INTERVENTIONS – RECOMMENDATIONS FOR PRACTICE (CONTINUED)

3. **Assess the potential problem areas.**

   Assessment of problem areas together with collaborative identification of goals between patient and staff, creation of a tailored action plan and systematic follow-up support (see below) have been suggested as the starting point of a sequence of activities for addressing health behaviour change among older people.

4. **Assess readiness to change of potential participants.**

   A variety of models are currently used to assess the readiness to change of potential participants of physical activity programmes.

   Those older people with the poorest health are most likely to visit their GP, but may be most resistant to change. The 50 per cent of those older people who are inactive are least likely to respond to a GP and may require a different type of intervention (eg, a peer health mentor scheme).

   Interventions might be more effectively aimed at semi-active older people who seem positively disposed to participating but need help to get started or to stay involved.

   Critical to working with people attempting to change their behaviour is an understanding of 'stage matching' to increase the likelihood that a person will successfully move through the stages of change. (Stage matching is when different intervention processes are adopted for each 'stage of change'.)

5. **Agreement on programme goals by both the older person and the professional .**

   Goals for physical activity may be very varied and include sustained mobility and independence, playing with grandchildren, and broader social outcomes as well as improved health.

   A mismatch between participants' and advisors' expectations is likely to result in disappointment and a reluctance to continue with change strategies.

6. **Identify and recognise social and environmental barriers to physical activity.**

   Finding out what triggers older people to try a physical activity programme is likely to open up a discussion about their beliefs about locus of control, the values they hold for certain types of activities, worries about risks, thoughts about personal capabilities, and the challenges involved in getting started.

7. **Draw up a tailored action plan which specifies activity.**

   Older people require clear messages about how much physical activity is beneficial for their health, but they also need reassurance that they are unlikely to over-exert themselves. For many older people, the concepts of physical activity and exercise are problematic and are associated with either 'drill' (especially among the oldest age groups), or with fashionable exercise such as aerobics or gym or health club based activities).

   Any physical activity prescription needs to be flexible to take account of the participant's psychological readiness to change, personal goals, current activity and health status, and their personal preferences.

   Developing a personal physical activity programme that takes into account health, preferences, ability and other factors increases levels of physical activity among older people.

8. **Ensure a choice and range of accessible local activities, including lifestyle activities.**

   There is conflicting evidence on whether older people prefer group or individual physical activity programmes. The social benefits of physical activity are an important factor for many older people.

   Home-based programmes with telephone-based counselling have been particularly effective in facilitating high programme participation, exercise adoption and programme adherence. However, group-based activities may be preferred, and the importance of social support has been demonstrated consistently.

   An increase in the number and breadth of physical activity classes and facilities for older people is a key element of programme effectiveness. Programmes that promote everyday lifestyle activities, like walking and cycling, are also effective.

ONE-TO-ONE INTERVENTIONS – RECOMMENDATIONS FOR PRACTICE (CONTINUED)

9. **Provide supplementary educational materials.**

   Having some sort of immediate support including targeted or tailored written materials that support the action plan, especially when new behaviours are difficult to sustain, is seen as valuable by participants.

   Other strategies should include providing educational materials on physical activity in languages and formats to reach all populations of older people eg, minority ethnic groups, and providing information on local physical activity resources and opportunities that are appropriate for older people.

10. **Ensure that support strategies are in place.**

    Ensure that there is systematic follow-up and support over a period of time, as the majority of studies on exercise and older people fail to demonstrate long-term maintenance (12 months or more) of initial gains. There needs to be a greater focus on sustaining behaviour change, long-term outcomes and maintaining initial gains.

    Social support is associated with positive changes in exercise behaviour, but many older people who live alone may lack the support of friends or family.

    Ongoing telephone contact appears to be an important component and is supported by a large literature on the efficacy of telephone-based health behaviour interventions. Other successful strategies have included newsletters.

    In supervised exercise programmes, the interpersonal skills of the exercise practitioner in providing technical support, supervision and attention are also important.

Summary – implications for practice

The model described above requires:

- a process-based intervention to help older people to become more active
- educating a range of people with the potential to work with and advise older people on physical activity
- investing more resources (time and people) to educate older people, help them understand the choices and opportunities that are
- the provision of longer-term support to sustain behaviour change
- an understanding of the recommendations for older people – types of physical activity, frequency and intensity – and how they can be translated into achievable targets
- an understanding of the barriers to activity that older people encounter and communication skills to reassure and motivate older people
- an understanding of older people's individual preferences and choices in physical activity opportunities
- knowledge of local opportunities for a range of activities appropriate for older people
- strategies to provide ongoing support to sustain behavioural change among older people.

References

The full references for this working paper are contained in the BHF National Centre For Physical Activity and Health Guidelines on Physical Activity for Older People. They have been omitted from this paper to permit ease of reading.

CHECK LIST FOR ONE-TO-ONE INTERVENTIONS

Component	Identify	Other information
Use of a health educator and an extended consultation time		
Assessment of problem areas		
Recognition of readiness to change		
Goals agreed by both the older person and the professional		
Identification and recognition of social and environmental barriers		
Tailored action plan which specifies activity		
A choice and range of accessible local activities including lifestyle activities		
Supplementary educational materials		
Systematic follow-up and support over a period of time		

WORKING PAPER 6

PROGRAMME EVALUATION

Who is this for?

This working paper has been designed to help you evaluate your physical activity programme with older people. It describes a step by step process designed to assist you in the planning, implementation and analysis of your evaluation activities.

In it, you will find a series of questions which will help you make decisions about the purpose and design of your evaluation and ensure that once completed, you will have sufficient information to be able to demonstrate to all those involved, how successful your project has been and the lessons you have learned.

What is evaluation?

Evaluation is an activity that we all undertake every day. We make choices about what clothes to wear, what food to eat and what to spend money on. We decide which is the best way to go to the town centre – by car, by bus or walking. We make these choices based on a judgement, or 'an evaluation'. This evaluation is based on our experiences, knowledge and abilities. We know what foods we like to eat and those we don't.

"Programme evaluation is the systematic collection, analysis and reporting of information about a programme to assist in decision making." (Ontario).

"The systematic examination and assessment of features of an initiative and its effects, in order to produce information that can be used by those who have an interest in its improvement or effectiveness." (WHO).

Project evaluation has a broad meaning and is often defined according to the setting in which it is used.

Common features of evaluation

Regardless of the definition used, programme evaluation involves the collection of information that will help programme planners improve the effectiveness of the programme. Project evaluation differs from research in that its primary aim is not to add to a body of knowledge but to learn how to improve a programme.

PROGRAMME EVALUATION (CONTINUED)

Defining the process and steps

To help you evaluate your programme, the activities that are required have been broken down into a sequential step by step approach.

STEP 1. Plan for evaluation

STEP 2. Engage stakeholders and partners

STEP 3. Identify and access resources

STEP 4. Design and plan the evaluation

STEP 5. Determine methods of assessment

STEP 6. Develop plan and timetable

STEP 7. Collect data, record and process credible evidence

STEP 8. Process and analyse data

STEP 9. Justify conclusions

STEP 10. Take action on results. And share lessons and learning

A series of checklists and examples are included to assist you in asking important questions and making decisions about your project evaluation.

The amount of time you need to spend on each step will vary according to the purpose and design of your evaluation and in particular will be affected by the range of project partners and amount of information you need to collect.

Your evaluation planning will also reflect the scope of the programme. A programme to increase participation at a local day centre may involve a small number of people and a limited number of questions and amount of evaluation activity. A programme in a residential care setting may require a larger number of evaluation questions with many indicators and sources of information.

STEP 1. Planning for evaluation

Clarify the purpose of your evaluation

Physical activity projects for older people should be evaluated to reflect on progress, to see where you are going and where you've come from, share what you've learned with colleagues and partners and improve our programmes.

Specifically, evaluation will enable you to:-

- collect evidence on the effectiveness and impact of your programme
- ensure accountability to your stakeholders and partners, participants, volunteers, staff or community
- identify ways to improve your programme eg, determining what works and what doesn't, assessing the needs of the target population, improving usefulness of programme materials
- compare your programme with other programmes
- assess the efficiency of your programme (cost benefit analysis)
- influence policy makers to ensure funding and sustainability.

You may want your evaluation to achieve many of these purposes but **it is important that you are clear about the purpose of your evaluation** and that it's design provides the information you need to achieve these purposes.

Evaluating effectiveness

Sometimes you may be expected by an organisation or funder to show if your programme is 'effective'. Finding out if a project is effective means comparing your programmes's participants with another group of people who are not participating in your project. So you need two sets of participants to accurately measure a difference between the groups. To demonstrate effectiveness may therefore be very expensive, complicated, time-consuming and will require specialist help. **Project evaluations, unless they are large budget outcome evaluations, are unlikely to be able to demonstrate effectiveness.**

Research

Evaluation is sometimes confused with research. The two can be very different activities. Research can also be expensive, requires rigorous methodology and aims to be widely generalisable. The results of evaluations are only generalisable to similar projects. **Undertaking research Is very ambitious and is not the same as evaluation.**

Describe or plan the project

Evaluation should be an integral part of project management and should occur during all phases of a programme. All project plans should describe how and when evaluation will take place.

Ensure that you start with a clear view of your project, it's aims and objectives and what it hopes to achieve.

A programme ready to be evaluated must have:

- clearly defined goals and objectives
- clearly specified success indicators and outcomes
- clearly defined audience and targets
- an organisational structure that can support the collection of information.

Defining goals and objectives

A **GOAL** is a purpose or mission – what you wish to achieve.

Objectives are specific, measurable outcomes which will lead to the goal.

The next step is to decide what questions or questions you want to ask of your project **(evaluation questions)** and then identify the measures that will indicate how successful your project has been. These measures are called **outcome measures**.

The importance of agreeing the aims and objectives of the programme has already been emphasised. This will help you to agree on the evaluation questions because it is usually possible to translate aims or objectives into evaluation questions. Some examples of how programme aims or objectives can be linked to evaluation questions and the possible outcome measures are given on the next page.

Sample project objectives, evaluation questions and possible outcome measures

Aim/objective of project	Evaluation question	Possible outcome measures
To increase participation in physical activity by older people.	Are more older people participating in physical activity? What sorts of physical activity are older people taking part in?	The number of a targeted group, eg, within a particular locality or neighbourhood that are regularly participating in physical activity as a result of the project. The number of older people involved in walking or cycling to work. The number of new recruits to a local sports club.
A partnership involving different organisations and groups in developing the skills of older mentors may suggest different evaluation questions and outcome measures. For example:		
To train mentors to encourage other older people to become more active.	Do mentors know more about physical activity? Are mentors sufficiently confident to undertake mentoring? Have mentors been successful in reaching other older people? Have those older people visited become more active?	Increased understanding and knowledge of components of fitness, physical activity recommendations and local opportunities to be active. Number of visits undertaken by mentors. Numbers of older people visited by mentors. Mentors' reports of those taking up physical activity.

Who is the population of interest?

If (as is most likely) you intend to conduct evaluation activities involving older people you will need to consider how you will do this.

- what are their demographics (age, gender, ethnicity)?
- where do they live?
- what is the best way to reach them?
- are they all similar or are there unique differences?
- are there specific target groups of older people?
- what methods will I use?

Are there specific procedural (eg, permission, supervision, confidentiality) or ethical issues relating to older people that your evaluation needs to consider?

Who is responsible for evaluation?

Responsibility should be agreed upon at the beginning of the evaluation. Many people from different organisations may be involved in the evaluation and be responsible for different activities. But one person should be responsible for the overall management of the evaluation.

Check list 1. To summarise planning for evaluation

Name of project

What is the purpose or goal of the project?

Brief description of the project

What are the project objectives?

1

2

3

4

5

What is the purpose of the evaluation?

Who is responsible for managing the project evaluation?

STEP 2. Engage stakeholder and partners

Particularly with multi-agency partnership projects, you will need to discuss the evaluation of the project with all those concerned.

Many progarmmes for older people are put together by a range of different organizations eg, a health promotion organisation, a local authority sports development department, local day care centres, a training provider and a group of older people. Although these organisations are all working together to develop and deliver a project, there may be different points of view about what is important about the programme, and this will influence how they view the purpose of the evaluation and what they want to find out about it.

For example:

- the health promotion organisation may be involved because they want to do something about improving older people's health
- the local authority sports development department may be involved because they want to improve their services for older people and want the programme to help them find out how they could do this
- day care centres might want the programme to help develop the knowledge and experience of their health and care workers
- the older people's group might want the programme to provide specific types of activities or provide transport.

The differences these reasons may not seem significant; however, each organisation will have a different perspective about evaluating a project.

Be clear about who the stakeholders and partners are.

These people and organisations will have a vested interest in a programme and the future use of the evaluation results.

They may include:

- those implementing the programme
- partners who are actively supporting the programme
- participants who are affected by the programme
- decision makers in a position to do something about the programme.

Discuss the evaluation with these people so that you are clear about:

- what are their interests in the programme?
- what do they want from the evaluation?
- what do they want to know about the programme activities, initial and longer term outcomes?
- will they be expected to undertake some of the evaluation?
- how rigorous do they expect the results to be?
- is there the potential for disagreement about the evaluation?
- can you agree on priorities?

Who are the stakeholders, what are their interests and priorities?

Name of project _____

Partners	Named contact	Interest and expectations	Priority questions
Experts			
Funders			
Health promotion			
Interest groups			
Local authority			
Media			
Carers			
People involved in similar issues			
Policy makers			
Project director			
Project participants			
Project staff			
Politicians			
Exercise teachers			
Volunteers			

STEP 3. Identify and access resources

Ask yourself – what resources do you and partners have available for evaluation?

Carrying out your evaluation will require resources – money, time and skills – and people to do it. Nearly all programmes have a budget. Part of that budget should be ear-marked for evaluation, for example to use for evaluation training, or to pay someone to collect information, or to store and analyse this information. Evaluation does not need to be expensive but evaluation should take up at least 10 per cent of the budget for any new health promotion project. (World Health Organization, 1998).

You can obtain relevant and helpful information from a variety of evaluation activities. But since evaluation can become expensive and time consuming, what you can do is often limited by resources. If this step is missed out you risk starting an evaluation you can't finish as time or money runs out.

The following check list will help you consider potential evaluation resources.

Area	Questions	Answers
Budget	How much money is allocated for evaluation?	
Staff	How many staff are available to assist? Do they need to be trained? Can volunteers be trained to assist?	
Equipment	What equipment will you use to collect, store and analyse information?	
Partner organisations	Are they willing to provide resources or staff for evaluation activities?	
Time	Do you need to test or pilot the evaluation activities? How much time do you have to gather the information? How much time can you give to the evaluation?	
Responsibility	Who is responsible for the evaluation? Do they have sufficient time and expertise?	
Expertise	Is there access to specific expertise to plan and support the evaluation?	
Anticipating demands	Have you and your partners anticipated all the resource implications of your proposed evaluation?	

STEP 4. Design and plan the evaluation

What type of evaluation will you be using?

There are two main types of evaluation: **outcome evaluation** and **process evaluation.**

- The aim of an **outcome evaluation** is to see **whether** a programme meets its aims and objectives, eg, was there an increase in the number of older people taking part in a particular activity or walking to work?
- The aim of a **process evaluation** is to see **why or how** the project meets or does not meet its aims and objectives eg, what training was provided for local sports leaders and coaches or what new partnerships were developed to promote walking to work?

Outcome and process evaluations therefore seek to answer different types of question about a programme. Neither type of evaluation is superior; the two are complementary. Often an evaluation will seek to answer questions about both outcome and process.

Outcome or process evaluation can be **formative** or **summative.**

Formative evaluations are most useful at the development stage of a project. They start and finish while the programme is going on and aim to help inform the direction the programme takes, eg, pre-testing involves trying out some of the parts of the programme before the full-scale project gets underway eg, an audit of local 50+ opportunities.

Summative evaluations are completed after the main activity of the programme is over. They aim to inform the direction of future programmes. However, they need to be planned when a programme is just starting eg, summarising the results of a family activity programme to disseminate to other potential providers.

Who should undertake the evaluation?

Determine if you have the expertise and resources to undertake your own evaluation. If you are fortunate to have sufficient resources you may be able to involve an external agency eg, a local university sport and exercise science department.

Internal and external evaluations both have strengths and weakness.

External evaluation:

- is not personally involved and may offer a "fresh look" at the project
- remains outside the politics and power structure of the project
- will be trained and experienced in evaluation
- will have the time to focus upon the evaluation
- but may not fully "understand" the programme.

Internal evaluation:

- may find it difficult to retain objectivity and clarity
- may be motivated by hopes of gain and desire for success
- lack the necessary skills and experience
- but is unlikely to threaten the programme or participants.

What timescale is attached to the evaluation?

Are there critical times, events and opportunities to undertake evaluation? eg, a one-off activity festival, at the end of a course for senior exercise teachers?

Do funders or other stakeholders have their own timescale for the completion of than evaluation eg, the end of a financial year or specific programme funding?

Is there sufficient time for analysis of findings, sharing with partners and completion of reports and dissemination activity?

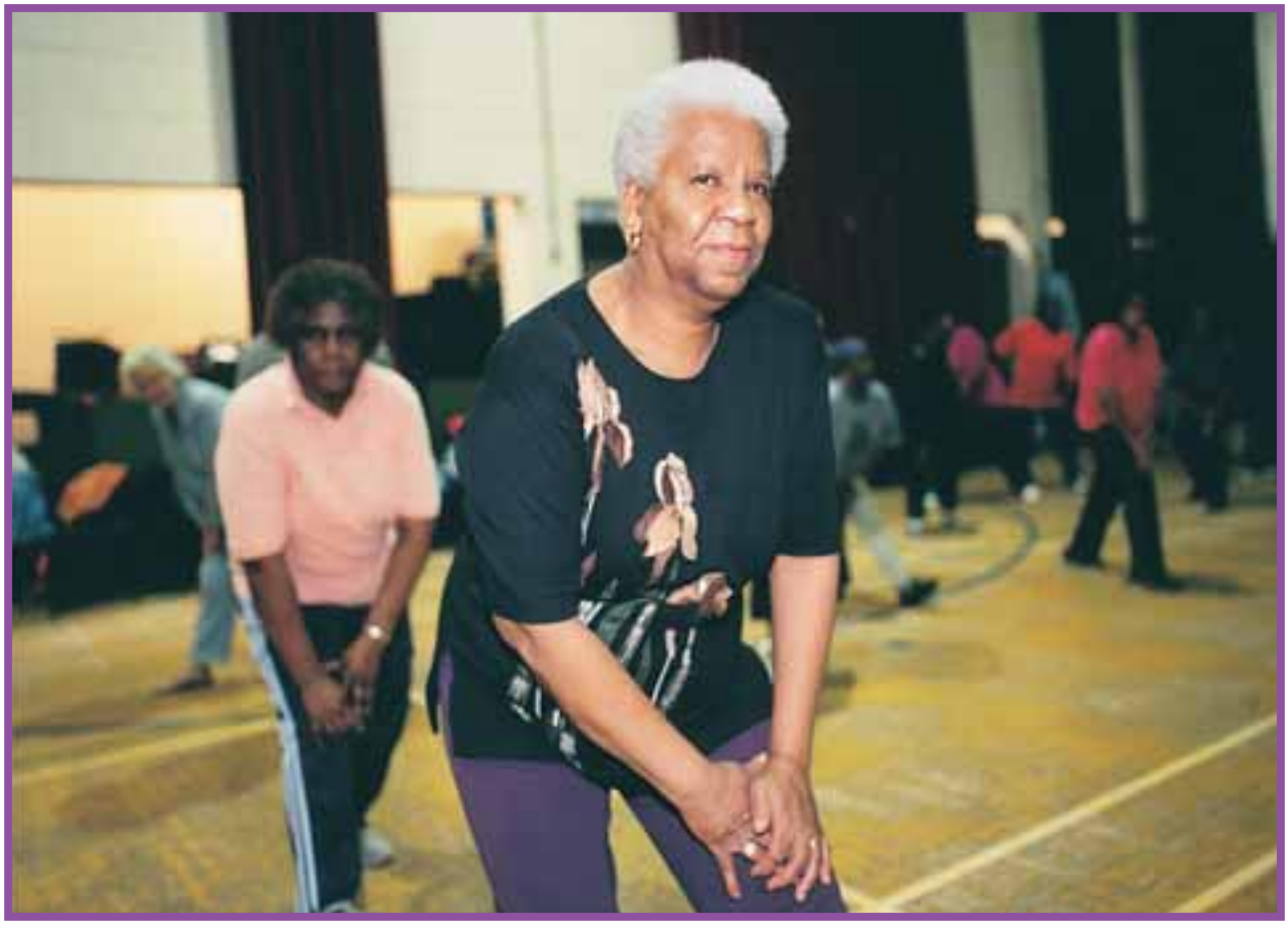
Evaluation – making sure it is not intrusive

One of the major lessons from the LEAP programme is that robust and detailed evaluation can become intrusive. Participants may be unwilling to be involved; they may have concerns over the questions being asked, the storage of information, the confidentiality, who will receive the results and what use will be made of them.

Evaluation priorities – how much can you evaluate?

Deciding on evaluation questions is an important task. Sometimes, scarce resources mean that not every part of a project can be evaluated. So decisions will need to be made about priorities and which part of the project should be evaluated. Discussions with other partners in the project, and participants, will reveal their expectations and priorities.

This check list will help you focus upon your programme priorities.



Check list – evaluation priorities

Name of project

1. What is the purpose of the evaluation?

2. List all the potential uses for the evaluation results (be as specific as possible)

3. Identify whether a process or outcome evaluation (or a combination) is most appropriate for your project

4. List all potential evaluation questions

5. Return to questions 2 and 4 and put a star beside the uses and evaluation questions that you think are most important and useful to project partners

STEP 5. Determine methods of assessment

In step 1, you considered your project objectives, evaluation questions and possible outcome measures. You now need to consider the methods of measurement and sources of information that can be used. (This example is from a walking for health project.)

Aims of project	Project objectives	Evaluation questions	Possible outcome measures	Data sources
To increase the number of independently living older people who walk to the shops	To develop safe walking routes to local shopping centres	Have older people used these routes? Have older people's attitudes towards walking changed?	Number of days walked in past week Changes in older people's attitudes towards walking to school	Surveys of older people before and after project
	To remove barriers to walking for older people and their carers	What are the barriers to walking and have they been removed?	Description of original barriers to walking	Walkability surveys Participant and volunteer interviews
	To develop partnerships including carers, roads safety officials and shops	How many partners have contributed towards this project?	Numbers of partners involved Description of contribution to project	Records of attendance and contribution to project planning meetings
	To promote and publicise walking routes in local areas	Are older people aware of the project?	Numbers of older people showing understanding	House and street survey Local meetings

What methods should be used to collect the information?

There is a wide range of methods of collecting information which will contribute towards evaluation, including questionnaires (written or oral), interviews, group discussions/focus groups, diaries as well as more formal assessments of fitness and functional capacity, or other methods of recording such as casework. Each of these methods has advantages and limitations.

Qualitative and quantitative methods

Qualitative methods of evaluation:

- provide in-depth information
- are not always generalisable to entire population
- provide language, context and ideas
- are "deep".

And may include:

- focus groups
- in depth interviews
- open ended survey questions
- diaries
- forms discussion groups.

Quantitative methods of evaluation:

- require structured data collection
- provide results that are quantifiable and generalisable
- provide width.

And may include:

- mail or telephone surveys
- records of service usage
- analysis of large datasets
- measures of indicators and behaviours.

It is important to choose methods which are suitable for collecting the information you require and are appropriate for older people.

For example, using one-to-one interviews may be time consuming and difficult when collecting information from large numbers of older people, but better for those with limited communication abilities. Group discussions may not be appropriate for assessing feelings and changes in behaviour but may help when a wide range of views is required or time is limited. Assessment of fitness and functional capacity are very time consuming and expensive and require expertise.

The following tables provide an assessment of the relative merits of different methods of evaluation.

Qualitative methods

Type	Description	Applications	Strengths	Limitations
Focus groups	Semi-structured discussion (8-12 people) Lead by facilitator who follows an outline and manages group dynamics Proceedings are recorded	To gather in-depth information from small number of stakeholders Pre-test materials with target audience To develop better understanding of attitudes, opinions and language Often used to prepare larger survey	Provides in-depth information Implementation and analysis requires minimum of specialised skills Can be inexpensive to implement	Participants may influence each other Subjective Potential for factor bias Can be difficult to analyse Results are not quantifiable to a population
In-depth interviews	Telephone or in-person one-to-one interviews Interviewer follows an outline but has flexibility Usually 10 -40 per type of respondent	To investigate sensitive issues with small numbers of people To develop better understanding of attitudes, opinions and language	Provides a confidential environment Eliminates peer influence Opportunity to explore unexpected issues More detailed information than focus group	More expensive to implement and analyse than focus groups Potential for interviewer bias Can be difficult to analyse Results are not usually quantifiable to the population
Open ended survey questions	Structure questions on a telephone or mail survey that allow respondent to provide a complete answer in their own words	To add depth to survey results To further explore the reasons for answers to closed questions For exploratory questions	Can provide depth with the potential to be quantified Adds depth to qualitative data Generalisable to the population	Time consuming to analyse properly Adds considerable time to survey Not flexible
Diaries	Detailed account of aspects of your programme Ongoing documentation by one or more of participants	Used primarily for process evaluation	Puts other evaluation results in context Captures information you may not have thought of Very inexpensive to collect	Can be difficult or expensive to analyse Observations are subjective

Source: The Health Communication Unit at the Centre for Health Promotion, University of Toronto.
www.utoronto.ca/chp/hcu/

Quantitative methods

Type	Description	Applications	Strengths	Limitations
Surveys	Completion of structured questionnaire with many participants within a relatively short space of time Can be completed by telephone, mail or in-person	To collect feedback that is quantifiable and generalisable to entire population	Results are generalisable to an entire population Standardised, structured questionnaire minimises interviewer bias Large volume of information can be collected in a short space of time	Rarely provides comprehensive understanding of respondent's perspective Can be very expensive Requires some statistical knowledge and other skills to process and interpret results
Process tracking forms or records	Collection of process measures in a standardised manner Usually incorporated into a project outline	To document the progress of a project To identify areas for improvement	Can be incorporated into routine Fairly straight forward to design and use Can provide very accurate detailed process information	Can be seen as an extra burden on staff or volunteers in project Risk that they will not always be completed accurately or regularly
Large data sets	Accessing existing resources of research data for information about your target group	To position project within a broader context To monitor trends in your target group	Can be inexpensive or free to access information Provides accurate, well researched information Can lead to networking and information sharing opportunities	Minimum usefulness for evaluating your project Can be difficult to relate to your project

Source: The Health Communication Unit at the Centre for Health Promotion, University of Toronto.
www.utoronto.ca/chp/hcu/

Suitability of different methods of collecting information

	Written questionnaire	Oral questionnaire	Interview (one-to-one)	Group discussion	Case study
Large numbers of people involved	**Suitable**	Possible	*Not suitable*	Possible (series)	Possible
Small numbers of people involved	**Suitable**	**Suitable**	**Suitable**	Possible	**Suitable**
Limited time available	Possible	Possible	*Not suitable*	**Suitable**	*Not suitable*
Limited resources	**Suitable**	*Not suitable*	*Not suitable*	**Suitable**	*Not suitable*
Limited communication skills	*Not suitable*	**Suitable**	**Suitable**	Possible	*Not suitable*
Dispersed target population	**Suitable**	*Not suitable*	Possible (by telephone)	*Not suitable*	**Suitable**
Need a wide range of views	Possible	Possible	*Not suitable*	**Suitable**	*Not suitable*
Need a very accurate response	*Not suitable*	Possible	**Suitable**	*Not suitable*	*Not suitable*
Discuss feelings, changes	Possible	**Suitable**	**Suitable**	*Not suitable*	**Suitable**
People suspicious of outsiders	*Not suitable*	**Suitable**	*Not suitable*	**Suitable**	**Suitable**

Source: Adapted from Monitoring and Evaluation Made Easy. A Handbook for Voluntary Organisations By A Connor. Published by HMSO, London, 1993.

Guidance on evaluation tools

Once you have decided on the methods of assessment, you should then consider what measurement tools you will use.

- select or develop your tools in collaboration with partners and those who will use them
- use an exiting tool, if one is available, that is appropriate for your target group and evaluation questions
- keep them as short and simple as possible
- collect the information that you need to know and avoid the "nice to know" information
- use the language of the group (eg, older people, carers, volunteers, coaches) who will be providing information
- for tools requiring written responses
  - use large print
  - avoid putting too much information on one page
  - leave lots of white spaces
  - be specific and direct as possible with your questions
  - provide enough room for written responses
- use a format which is easy to read and complete
- pilot test your tools with the group.

Decisions on sampling

You may not have sufficient resources to involve everyone in the project in the evaluation activities. Sampling can be used to reduce costs while still obtaining a representative sample of the population group. But it is essential that the number of individuals providing information for the evaluation be large enough to produce results that are reliable and represent the target group. Regardless of the method of measurement, you will need to decide how many older people will be included and how they will be selected.

STEP 6. Develop plan and timetable

Conducting evaluation takes time and requires resources that are easily overlooked or not always immediately recognisable. It is essential that you include specific evaluation activities and steps in your overall project plan.

You will need an evaluation plan that includes details of the timing and development of:

- evaluation design
- measurement methods
- pilot testing and revising measurement methods if required
- collecting and processing data
- analysing the data and findings
- writing the evaluation report
- disseminating results to those involved

Using an evaluation plan will help you to organise your evaluation and make sure that all steps and activities are considered and included in your overall project plan.

Have you assessed the skills and experience of those involved?

Is training required for those staff involved?

Will you be using volunteers or students?

(Volunteers and students may be able to contribute to your evaluation, but if they are not properly trained or do not have sufficient commitment to the project, their use could backfire on you).

Do you have sufficient in-house resources?

(Skills, availability and interest of staff, hard and software)

If not will your budget allow you to make use of external agencies? (eg, local university department)

STEP 7. Collect data, record and process credible evidence

Collecting data

Ensure that those involved in collecting information are trained in the appropriate data collection procedures.

Prepare data collection forms in a format that is easy for people to complete and that is also easy to analyse at a later date.

Monitor, support and encourage those undertaking data collection (it can be frustrating and boring at times).

Check that the information you need is being collected.

Are you on time for completing your evaluation?

When collecting qualitative data, be sure that those providing information write neatly and in complete sentences as much as possible.

Recording data

Audio tape interviews and focus group discussions (consent to record information should be obtained).

Where possible, computerise data collection to make it easier for participants and easier to share and analyse results.

Processing data

Processing the data involves preparing and translating the data for analysis. It involves taking the completed information (databases, questionnaires, forms or transcripts) and putting them into a format that can be summarised and interpreted.

Statistical data can be entered into most spreadsheet packages like Microsoft Excel.

STEP 8. Analyse information and draw conclusions

Once you have completed the collection of all the information, you can begin to analyse the information and draw conclusions.

Your analysis should help you answer your original evaluation questions.

Analysing the results is one of the most crucial steps in getting useful findings that accurately reflect the opinions and views of the participants involved.

If you are using large amounts of information, or complex information, ensure that you have access to specific expertise in analysing such information.

The results of focus group or in-depth interviews should be interpreted carefully. Look for trends and patterns in participant's perceptions rather than using a "he said .. she said" analysis.

Are your results similar to what you expected and are there unexpected results from your project?

Keep your original evaluation questions in mind, organising your information by the original questions and use the results to answer those questions.

Involve partners in the understanding and interpretation of findings and conclusions.

STEP 9. Present findings and conclusions

Keep your audience in mind when preparing a summary report, ask yourself what do they need and want to know?

Consider and be honest about the possible limitations of your evaluation eg, you were not able to evaluate every part of the project.

It is easy to be overwhelmed with too much information. Focus on the evaluation questions and only present information that answers those questions.

When presenting and sharing results, choose a format that highlights the key results.

If you are using large amounts of information use tables and charts to present results. Use written descriptions to highlight the important information in the charts.

Partners needs and interests (eg, funders, staff, politicians) as well as participants should be considered in deciding the most appropriate way to communicate the information to them.

How do you plan to communicate unfavourable results and their possible causes? eg, a local sports club which is disappointed in a low response from older people?

Communicating your evaluation findings to all those involved is an important step. It is important that the results are communicated adequately so that action can be taken upon results.

Involve older people in sharing the learning from the project evaluation – their experiences are the most important.

STEP 10. Take action on results

Take action to implement changes and improve your project

(Taking action here refers to implementing the changes your evaluation results suggest).

Write a list of recommended actions that address the findings of your evaluation.

Communicate these actions to all concerned in the project.

Prioritise those changes which are most important and feasible to implement.

Find ways of persuading project partners to act upon recommendations.

Set up an action plan to implement the recommended changes.

- be clear about the purpose of your evaluation and ensure that it's design provides the information you need to answer your questions
- the evaluation plan should be agreed upon by all concerned at the beginning of the project
- one person should be responsible for the overall management of the evaluation process
- ensure that there are sufficient resources allocated to complete the evaluation
- choose evaluation methods which are suitable for collecting the information you require and are appropriate for older people
- it is essential that you include specific evaluation activities and steps in your overall project plan
- assess the skills and experience of all those involved
- ensure that data collection is undertaken in a format that is easy for people to complete and that is also easy to analyse at a later date
- keep your original evaluation questions in mind, organising your information by the original questions and use the results to answer those questions
- communicate the results of your evaluation to all those concerned and interested in the project including those older people involved
- involve older people in sharing the learning from the project evaluation – their experiences are the most important.

Ask yourself – is the evaluation:

- **Useful** – Will the amount and type of evaluation you collect meet the needs of those who intend to use the evaluation findings?
- **Feasible** – Will the evaluation be practical, achievable and realistic?
- **Accurate** – Will the evaluation findings be correct?
- **Fair** – Will the evaluation be conducted with awareness of the rights of the people involved in the programme in mind?

PROGRAMME EVALUATION (CONTINUED)

Further information can be obtained from

Connor, A (1993). Monitoring and Evaluation Made Easy. A Handbook for Voluntary Organisations HMSO, London, 1993.

Department of Health and Human Services (2002). Physical Activity Evaluation Handbook at ***www.cdc.gov/nccdphp/dnpa***

The Center for the Advancement of Commuity Based Public Health. (2000). An evaluation Framework for Community health programmes, Durham NC: The Center for the Advancement of Community Based Public Health.

US Department of health and Human Services. Promoting Physical Activity; A guide for Community Action. Atlanta GA: US Department of health and Human services, Centers for Disease control and Prevention; 1999.

WHO European Working Group on Health Promotion. Health Promotion Evaluation; Recommendations to Policymakers. Copenhagen: World Health organisation; 1998.

WORKING PAPER 7

TRAINING FOR THOSE WORKING WITH OLDER PEOPLE

This working paper outlines the key issues in relation to the planning and provision of training for those working in a variety of settings with older people. It looks at:

- the range of potential providers (those who will be providing the classes or activity opportunities to the older people)
- the needs to be met when providing physical activity for older people, and the training implications
- the types of qualifications that are appropriate.

It also includes a checklist of questions that participants can ask about individual courses, and information about the NVQ framework and affiliation of courses with the Register of Exercise Professionals.

Refer to the Training section of the Information directory, for a summary of training programmes currently available, and details of training providers.

Introduction

The provision of appropriate training for all those involved in leading, teaching and instructing in physical activity programmes is an essential feature of the planning phase of interventions designed for older people. It should therefore be included within any audit undertaken, as described in *Evidence based planning*, in section 3 a *Guide to Programme Planning*.

Training courses for those delivering physical activity programmes for older people are a relatively recent area of development. When considering individual courses, local co-ordinators will need to consider carefully:

- how appropriate the course content is
- the experience and expertise of the course tutor team
- external validation and continuing education requirements
- assessment procedures and certification
- access to national courses at a local level
- the national reputation and credibility of courses.

They will also need to ensure that the courses meet the necessary quality standards and are meaningful in educational terms.

Who should receive training?

In the past, work in providing physical activity opportunities for older people was largely undertaken by exercise teachers and fitness instructors, people working for medical charities, physiotherapists and occupational therapists. Exercise classes were predominantly based in community settings (led by a fitness or movement teacher), residential and care settings (mainly chair-based movement), or in the hospital and rehabilitation setting.

More recently there have been exciting developments, with a range of providers developing new opportunities for older people. A recent survey by the BHF National Centre for Physical Activity and Health indicates that current programmes for older people include:

- exercise programmes designed for older people in a range of residential and care settings (predominantly chair-based exercises, assisted walking, dance and games activities)
- sports-based programmes designed for older people in a range of community settings (eg, short tennis)
- national and local schemes promoting health-enhancing activities such as dance, walking and swimming
- fitness and health clubs and leisure centre programmes targeting older people
- primary health care exercise referral schemes targeting those people with specific health-related physical activity needs
- specific programmes designed for promoting independence eg, intermediate care and rehabilitation programmes
- specific exercise programmes included within hospital-based rehabilitation schemes eg, cardiac, falls, mental health and for patients with COPD (chronic obstructive pulmonary disease).

The variety of types of provision has arisen in response to the diversity of interests, health needs and functional capacities found among older people. To meet these needs it is essential to widen training provision to include different levels of training delivery by different groups of people including both professionals and volunteers.

The needs to be met when providing physical activity for older people – and the training implications

The developments described above, and the different styles of working, have been brought about by a number of needs:

Increasing older people's access to physical activity by training the front-line workforce

There is a need to increase access to physical activity for older people by encouraging a greater range of people to become involved in initiating opportunities, and in leading, teaching and instructing programmes. These may include volunteers, family carers, health and social care workers, physical education teachers, and sports and recreation leaders, who in the past may not have considered promoting physical activity with older people.

Promoting an inclusive model of physical activity

Physical activity opportunities available to older people should include not only structured exercise classes with the specific purpose of improving health and functional capacity, but also activities such as walking, adapted sporting activities, swimming, gardening and dance – where the emphasis is on meeting broader recreational and social needs.

Opportunities should also be available for older people with specific conditions such as Parkinson's disease, arthritis and dementia.

The importance of evidence-based practice

Where physical activity programmes are designed to meet specific needs – for example for special populations such as frail older people – the principles of adaptation of exercise must be based on current evidence and published guidelines for best practice.

Within certain and specific types of programming for the older person – for example in falls prevention or cardiac rehabilitation – it is important that interventions are based on strong, established evidence to ensure effectiveness in the achievement of intended outcomes.

What types of qualifications are appropriate?

In making decisions about what types of qualifications and experience are needed in order to provide enjoyable, safe and effective programmes for older people, it may be helpful to consider the following three questions:

1 Who is the participant expecting to work with?

The type of training and qualification required will be determined by:

- whether the participant wants to become involved with older people doing a certain type of activity (eg, weight training, dance or walking)
- if there is a requirement to meet a specific health need of a group of older people as a result of advice, guidance or a referral by a health professional (eg, within a primary health care exercise referral scheme or a falls prevention programme)
- the health risk factors of the participants (eg, relatively healthy older people, or frail older patients with multiple pathology)
- whether the type of activity requires a particular degree of competence of the leader/teacher (eg, chair-based leadership skills, seniors weight training, falls prevention advanced instructor skills)
- the context and setting within which the activity might take place (eg, in a day centre, residential setting or hospital) and the health risks of the activity in relation to the health risks of the participant and the degree of responsibility of the facilitator.

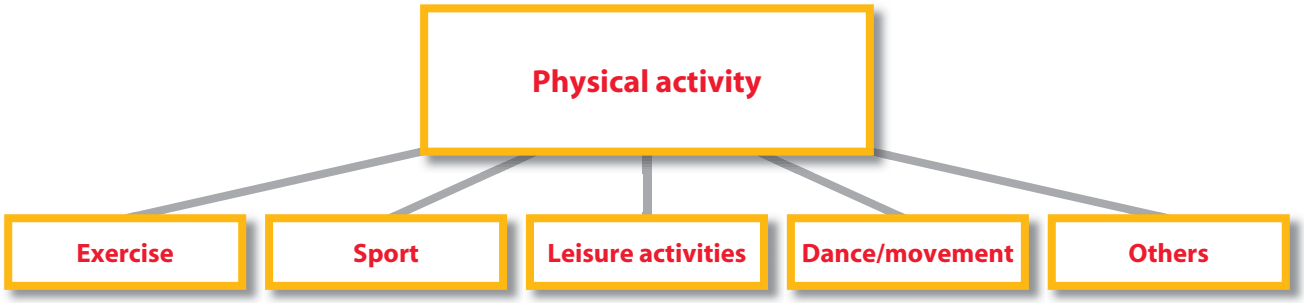
All types of physical activity can be made more enjoyable, safer and more effective through the education of the participants and facilitators, but the training requirements will vary greatly in relation to the intended outcome (the purpose) and the intensity of the activity.

Using the three strands of the *Active for Later Life* framework – Making Activity Choices, Increasing the Circle of Life, and Moving in the Later Years (see Section 4) – can help to match programmes and appropriate training to the different needs of the older person.

2 What types of activity do older people want to take part in?

The model of physical activity below can be used as a means of classifying the nature of activity to be provided. Although there may be some overlap between the areas of activity, the summary of courses listed in the Training section of the Information directory indicates which courses fall into these categories.

Diagram 7 – The sub-categories of physical activity



Source: President's Council on Fitness and Sports, 2000

3 What is the purpose or expected outcome of the programme?

For example, is it:

- specific changes in habitual lifestyle behaviour eg, regular walking, leading to an improvement in general health and well-being
- an improvement in functional capacity, mobility and independence
- a reduction of falls and accidental injuries
- increased social contact and interaction.

The following provides you with a checklist of key questions to ask when choosing a course.

Checklist – Choosing a training course

Is the course available locally?	There is no single database of all the courses and qualifications available for those working with older people, although many training providers ensure that their courses are provided nationally. Details of courses and qualifications can be obtained from individual training providers and from the national governing bodies for exercise and sport. See the *Training* section of the *Information directory*. For contact details of organisations, see the A to Z.
Has the course been designed using evidence-based practice?	Few courses and qualifications have been designed using scientific evidence relating to evidence of effectiveness. When deciding which course to choose, details of the evidence used should be obtained from the training provider.
Is the course quality assured (through internal and external verification)?	Ask the training provider to supply details of verification procedures and other details such as the entry level of the course, and details of theoretical and practical assessments.
Is the course aligned to the NVQ national framework?	Ask: • Does the course enable participants to complete a full NVQ Level 2? • Does the course enable participants to begin a portfolio of evidence towards a full NVQ Level 2 award?
Does the course consider the specific impact of exercise on the older person?	No minimum criteria have been established for the design of courses relating to older people. The following are common elements of the curricula of courses currently available, so you could ask individual training providers if these elements are included in their courses: • how the body works – physiology and anatomy related to ageing • the components of physical activity and exercise – eg, strength, endurance, flexibility • teaching strategies, organisation and planning • safety considerations including assessment, emergency action planning and cardiopulmonary resuscitation • adaptation of activity and the impact of impairments, disease and pathologies on activity • motivation of older people including readiness to exercise, and intrinsic and extrinsic barriers • theoretical and practical assessment.

The NVQ framework

The development of a UK framework for national occupational standards (NOS) and national vocational qualifications (NVQs) began in 1986. This framework was developed to establish a new system of qualifications designed to prove competence in doing a task or job.

The exercise and fitness industry is implementing teaching/instructing qualifications based on national occupational standards. This provides a uniform minimum standard which describes the knowledge and skills that all teachers/instructors need in order to deliver exercise and fitness activities.

The NVQ exercise and fitness award

There are various qualifications in the exercise and fitness industry, but there is only one award – the National Vocational Qualification (NVQ). The NVQ award is based on national occupational standards. There is currently just one level of award available – NVQ Level 2 Coaching, teaching and instructing in an exercise and fitness context – although it will eventually be offered at four levels. Assessment against the national occupational standards enables a teacher/instructor to prove his or her competency.

Current training at NVQ Level 2

As the national occupational standards are still new to many training providers, not all courses include full completion of NVQ Level 2. Individuals embarking on a career in the exercise and fitness industry should find out if their training programme will lead to a recognised award. Anyone deciding to take a course in exercise and fitness should ask:

- Does the course enable me to complete a full NVQ Level 2?
- Does the course enable me to begin a portfolio of evidence towards a full NVQ Level 2 award?

Higher level awards – teaching people with particular health and fitness needs

Qualifications are also available to teach health-related exercise/activity and a range of related matters to individuals and groups who have particular health and fitness needs. These are at a higher level than the NVQ Level 2 but they are not yet linked to the NVQ framework.

The Register of Exercise Professionals

The Register of Exercise Professionals (REPs) has been set up to help safeguard and to promote the health and interests of people who are using the services of exercise and fitness instructors, teachers and trainers. The Register uses a process of self-regulation that recognises industry-based qualifications, practical competency, and requires fitness professionals to work within a Code of Ethical Practice. Members of the Register are given a card and registration certificate to prove their qualification and membership. Also known as the Exercise Register it operates in the UK and across the world to recognise personal achievement and competencies of qualified fitness professionals.

For more information go to ***www.exerciseregister.org***

The future implementation of the National Occupational Standards at Level 3 and the expansion of the Register of Exercise Professionals to this level will bring about uniformity to the specialist qualifications which already exist including:

- exercise for older people
- exercise for people with disabilities
- exercise referral schemes.

Exercise and fitness coaches, teachers and instructors working at level 3 are termed 'advanced instructors'.

For more information of the development of skills in the fitness industry including National Occupational Standards go to Skills Active at ***www.skillsactive.com/healthfit***

Definitions

Awarding bodies

Awarding bodies are organisations which have been approved by the Qualifications and Curriculum Authority (QCA) to offer vocational qualifications (NVQs). Awarding bodies accredit candidates with their award, and provide relevant certification, through approved centres (see below).The awarding bodies for exercise and fitness are City and Guilds, EdExcel, OCR and Scotvec. Details of awarding bodies are available from Learning Direct on 0800 100 900.

Approved centres

An approved centre is a provider of fitness education and training which has been approved by the awarding body to offer NVQ assessments and awards in exercise and fitness. Sprito maintains a list of approved centres.

Exercise referral schemes

The Department of Health publication Exercise Referral Systems – A National Quality Assurance Framework provides guidance on the training and qualifications required for exercise professionals (exercise and fitness coaches and instructors or 'advanced instructors' who work with referred patients, Department of Health, 2001). Operating at Level 3 of the national occupational standards, these exercise professionals must demonstrate that they are able to adapt physical activity and develop appropriate long-term physical activity programmes. Further details of the competencies required by exercise professionals and advanced instructors are given in the publication mentioned above.

Sports coaching qualifications for those working with older people

Few national governing bodies of sport have courses designed specifically for leaders, coaches and teachers working with older people. Details of courses for individual sports may be obtained from the individual national governing bodies. For details of these governing bodies contact Sport England ***www.sportengland.org***

Movement and dance

The Central Council of Physical Recreation's Movement and Dance Division provides training and education for movement and dance leaders and teachers. It has published a national database of teachers and leaders qualified to work with disabled and older people. ***www.ccpr.org***

Details of other movement and dance training providers are also in Training for those working with older people in the Information directory.

Finding a suitable training provider

If you are looking for a suitably trained teacher or instructor, you should consult the Register of Exercise Professionals (England). This is a system of self-regulation for all coaches, teachers and instructors involved in exercise and fitness. It is supported by Sport England and operated by the Fitness Industry Association under the auspices of the National Training Organisation for Sport Recreation and Allied Occupations (SPRITO). This register performs the same function for exercise instructors as professional registers do for other groups of health professionals. Registration means that the exercise professional meets standards for practice, including continuing education, and insurance. Similar systems of registration are being established in Scotland and Wales and details can be obtained from the relevant organisations in the A–Z of national organisations in the information directory.

See also the Training section of the information directory, for details of organisations related to the provision of training.

References

Department of Health. 2001. Exercise Referral Systems – A National Quality Assurance Framework. London: The Stationery Office.

President's Council on Fitness and Sports. 2000. Research Digest, Health, Fitness, and Physical Activity. Definitions: Health, Fitness and Physical Activity. Washington DC: President's Council on Physical Fitness and Sports.

WORKING PAPER 8

PROMOTING AND MARKETING PHYSICAL ACTIVITY WITH OLDER PEOPLE

Introduction

Health professionals will want to be in a position to promote and market physical activity to older people both as a means of communicating appropriate educational messages (including the benefits of physical activity and how much activity they should be doing) and as a means of recruiting older people into programmes and opportunities.

This working paper highlights a number of key questions relating to how physical activity can be promoted to the older person and is based in part upon social marketing principles that can encourage the adoption of physical activity.

Key features of social marketing

The key features of social marketing have been defined as:

The customer or consumer is placed at the centre

The main concern is to ensure all interventions are based around and directly respond to the needs and wants of the person.

Contains clear behavioural goals

Social marketing is driven by a concern to achieve measurable impacts on what people actually do, not just their knowledge, awareness or beliefs about an issue.

Develops Insight

To develop such insight means moving beyond traditional information and intelligence to looking much more closely at why people behave in the way they do.

Uses market segmentation

This goes beyond traditional marketing approaches that may focus on demographic characteristics or epidemiological data, by considering alternative ways that people can be grouped and profiled.

Employs an "Intervention" and "Marketing" mix

Recognising that in any situation there a range of intervention options or approaches that could be used.

(Adapted from – Social Marketing Works – Chartered Institute of Environmental Health.) ***www.nsms.org.uk***

PROMOTING AND MARKETING PHYSICAL ACTIVITY WITH OLDER PEOPLE (CONTINUED)

1. Social marketing principles

Social marketing is about capturing the minds and imagination of people sufficiently that they would want to do something, eg, buy a car or a holiday. The six "p"s of social marketing principles (Nichols et at 2004) provide a framework for recruiting older people into physical activity programmes and will assist those promoting physical activity on the best ways to reach their intended audience and potential participants.

In short, they need to consider – what makes the programme or activity attractive to the intended audience and why?

1. Participants – Define and identify the needs of the audience

- what are their needs, beliefs, concerns and expectations?
- what are there perceptions about the benefits of physical activity and a more healthy lifestyle?
- what challenges do they face in coming to programmes and making physical activity a part of their lives?

2. Product – Select opportunities that are relevant and attractive

- how does it meet their needs, beliefs and concerns about being active?
- how does it compare to other opportunities to be physically active?
- how does it compare to other opportunities to do something else?

3. Price – Include all the costs of participation

- what is the cost in terms of time, effort and emotional input?
- what are the intangible costs (eg, time, effort and energy) as well as the benefits?
- consider if the benefits outweigh the costs?
- can some financial costs be reduced or waived for some participants?

4. Place – Accessibility including location, convenience and acceptability

- what sites will be convenient, welcoming and comfortable?
- can transport be arranged on a regular basis?

5. Promotion – Organise a comprehensive recruitment plan

- what is the focussed message that you will use?
- in what ways do older people access information?
- what communication strategies do you need to use to reach the target group?
- who can communicate the message to the target group?

6. Partnership – build relationships with organisations and people who can enhance recruitment

- who do we work with who can help us reach the target group?
- what do we have to offer our partners?
- what do our partners have to offer us?

2. Targeting your market – who are they and how well do you know them?

Is there such a thing as market segmentation and how should I think about it?

The term 'older people' covers a wide range of interests, circumstances (eg, life stages) and backgrounds. It is known that mass marketing does not work in appealing to the mature population. Older people are not all the same, so effective marketing involves targeting different segments of the older population. So you need to decide in what way you wish to segment the market.

Targeting by needs

Evidence included in section 1 suggests that great health gains can be achieved by reaching those older people who are sedentary and the focus of health policy has been to reduce health inequalities by targeting those who experience the worst health eg, isolated older people who remain in their own homes.

Other policies will highlight the need to reach those identified as being "at risk" or those with specific diseases or condition eg, fallers, obese people or those at risk of diabetes or heart disease.

Targeting by attitudes and intentions

Two recent studies reveal different attitudes towards health and physical activity among older people which might indicate the need to develop different strategies to target specific groups.

The American Association of Retired People (AARP) researched health behaviour in older people and in particular, physical activity. The purpose of the research was to understand those older people who were inactive, what motivates them and what keeps them from being active. AARP found big differences in the attitudes and behaviours of those who were "pre-tired" (in the pre-retirement stage of life), retired and in midlife.

Midlife (40 – 60 year olds) saw midlife as a time of reckoning and change; they would hold on tightly to midlife and were not prepared to let go. Work remained central to their lives with continuing caring roles (both for their parents and children) and weren't sure how to fit physical activity into their lives.

Pre-retired and older than midlife people were also hanging on to this stage of life and not ready to move on. Although still in (part-time) work, they were beginning to experience changes in their health and were battling the ageing process.

Retired people in this segment had a new sense of time as their attitudes and beliefs began to change. Health and disease concerned this group as did maintaining independence and function as well as what they should do to maximise it.

AARP then segmented the market based on attitudes towards exercise, physical activity and the likelihood of being physically active, rather than health status or age. They derived the following four segments from their research:

Committed couch potatoes were happily sedentary and had hundreds of excuses for why they could not be physically active. There was little that the health and fitness industry could do to get them off the couch.

Habitual exercisers had built exercise into their lives, were committed to regular physical activity and would never think of missing it (a small part of the population as we know!).

Planners were people with good intentions, but thought that physical activity was too hard. They found it difficult to fit physical activity into their lives, did not know how to get started or what to do and did not accept the '30 minutes moderate physical activity on most days of the week' message – to them 30 minutes was too much.

Tryers had built physical activity into parts of their lives, but couldn't work out how to reach the '30 minutes on most days of the week' guidelines. Tryers didn't see how they could possibly do more and looked to others to see how to fit physical activity into their lives. They relied on information to help them decide what to do.

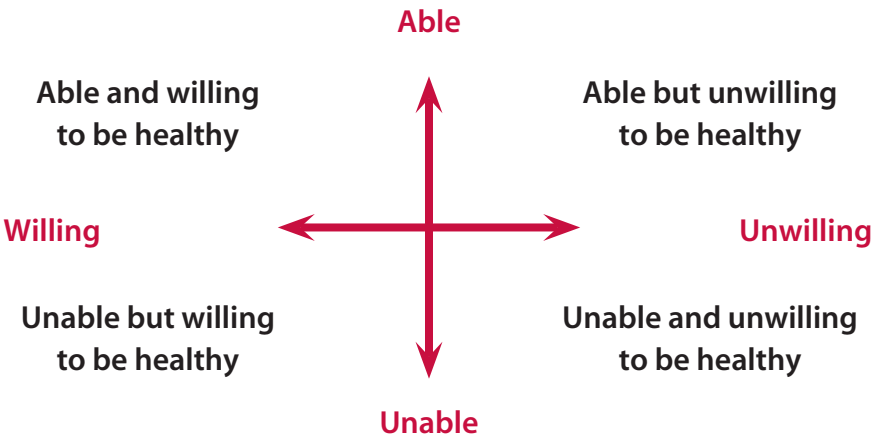
Each group displayed certain characteristics, regardless of age, gender, lifestyle or perceived health status. But **planners** and **tryers** had something in common. They looked for information, tips, ideas and strategies to help them become physically more active. They were open to the message and they wanted help.

Older people and lifestyle

A similar area of work was undertaken by Age Concern relating to health and lifestyle change. (As fit as a butchers' dog *Age Concern 2006.*)

In terms of adopting "healthy" or "less healthy" lifestyles, four main type groups emerged from the research. These are based upon factors which affect whether a person is "willing" and/or "able" to take up and maintain lifestyles which are good for health. Factors affecting someone's ability to adopt healthy habits are more often practical issues such as health literacy, ill-health or disability and access to services. Factors affecting willingness concern attitudinal issues such as philosophy on life such as "zest for life", attitude to ageing, apathy, fatalism and resistance to change.

The four types identified are



Targeting by life-stages and events

It is also recognised that there are key triggers in people's lives, certain key life events that often trigger a person's thoughts towards positive attitudes towards physical activity.

These are known to include:

- turning 50
- retirement or a move towards part-time working or volunteering
- declining health or major health incidents eg, onset or discovery of heart disease
- social stages eg, empty nesting, retirement and grand-parenting and sadly for others, bereavement.

Targeting by health status

The framework for defining the physical activity and health needs of older people, described in section 1, outlined three related and overlapping categories of older people defined by the National Service Framework for Older People. These are:

People entering old age – Making Activity Choices

People in the transitional phase – Increasing the Circle of Life

Frailer older people – Moving in the Later Years

However, these are broad categories and further sub-division of these groups will be required as part of an overall marketing strategy eg, older people in the transitional phase may be reached whilst in their own homes, via their GPs or via day care services.

Targeting by setting

Another common approach to reaching and recruiting older people is to consider the setting or location where they may be reached. This approach requires the support of key partners eg, those in:

- primary health care who may refer individuals and groups to appropriate programmes
- acute services eg, falls prevention, cardiac rehab or diabetes services, who can refer people into specific exercise programmes
- home visitors and community services who visit older people in their own homes
- day care providers eg, luncheon clubs
- residential services eg, sheltered and supported living managers
- nursing homes.

3. What's the message – what is it that we are trying to sell?

The 50+ population mainly know that exercise and physical activity are vital for good health and well-being eg, in preventing disease, reducing stress and fighting the effects of ageing and in particular, losing weight.

Promotional messages must assume that older people know the benefits of physical activity, but for some reason haven't taken advantage of that message. The message must be about inspiring people, persuading them to get off the couch without alienating them.

Trends and patterns of behaviour are not so simply explained among older people; they're more individual, more difficult to pin down and less predictable, and clearly don't behave in the same way as young people.

The message should feature ordinary people doing ordinary things. Older people respond best to promotional materials when they could identify with the people and the activities in the materials, they prefer to see "people like us", or someone they would like to have as a friend.

Some simple guidelines

- older people require specific and concrete information and encouragement to get moving, information about how to get started and exercise safely
- recommendations and messages need to be simple, clear and consistent, avoiding vagueness
- messages must recognise the obstacles that older people face, eg, "we have busy lives and other responsibilities"
- use messages that suggest that physical activity will help you take control of your life eg, age on your own terms
- offer something that will meet their needs eg, positive reasons to be more active "she deserves to dance with granpa"
- self efficacy – i.e. "you can do it, just believe it" (overcome the obstacles, pressures and demands) – is a powerful message
- remind people of their excuses, and use humour to overcome these reasons for not taking part
- use words and graphic pictures of experiences people would like to have, not what's good for them.

Older people have also said:

- tell a story, offer me a context of why and how
- make me smile, make me feel good, not scared
- understand me and my busy life
- show the impact, the difference between exercise and no exercise
- fight the effects of ageing by being active
- exercise for (and with) the ones I love
- be realistic about what I can achieve – it can be difficult to commit to being active
- empathy, understanding and encouragement are key ingredients.

What to avoid

- don't make exercise look like work – fun is more inspiring than hard work – or use images that look over-strenuous; they prefer to see people smiling and chatting with an activity companion
- avoid confrontation and exhortations, these are a turn off
- avoid hype, relying on fear (it will be too late) and directive language
- people in midlife are more resistant to attempts to bend their will and pressure them.

Language

- be careful with language eg, the E (exercise and endurance) words are problematic as they suggest hard work, effort and possible exposure to risk or harm
- use terms that work – 'activity' has a very positive response; it suggests engagement with life, family, friends and the community. "Physical activity" is associated with variety and choice
- sometimes specific language like 'seniors' or 'senior members' is off-putting
- men are more likely than women to respond to the promotion of strength and endurance
- use language that is evocative of sensory experiences and feelings
- Don't assume that staying young is the most important message – successful ageing may be more appropriate.

4. How do we reach them?

Older people and media and technologies

Older people have specific media habits and use specific formats. Free newspapers, daily newspapers and the radio remain very popular, although with younger, older people eg, the Baby Boomers, internet use is growing and will continue to do so (especially in searching for health information).

One-to-one communications

As well as specific media promotional activities, another essential aspect of recruitment and promotion is one-to-one communication that addresses expectations and beliefs.

Word of mouth and the communication channels employed by professionals, older people's groups and organisations, friends and age related community organisations.

NB: The older older person accepts the authoritative role of GPs; they trust their doctor to guide them, to recommend, refer to and reinforce other messages.

Older ambassadors and health mentors, i.e. other active older people, can also be successful in communicating messages and information to their peers, via presentations, meetings and educational events.

Members of existing activities and groups can share experiences about the impact of physical activity on their lives and how they got started.

It is also important to involve the older person's family, care givers and support systems so that they can re-inforce positive messages.

Materials

Here are some do's and don'ts for the graphic design of materials:

- ensure bright colours in high contrast – best for readability and lay out
- use minimum of 14 font size and ensure a contrast with main headings (18 – 20 font size)
- font size 16 – 18 is recommended for visually impaired people but this may be difficult for producers of materials, so keep font size as large as possible
- use lots of white space and simple, short and pointed headlines
- employ clean and clear backgrounds with wide margins to enhance readability
- no ornate type faces – use Serif type eg, Times New Roman, Garamond, rather than sans serif type (Arial, Univers)
- bulleted points are helpful
- use a mix of upper and lower case letters
- ensure that materials are easy to handle (not unfolding road maps)
- use matt finished paper – glossy paper creates glare which may create a problem for many older people
- use simple charts and tables
- accommodate those that read at the lower levels of literacy.

Simple use of words is also important eg,

- food or what you eat – rather than nutrition
- right or correct – rather than appropriate
- add or total – instead of calculate
- heart in place of cardiovascular, bones in place of skeleton
- deltoid – the large muscle on your shoulder
- quadriceps – the big muscles on the front of your thighs
- no abbreviations like pecs, quads, abs, glutes
- working with other professionals
- include those who can influence OP.

The 5 simple rules of marketing to older people (ICAA 2002)

1. clearly identify your audience
2. have a clear concept of what you want to communicate
3. target your message to your audience's preferences
4. understand your audience's media habits
5. use mixed media but keep the message consistent.

Sources of further information

Age Concern (2006) As Fit as Butchers' Dogs? – a report non healthy lifestyle choice and older people. Age Concern Books.

Chartered Institute of Environmental Health – Social Marketing Works – a short introduction for environmental health practitioners National Social Marketing Centre. London ***www.nsms.org.uk***

International Council on Active Aging (2002) Marketing Physical Activity to the Older Adult – a how guide for fitness and wellness professionals.

Help the Aged – ***www.helptheaged.org.uk***

National Council on Aging – Recruiting Older Adults into Your Physical Activity Programs ***www.healthyagingprograms.org***

Nichols, L et al (2004) Social marketing as a framework for recruitment: Illustrations from the REACH study. Journal of Aging and Health, 16(5), 157S-176S.

Marketing and promotion check list

Component	Task – Identify	Solution
Participants – audience needs	Identify needs, beliefs, concerns and expectations Identify perceptions Identify challenges	
Product – relevance and attraction	How does it meet needs Comparison with other activity opportunities Comparison with other competing interests	
Price – include all costs	Time, effort required Intangible costs Benefits Policy – reductions or waivers	
Place – access and convenience	Convenient and welcoming Transport	
Promotion – a recruitment plan	What's the message? Channels of communication Agents of communication	
Partnerships – who can help?	Who can help? What can they offer us? What can we offer them?	

WORKING PAPER 9

EFFECTIVE PHYSICAL ACTIVITY AND EXERCISE PROGRAMME PLANNING FOR OLDER PEOPLE

Introduction

This working paper highlights one area drawn from the Guidelines on Promoting Physical Activity with Older People drafted by the British Heart Foundation National Centre for Physical Activity and Health.

The guidelines were drawn from recent published reviews of effectiveness of physical activity interventions together with other published articles and guidelines in addition to learning from current professional experiences eg, the Local Exercise Action Pilot programmes (DOH 2006).

In summarising the learning from these sources of evidence, the guidance highlights recommendations and **components of good practice** that can be used to plan interventions at three levels:

- **Population wide interventions,** eg, environmental and policy interventions, campaigning and promotion

Click here to go to Working paper 3.

- **Community/locality based interventions,** eg, facility-based programmes, area-based physical activity projects and activity/participation events.

Click here to go to Working paper 4.

- **One-to-one interventions,** eg, lifestyle counselling and advice.

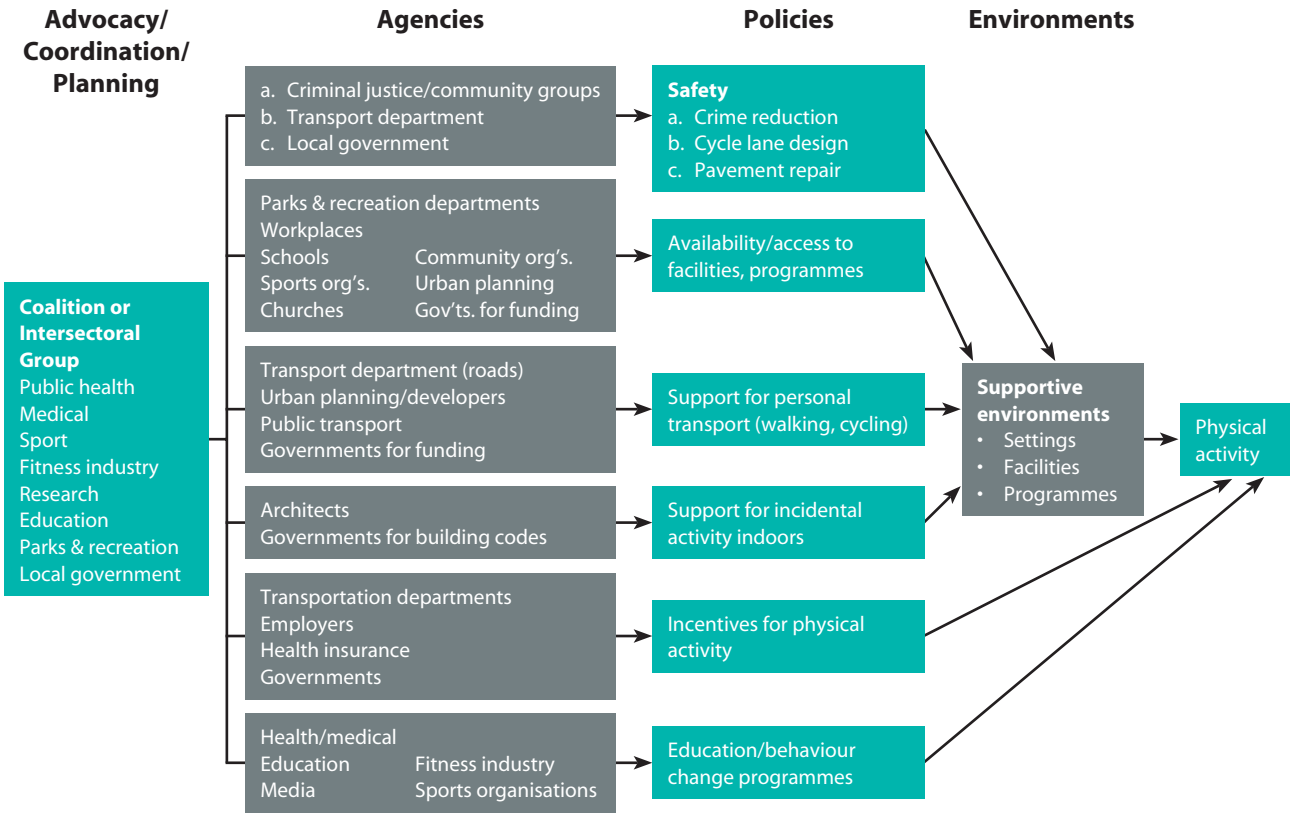
Click here to go to Working paper 5.

In addition, the guidelines offer an outline of best practice in:

- **Physical activity and exercise programme planning,** eg, for those leading and instructing groups involved in a range of activities eg, walking, tai chi, music and movement classes and chair based exercise.

EFFECTIVE PHYSICAL ACTIVITY AND EXERCISE PROGRAMME PLANNING FOR OLDER PEOPLE
(CONTINUED)

Sociological model of healthy ageing (Sallis et 1998)



Recommendations for physical activity and exercise programme planning

These guidelines are designed for use by organisers, teachers and leaders of programmes for older people as part of a class or group.

NB. They are not designed to provide specific advice on exercise prescription. (eg, frequency, intensity, time and mode). Such recommendations relate to the needs, interests and functional abilities of the individual and will vary according to exercise history and individual risk factors and are the function of exercise teachers and training programmes and other guidelines eg, American College of Sports Medicine. (ACSM)

Guidelines for the older population have been published in ACSM's *Guidelines for Exercise Testing and Prescription* (ACSM 2000). These guidelines include general exercise guidelines for a wide range of participants as well as addressing considerations in special populations such as cardiac patients, those with type II Diabetes and older people.

Physical activity and exercise programme planning – components of good practice

1. Making a start and overcoming the barriers

Older people understand the benefits of physical activity but are often reluctant to get involved. Questions that they need answering might include:

- how can I get started, will it be fun and will I be able to enjoy it?
- will there be other people like me and will I feel welcome?
- will the leader understand and support me?
- is the leader someone I can trust?

The beginner will require information and re-assurance about medical concerns (including fear of injury), attitudinal barriers (such as perceived lack of ability and incorrect beliefs about exercise and physical activity) and illness and injury.

2. Involve participants in the process

Participants must be actively involved in all aspects of programme development including planning, promotion and evaluation. Involving participants assists in identifying needs and developing an understanding of the barriers to participation. It also helps ensure that the programme is appropriate for the intended audience eg, scheduling and timing. Actively engaging participants also ensures that the programme remains focused upon the needs of the participants.

3. Ensure accessibility

Ensuring that opportunities are accessible is consistently identified as one of the most important components of programme planning. This includes proximity to residences in a conducive, accessible, well-lit facility with good public transport, refreshments, and changing and toilet facilities.

Improving access to places that people can be active, such as walking or bike trails, classes at gyms or senior centers and recreation facilities is known to increase participation.

4. Provide an appropriate induction session

For new participants, joining a class or group may be the first such experience for some considerable time if not completely new to them. It may also be a daunting experience. Induction sessions will be helpful in overcoming concerns, but also by providing information and re-assurance about the level of physical activity, clothing, safety and that the programme is designed to meet individual needs and goals.

5. Undertake an assessment of needs

Pre-screening and assessment will assist in determining the individual level of function and readiness to join a programme and should include enquiring about medical background, medication and pre-existing health conditions. The psychological aspect of assessment is a critical, but often overlooked component of developing programming that addresses needs as well as personal objectives relating to exercise participation.

6. Leadership

Establishment of friendly and mutually respective style of communication between participant and leader is important.

The ability of the leader to create a friendly, enjoyable and welcoming group atmosphere is critical.

EFFECTIVE PHYSICAL ACTIVITY AND EXERCISE PROGRAMME PLANNING FOR OLDER PEOPLE
CONTINUED

7. Consider the components of fitness

A well rounded physical activity programme should include endurance, strength, balance and flexibility components. Activities tailored to the individual's needs will ensure maximum enjoyment and greatest adherence to the programme.

8. Individual goal setting and progression

Participants should be encouraged to set their own programme goals and targets that are realistic and appropriate for their current lifestyle and motivation. Such goals may relate to health, function, activities of daily living, motivation or small lifestyle changes.

Steady and careful individually-based progression, particularly in the early stages, is essential to ensure early achievement and boost confidence. Appropriately paced programmes and progression further build confidence and are particularly important in the early stages. Intensive tuition and one-on-one support during the first weeks of the programme is important for increasing mastery beliefs and confidence.

8. Develop belonging and ownership

A programme can operate like a club within a facility, so develop opportunities to build relationships and friendships between peers with similar interests and skills.

Develop an enjoyable, social and welcoming atmosphere with a strong group allegiance and sense of ownership among participants.

Involvement of participants in programme elements, their own progression, the promotion of the group and recruitment of new members assists in developing a sense of belonging.

Developing a sense of belonging (to join and be accepted into a group) provides energy and enhances the performance of participants.

Leaders are instrumental in creating environments that motivate older people to do more. They provide the experiences that offer fun and socialisation and a sense of belonging appropriate to shy apprehensive beginners.

Beware of creating a too strong a group identity and sense of belonging that may present barriers to newcomers, and ensure a warm welcome and familiarisation opportunities for new members.

9. Recognise achievement and progress

Sometimes it takes a while for the more obvious rewards of regular physical activity to be realised eg, weight loss, improvements in strength or flexibility. Ensure that no matter how small, all forms of individual achievement are recognised. This may take the form of recognising regular attendance or individual progress. Leaders can recognise individual achievement (privately or publicly) by providing a compliment, with a handshake, or by certification. Even a member returning after an absence requires recognition.

EFFECTIVE PHYSICAL ACTIVITY AND EXERCISE PROGRAMME PLANNING FOR OLDER PEOPLE
CONTINUED

10. Educating participants

Teachers and leaders should take all opportunities to educate participants about:

- their responses to physical activity and to understand the normal and abnormal responses to physical activity
- their bodies and the specific condition they may have eg, osteoporosis, arthritis
- balance, strength, flexibility and other components of fitness
- muscle groups and joints, their functions and their contribution to the activities of daily living
- how to monitor their own progress, self-monitoring, evaluation, how am I doing?
- the importance of additional opportunities for regular physical activity outside of the group

Provide regular encouragement, feedback, reinforcement and problem solving techniques that help to sustain progress and interest and teach participants how to incorporate physical activity into daily routines.

Build other educational opportunities into programmes such as visiting speakers and discussion on other related health topics identified by the group eg, falls prevention, good nutrition, relaxation.

11. Build social support

Establish programs that help build social support (at work or in the community) for physical activity. This can be achieved by incorporating Peer Mentors or buddies in a programme to improve recruitment, retention and motivation.

Recognise and follow up absentees from a programme and develop a rota to visit someone who may be unwell.

12. Provide exit routes and opportunities for change

Ensure that there are appropriate 'exit routes' to other exercise opportunities should a programme close or the individual needs (and/or) interests change to such an extent that a different (eg, more or less challenging) class might be more suitable.

Check list – components of Physical activity and exercise programme planning

Component	Additional sources of information
Ensure accessibility	
Making a start and overcoming the barriers	
Involve participants in the process	
Undertake an assessment of needs	
Provide an appropriate induction session	
Consider the components of fitness	
Individual goal setting and progression	
Develop belonging and ownership	
Leadership	
Educate participants	
Recognise achievement	
Build social support	

EFFECTIVE PHYSICAL ACTIVITY AND EXERCISE PROGRAMME PLANNING FOR OLDER PEOPLE
CONTINUED

References

The full references for this working paper are contained in the BHF National Centre for Physical Activity and Health Guidelines on Physical Activity for Older People. They have been omitted from this paper to permit ease of reading.

Further information

Designing safe and effective physical activity programmes. National Council on Active Aging.
www.healthyagingprograms.org

Jones J.C & Rose, D. J. Eds (2005) Physical Activity Instruction of Older Adults. Human Kinetics Champaign, Illinois.
www.humanKinetics.com

WORKING PAPER 10

OLDER PEOPLE, COGNITIVE DECLINE AND DEMENTIA

This working paper sets out to outline some of the key considerations relating to the promotion of physical activity with older people with dementia. Dementia is not an disease itself but a collective term used to describe a group of symptoms eg, a gradual loss of memory, a decline in the ability to think or reason and problems with communication.

How many people are affected by dementia?

- Dementia currently affects over 750,000 people in the UK. Approximately 18,000 people with dementia are under the age of 65
- Dementia affects one person in 20 over the age of 65 and one person in five over the age of 80. The number of people with dementia is steadily increasing. Alzheimer's disease is the most common form of dementia, making up 55 per cent of all cases of dementia
- There are nearly 18 million people with dementia in the world
- It is estimated that as many as 75 per cent of people in care homes may have some form of dementia.

Each person is unique and will experience dementia in a different way. Although most people with dementia are older, dementia is not an inevitable consequence of ageing and most older people do not have it.

However, with the increase in the older population, it is anticipated that there will be an increase on people with dementia, both living at home and in care settings.

Projected growth

It is estimated that by 2010 there will be about 870,000 people with dementia in the UK. This is expected to rise to over 1.8 million people with dementia by 2050.

The potential of physical activity

The potential for participation in activity to enhance physical and mental health is well known. There is evidence that the physical, cognitive and social benefits of participation in activity can reduce levels of depression, challenging behaviour, falls and dependency among older people.

Conversely, inactivity can result in a range of adverse physical and psychological outcomes, such as reduced muscle strength and postural instability (thus increasing the risk of falling); decreased respiratory, cardiac and intestinal function; disorientation, anxiety and ill-being. This in turn can lead to increased levels of dependency, increased risk of infection and increased incidence of incontinence.

Hence, the opportunity to participate in purposeful activity is an essential component of health and quality of life for all older people, particularly those who may be deprived of such opportunities such as those living in care homes.

Common types of dementia

Alzheimer's disease – This is the most common cause of dementia. During the course of the disease, the chemistry and structure of the brain changes, leading to the death of brain cells.

Dementia with Lewy bodies – This form of dementia gets its name from tiny spherical structures that develop inside nerve cells. Their presence in the brain leads to the degeneration of brain tissue. Memory, concentration and language skills are affected.

Vascular disease – If the oxygen supply to the brain fails, brain cells may die. The symptoms of vascular dementia can occur either suddenly, following a stroke, or over time, through a series of small strokes.

Fronto-temporal dementia (including Pick's disease) – In fronto-temporal dementia, damage is usually focused in the front part of the brain. Personality and behaviour are initially more affected than memory.

Rarer causes of dementia – there are many other rarer causes of dementia, including progressive supranuclear palsy, Korsakoff's syndrome, Binswanger's disease, HIV and Creutzfeldt-Jakob disease (CJD). People with multiple sclerosis, motor neurone disease, Parkinson's disease and Huntington's disease can also be at an increased risk of developing dementia.

For more information about dementia vist ***www.alzheimers.org.uk***

The stages of dementia

Every person with dementia is different but the following provides an outline of the different stages of dementia and some of the difficulties that may be experienced. (N.B. not everyone will go through every "level")

Early stage dementia	Middle stage dementia	Late stage dementia
This phase may only be apparent in retrospect. At the time it may be put down to overwork or old age. The start of dementia is very gradual and it is usually impossible the identify the precise moment it starts.	Here problems are more apparent and disabling.	Here the individual is more severely disabled and needs a great deal of support.
The person may:- • be apathetic • show less interest in hobbies or activities • be unwilling to try new things • find adapting to change difficult • become less good at decision making • be slower to grasp complex ideas • blame others for stealing mislaid items • become self-centred • forget details of recent events • be more likely to repeat themselves or lose the thread of thought or conversation • become irritable or upset if they fail at something.	***The person may:-*** • be very forgetful of recent events – memory of the distant past is better • be confused regarding time and plave • become very "clinging" • rapidly become lost if not in familiar surroundings • forget names of friends and family • forget about household tasks eg, saucepans on stoves • wander around streets, perhaps at nights, becoming lost • behave in odd ways eg, going out in night clothes • see or hear things that are not there • become repetitive • neglect hygiene or eating • become angry or distressed very rapidly.	***The person may:-*** • be unable to find their way around • be unable to remember, even for a few minutes, a recent event • constantly repeat words, phrases and sounds • be incontinent in urine and/ or faeces • show no recognition of friends and relatives • need assistance with activities of daily living eg, dressing, washing • fail to recognise everyday objects • have difficulty in understanding what is said • be disturbed at night • be restless, looking for a relative or small child • be aggressive, especially when feeling threatened or closed in • make involuntary movements • have difficulty walking.

(Adapted from Caring for the Person with Dementia - Alzheimer's Society 2002)

The benefits of activity for people with dementia

A recent study assessed daytime activities as an unmet need for 76 per cent of care home residents with dementia. (Hancock et al 2005)

This is despite the evidence that participating in activity can reduce the levels of depression, challenging behaviour, falls and dependency in care home residents.

Specifically:

Up to 70 per cent of people with Alzheimer's disease also have symptoms of depression. They gradually loose the ability to participate in activities they once enjoyed, and eventually may withdraw from all activities.

People with dementia have a higher risk of falls and fractures than people of the same age without the disease. Once injured, they are also more likely to re-injure themselves. Moderate exercise improves strength and co-ordination, which can reduce the risk of falls and injury.

For more information see Working paper 11 – Working with older people in falls prevention

Sleep disturbances are common for people with Alzheimer's disease. They may become agitated at bedtime, wander at night or sleep fitfully. Regular physical activity is a natural sleep enhancer. A daily walk or exercise class can help a person with Alzheimer's sleep more soundly at night.

As dementia progresses, the tendency to wander away from home and get lost increases. In many cases, people with dementia tend to wander because of boredom or loneliness. Programmes that engage individuals in meaningful activities, eg, exercise and social interaction, may reduce the frequency of wandering.

Regular physical activity can help control many of the general health problems common among older people eg, high blood pressure and diabetes. It may also reduce some of the behaviours that make it so difficult to care for a person with dementia.

Click here to go to Working paper 11 – Working with older people in falls prevention.

Maintenance of physical function

Activities of daily living normally associated with independent living and performed with the support of care-givers, should be complimented with additional functional activities such as mobility and stretching and, importantly, sit and stand and walking activities).

Activities of daily living
Brushing teeth; Combing hair; Toileting; Dressing
Activities of daily living to include
Rhythmical movement (eg, chair walking, arm swings); Mobility; Stretching; Sit and stand; Walking eg, into a garden, to the shops
Weekly activities to include
Strengthening exercises 2-3 times per week; Walking and extended chair walking (if not possible daily)

The benefits of regular physical activity also apply to the care-giver of the person with dementia, professional, friend or family and may provide an activity that both can enjoy together.

Participation in purposeful and meaningful activity can provide:

- **conversation and company –** social life that provides feelings of contact, companionship and belonging
- **variety and choice –** essential elements of keeping people engaged in activities and the building of self-esteem
- **movement and exercise –** for the maintenance of good health and well-being
- **opportunities to feel useful and busy –** to counteract the feelings of uselessness or incompetence that many people with dementia experience
- **engagement of the senses –** reduced hearing, sight and smell is common among older people - through the use of photographs, pictures, music
- **stimulation of the mind and memory –** long term memory is better preserved, discussions and quizzes can engage the intellect and stimulate the mind
- **giving and receiving of attention –** for those who have lost relatives and friends, opportunities for intimacy, touching and friendship
- **maintaining interest and connections with the outside world –** the world gets smaller for people with dementia – support from workers and family to stay in touch with what is going on is important
- **creativity and self-expression –** through long standing or new interests, like painting, preparing food, dance, gardening
- **fun, laughter and play –** dementia can cause a loss of inhibition and free a sense of humour or playful spirit and enhance well being
- **spiritual well-being –** through music or experience with the natural environment.

Adapted from Knocker, S. (2002)

Promoting activity

The National Minimum Standards for Care Homes for Older People require care homes to provide:
"Opportunities for stimulation through leisure and recreational activities in and outside the home which suit the residents needs, preferences and capacities". (DOH 2003)

A number of factors influence such provision including:

- the physical environment
- staffing levels, skills and interests
- the organisational culture
- and residents interests abilities and motivation.

The selection of appropriate and meaningful activities requires providers (and in particular staff) to understand the nature of dementia and how it affects the ability 'to do'.

The main considerations when selecting and providing activities are **knowing the person** and **analysing the activity**. It is vital to match the person's level of ability and interest with a **meaningful activity** with the **correct degree of challenge**.

Knowing the person	The individual's ability 'to do'
Information about the person's life, background, family and social networks Past interests and hobbies and what was it about them that is valued	The capacity to remember a task Communications skills Orientation Other conditions eg, hearing or visual impairment

"Confronting the resident with an activity they no longer have the ability to complete, or have no interest in, is doomed to fail and can leave both resident and provider feeling frustrated and defeated. Conversely offering an activity that is too easy can be seen as boring or even patronising."

(Wenborn, J. 2005)

Analysing the activity

Most activities require a combination of skills and abilities, so in addition to analysing the individual's skills and abilities, an analysis of the potential of different activities and their different components is a complimentary starting point.

Physical skills are acquired by young people on a developmental gradient which increases exponentially in scope and complexity until maturity. It may be interpreted that dementia is a return through this gradient so that the capacity for performing skills and activities are lost in much the same sequence as they were originally gained.

Component	Descriptors
Physical	Range of movement, strength, co-ordination, physical endurance, speed
Sensory	Interpreting and interacting with the world around us, sight, smell, touch, hearing, taste
Cognitive	Memory, problem solving, logical through processes, ability to organise oneself and time, communication
Emotional	Internal drives and beliefs Previous life experiences
Social	Interaction with other people Development of relationships

It is the matching of the activity to the individual that forms the basis of programming.

Promoting physical activity with people with dementia

Providing appropriate activities for older people at different stages of dementia will require the selection of an activity or activities that match the cognitive level of the participant. One such model has been outlined by Perrin and May (2000) who have identified four developmental stages which correspond to the different stages of dementia. The four developmental stages are: reflective, symbolic, sensori-motor and reflexive. They also suggest activities which are suitable for each stage.

Suggested activities for people in different stages of dementia

Stage of dementia	Component	Activities
Early dementia	Reflective	Games, sports, quizzes, discussions, crafts, end-product tasks
Early to middle dementia	Symbolic	Music, dance, drama, art, pottery, reminiscence, story telling, festive
Middle to late dementia	Sensori-motor	Movement, massage, cooking, stacking, rummaging, dolls and soft toys, balls, exercise, bubbles and balloons, gardening, folding, clowning
Late dementia	Reflexive	Singing, rocking, holding, non-verbal communication, smiling, stroking, cuddling

Adapted from Perrin et al, (2000).

Theories of play related to movement, liberation, creativity, festivity and fantasy may also apply to older people with dementia. In particular, play described as 'free unimpeded movement' can be interpreted as:

- opportunities to be physically active including: vigorous bodily action, dance or display, clapping of hands, and concepts associated with images of flitting or fluttering, flickering, glittering, rippling, vibrating and swaying
- activities for amusement or diversion including: sports, games, and musical and dramatic performances.

Getting out and about

Access to the outdoors is an important part of a care home resident's life as it offers sensory stimulation, opportunities to engage with neighbourhood and community, contact with wild-life, fresh air and exercise, and stimulates conversation and reminiscence.

Click here to go to Guidelines for Working with people with dementia.

Guidelines on working with people with dementia

- make activities person centred (including life histories, medical information, 'can do')
- use eye contact to assist communication, speaking clearly and simply, keeping explanations brief
- demonstrate movement as you talk
- use touch skilfully to increase communication. Effectiveness, encouragement
- use your own body as a reference point eg, "can you touch my hand?"
- ensure that movement is comfortable for the person, observing for signs of discomfort
- never manipulate a person's limbs or joints (unless you are medically trained eg, a physiotherapist)
- use vocal tone to focus attention, varying volume and attention
- use large moves, simple movement patterns and lots of repetition
- pay attention to body language recognising that mood, likes and dislikes may suddenly change and that what worked last week, may not work today
- if a participant becomes distracted, help them to refocus by changing the action
- maintain an empathetic sense of humour, laughing with them, not at them
- have a wide range of equipment and music available to ensure variety
- avoid sharp or harmful equipment
- encourage participants to touch, play with, smell, and listen to different pieces of equipment
- use familiar household objects (eg, water bottles, tennis balls) as well as more traditional equipment (eg, weights, bean bags)
- praise all attempts to respond
- always finish with tea and a chat with participants.

Adapted from Dinan S.M. (1998)

The role of residential and care settings

Studies suggest that almost 50 per cent of care home residents' time is spent asleep, socially withdrawn or inactive, with only 3 per cent spent on constructive activity. (Help the Aged 2006).

'The key person in the creation and maintenance of a good inclusive activity care system is the manager'. (Smith. P 2004).

The primary role of the manager in setting the foundations for an activity programme is essential to its success. It is the manager's role to motivate and encourage staff to provide a rewarding lifestyle for the residents and contribute to favourable life satisfaction outcomes necessary for older people. This will involve harnessing the resources of the staff, relatives and wider community and 'conduct the orchestra' encouraging contribution from all 'departments' (housekeeping, maintenance and catering).

It is the managers' responsibility to pay attention to:

- the physical environment in making it comfortable and easy to find one's way around
- developing a shared philosophy of holistic care for all involved in meeting the daily activity needs of those in their care
- developing a culture that is relationship focused rather than 'cosmetic' (Nolan 2003), and led by example and encouraging harmonious teamwork and motivating people towards enjoyment of physical and other activities outlined above
- developing a culture that is open to new learning and development opportunities for older people to enhance and improve retained abilities
- the importance of training staff and others in understanding the importance of physical activity for the frail, and involving care staff in meeting activity needs within the everyday pattern of care (Miller K 2004)
- becoming a 'change agent' to promote ongoing change in order to develop 'vibrant living environments', full of expectation, and movement. This will also have the effect of motivating staff and others
- 'strive for freshness and innovation and do not stand still'
- praise all attempts to respond
- always finish with tea and a chat with participants.

(Hurtley R. 2005)

The New culture of care

Over the last ten years the culture around providing activities for older people has developed considerably, particularly with the increasing challenge of dementia at its different stages. The evidence suggests that we need to move our understanding forwards to meet these challenges. The New Culture of Person and Relationship Centred Care believes that:

Activities are **essential**

(a) in the care for older people (a moral imperative) and

(b) to encourage re-enablement, improvement of function and well-being.

Old Culture of Activity	New Culture of Activity
• older people want to disengage • entertainment is enough • all older people are the same • there is no need for training • no choice or imagination • sedentary lifestyle • activity is a 'soft option' • imposed without adequate consultation • no need to understand an individual in the context of their life experience as a whole • seen as an optional extra • limited opportunities and 'tokenism' • people with dementia cannot engage in activity.	• appropriate activity potentially improves wellbeing • activity is essential to health, well-being and quality of life • it is an agent of positive change • training is necessary • activity is integral to care • enthusiastic managers are a key component to success • requires consultation and understanding of various aspects individuals past and present living experience • withholding activities is negligent • activity is carried out at intervals around 24 hour clock • activities need to be based on observation and assessment to enable maximum participation and engagement.

Adapted from NAPA Good Practice Guide (2001) and Perrin 2004

Managers of residential and other care settings should:

- appoint and maintain the function of an activity co-ordinator
- key resource
- ensure that the activity programme is known and understood by everyone and that staff are scheduled to help
- provide staff training – essential to ensure that everyone is
- familiar with the aims and outcomes of the programme
- what is required for the preparation of the activity area and patients
- prepared to assist with the programme
- regularly monitor and evaluate the programme
- ensure appropriate scheduling (eg, an hour before or after meals)
- maintain an appropriate activity area (clean, lit and spacious)
- provide and maintain an equipment and resource library (in particular straight backed chairs for seated activities).
- ensure that activities are included within safety and risk management strategies
- ensure that programming for individuals is reflected within the individual care plan
- ensure the provision of off-site opportunities to "get out and about".

Sources of information

The following publications are available from the **Alzheimer's Society**

Caring for the Person with Dementia –
The Alzheimer's Society Book of Activities –
Make a Difference in Dementia Care Training
Quality Care in Care Homes – Person Centred Standards

Oddy R. (2003) Promoting Mobility for People with Dementia – a problem solving approach. Age Concern Books.

Dinan S. (1998) Fit for Life: why exercise is vital for everyone. In The Journal of Dementia. Vol. 6 No 3 May/June

Hancock et al (2005) The needs of older people with dementia in residential care. International Journal of Geriatric Psychiatry.

Hurtley R per cent. & Wenborn, J. (2005) The Successful Activity Coordinator Age Concern Books

Perrin T and May H. (2000) Developmental Model of Practice for Dementia Care In Wellbeing in Dementia. Churchill Livingstone, London

Alzheimer's Society ***www.alzheimers.org.uk***

The Bradford Dementia Group
www.brad.ac.uk/acad/health/bdg/index.php **(research)**

Dementia Plus ***www.dementiaplus.org.uk/index.htm***
The Learning Education Development Centre for Older People & West Midlands Dementia Services Development Centre

For dementia ***http://www.fordementia.org.uk/***
For Dementia training specialises in the provision of high quality training courses for those who work with older people and people with dementia.

Jabadao – Centre for Movement Studies ***www.jabadao.org***
Movement studies for those working with frail elderly people and people with dementia.

Signpost ***www.signpostjournal.co.uk***
Signpost is the specialist journal produced by the Practice Development Unit of Cardiff and Vale NHS Trust in association with Dementia Services Development Centre Wales.

National Association of Providers of Activities for Older People ***http://www.napa-web.co.uk***

OTOP (College of Occupational Therapists Specialist Section for Older People) **Care Homes Network.** ***www.cot.co.uk***

WORKING PAPER 11

WORKING WITH OLDER PEOPLE IN FALLS PREVENTION

INTRODUCTION

This working paper focuses on the relationship between physical activity and tailored exercise programmes and the prevention and management of falls and fall related injuries among older adults. It draws on a number of published reviews and a selected search of the literature and also takes account of information and evidence included in other sections of the Active for Later Life resource.

There is now overwhelming research that confirms that physical activity in later life has important preventative and therapeutic benefits including:

- disease prevention
- greater mobility, falls and fractures prevention, improved muscle strength
- enhanced well-being and quality of life.

The effect of falls and fall-related injuries on the individual

For many previously fit patients a fall means loss of prior full mobility; for some frailer patients the permanent loss of the ability to live at home, and for the frailest of all it may bring pain, confusion and disruption to complicate an already distressing last illness.

The consequences of falling include death, injury (the most serious of which is fracture of the proximal femur), fear (of a future fall), institutionalisation, decreased activity, functional deterioration, social isolation, depression and reduced quality of life[iii].

Falls and unsteadiness are very common in older people. Roughly 30 per cent of over 65s report a fall in the past year, a figure that rises to over 40 per cent in the over 80s, and even higher in the frailest and those with dementia. Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK[iii].

The prevalence of falls for men and women is about equal[2], but men are far less likely to injure themselves. Men are typically 20-30 per cent stronger than women of the same age and have stronger bones[iv].

Even in the absence of falls the fear of falling significantly limits daily activities and increases the risk of admission to care, and osteoporosis can cause fear, anxiety and depression, particularly in women[v].

Hip fracture is the most common serious fall related injury, and is becoming commoner. Between 1982 and 1998 (the last year for which complete data is available) the number of hip fractures sustained annually in Scotland by people over 55 years rose from just over 4,000 to 5,700, with 80 per cent occurring in women[vi].

Despite significant improvements in both surgery and rehabilitation in recent decades, hip fracture remains, for patients and their carers, a much-feared injury. Up to 14,000 people a year die in the UK as a result of an osteoporotic hip fracture[vii].

The vast majority of fractures in older women result from falls, including over 90 per cent of hip fractures. After an osteoporotic fracture, 50 per cent of people can no longer live independently[viii].

80 per cent of the over 80's would rather cease to live than suffer the loss of independence that a hip fracture and subsequent nursing home admittance may bring[5].

Falls and Injuries – a growing concern to the NHS

A third of people aged 65 and nearly 50 per cent of the over 80's fall each year and without effective intervention, demographic trends alone will result in substantial increases in the number of falls, falls injuries, and fall-related deaths amongst older adults in the UK[2].

The care of hip fracture is costly. An average figure of £10,000 for hospital care and subsequent costs of community support and institutional care for those who need it is widely accepted, with total costs in Scotland probably amounting to around £60 million a year[6].

The annual cost to the NHS of treating osteoporotic fractures sustained in the absence of major trauma among men and women over the age of 50 is of around £1.7 billion. This covers acute costs, social care costs, long-term hospitalisation, drugs and follow-up, but not the cost to social services and long-term institutional care[10].

Nearly half of nursing home admissions are due to falls and postural instability[5].

Risk factors for falls and injuries

The tendency to fall increases with age. Risk factors for falling tend to increase in prevalence with age, leading to more frequent falls. Evidence from cohort studies strongly suggests that the direction of the fall (to the side rather than forward) is critical in determining hip fracture and is also an age-related effect. Poor visual acuity, use of hypnotics, neurological disease and slow gait speed have also been shown to be significant risk factors[ix x xi].

Risk factors for falls are of most significance if they are (1) easily identifiable and if they are (2) potentially reversible. Potentially reversible risk factors (see Table 14) are an obvious target for intervention, provided that the preventative approach is cost-effective. Identifiable risk factors which cannot be reversed might be used to target protective devices.

Table 14. Identifiable risk factors for falls (potentially reversible)

Muscle weakness
Abnormality of gait or balance
Poor eyesight
Drug therapy – hypnotics / sedatives / diuretics / anti hypertensives
Neurological disease eg, Parkinson's disease, stroke
Foot problems / arthritis
External environment (eg, uneven footpaths, poor lighting)
Home environment (eg, loose or slippery floor covering, baths without handles)

The role of physical activity and tailored exercise in the prevention of falls

Fitness depends on a number of attributes: aerobic fitness, local muscle endurance, muscle strength, muscle speed, flexibility, body composition and motor skills (balance, co-ordination). All of these components of fitness decline with age, but a fair proportion of this decline is in fact due to disuse[xii]. This loss of physical function is exponential and will eventually cross a threshold level beyond which a person cannot maintain an independent life[xiii].

Strength, balance and co-ordination appear to be key factors in maintaining upright posture in dynamic situations.

Speed of movement and reaction time are also vital to prevent a trip becoming a fall.

An appropriate exercise programme which helps to reduce the age related decline in fitness, and particularly training to improve strength, balance and coordination is highly effective in reducing the incidence of falls among people in later life[xiv]. Research has shown that physical activity programmes combining strength, balance and endurance training, reduced risk of falling by 10 per cent; programmes with balance training alone reduced the risk by 25 per cent; however, Tai Chi with individual coaching has been shown to reduce the risk of falling by 47 per cent[xv].

Physical activity can slow down the rate at which bone mineral density is reduced and may therefore delay the progression of osteoporosis[xvi]. The aim of a physical activity programme for those who have osteoporosis but who have not sustained fractures is to maintain bone strength, prevent fractures, improve muscle strength balance and posture and thus reduce the risk of falling. The types of activities recommended include weight-bearing activities and site-specific strength training.

For those who have osteoporosis and have sustained fractures, the aim of a physical activity programme is to prevent further fractures, improve muscle strength balance and posture, reduce and control pain and importantly reduce the risk of falling and sustaining further fractures. The types of activities recommended include:

- low intensity, low impact activities such as chair based aerobics and water aerobics; and
- strength training using short levers and body resistance.

Even those who take up exercise in later years and frail older people with multiple pathologies and disabilities can reap significant functional, mental and social benefits from regular physical activity[13]. Significant improvements in functional ability[xvii], mobility, depression and mood[xviii], strength[17], urinary urgency and other risk factors for falls can be seen, at any age, with specific tailored exercise regimes[13].

The role of physical activity and tailored exercise in helping to cope with a fall

The maintenance of an active life as people age is also important in:

- enabling them to have the functional capability to get up from the floor in the event of a fall thus preventing a 'long lie'
- helping in the long term repair of injury
- helping people to regain confidence and independence[12].

Many falls may not lead to an injury, but may result in a 'long lie' if the person is unable to get up from the floor unaided. The complications associated with a long lie include pressure sores, hypothermia, pneumonia, the psychological effects of helplessness, or even death[1].

What type of physical activity is most effective?

As outlined in Section 1, for general health benefit, adults should achieve a total of at least 30 minutes a day of at least moderate intensity physical activity on 5 or more days of the week and international research suggests that the recommendations for adults are also appropriate for adults in later life. However, these are general guidelines and a review of evidence by the Department of Health in 2004[xx] proposed some important additional considerations that are particularly beneficial for adults in later life. These are summarised in Section 1.

Evidence suggests that exercises classes that are 'general' in nature (ie, chair based mobility classes or general keep fit) do improve certain risk factors for falling (ie, strength), however, they do not reduce the actual risk of a fall or fall-related injury[12].

Researchers in this area[xxi] suggest that for effective falls management in an older group the physical activity programme should include tailored exercises that are progressive and specific to the following physical components:

- **balance**
- **power**
- **flexibility**
- **co-ordination and reaction time**
- **bone**
- **strength**
- **posture**
- **gait**

and also include adapted Tai Chi, coping skills and floor activities.

Most falls are multifactoral in origin, and there is now a clear understanding of the risk factors involved. The more risk factors present, the greater the risk of falling. Successful interventions are those which address multiple risk factors. A number of randomised controlled trials (RCTs) have studied the use of exercise programmes in the prevention of falls. In most of the trials, exercise was combined with other interventions such as home assessment, dietary change, use of hip protectors, education, cognitive intervention or medication change[11] [xxii]. Multifactorial interventions, including tailored exercise programmes, have been recommended in evidence-based guidelines for the prevention of falls in older people published by a collaboration between the American and British Geriatrics Societies and the American Orthopedic Association[xxiii].

Specific evidence on types, amounts and specificity of physical activity programmes for the prevention of falls is unavailable at present, however, evidence from a number of randomised controlled trials to date indicate a number of effective interventions that have resulted in a reduction in falls in older people. Home-based programmes to improve strength and balance have been shown to significantly reduce the number of falls and injuries experienced by women in community settings aged 80 years and older[xxiv]. A number of other studies also emphasise the importance of specificity, or tailoring of exercise programmes. These are summarised below.

FICSIT programme[xxv] – the effects of different exercises on falls in the elderly

This was a large series of randomised, controlled trials with seven sites across the US each providing an exercise component with differing focuses. Some considered strength training, some endurance and flexibility training and others concentrated on balance training. The combined reduction in risk of falls for all the exercise interventions was 10 per cent.

The effect of Tai Chi[xxvi]

This study found that Tai Chi delayed the onset of the first or multiple trips or falls by half. It appears that taking up Tai Chi in older age (mid 50's), helps in the maintenance of good balance. A cross-sectional study of long term (greater than 10 years) regular Tai Chi Chuan has shown favourable effects on balance control and flexibility in men aged 65 and over[xxvii].

Home based programme of strength and balance exercises[xxviii]

This study showed that an individually tailored and supervised year-long home-based programme of strength and balance exercises twice per week and five minutes walking everyday can reduce falls in women aged over 80 without a previous history of falls. The programme has been shown to be effective in reducing the risk of falls and injury in the over 65's, but is only cost-effective in those aged over 80[xxix]. Interventions targeting those aged over 80 may see more significant changes to quality of life because they are targeting those who fall more frequently, injure more easily and recover more slowly.

Other studies have highlighted the importance of specificity, showing that not all types of exercise will beneficially affect the number of falls.

A long term (10 year) follow-up of regular walkers[xxx]

This study showed that although the health and mobility of the walkers was better than those who were sedentary, there was no significant reduction in the number of falls they had compared to the group who stopped regularly walking. Other trials considering seated exercise work (exercise bicycles, seated strength training) or forms of exercise that concentrated on strength or endurance rather than balance have also been shown to not be effective in reducing falls even if they address certain risk factors.

Similarly, in terms of bone health, the evidence is clear that walking can only help maintain bone density if it is regular, frequent and brisk. Swimming is not effective for bone health as the water supports the weight of the body. Bone health needs a site-specific approach to best target the main fracture sites – the wrist, hip and spine. Strength-training and weight-resisted exercise are most effective if performed at least three times a week[xxxi].

Safety issues

Assessment and exercise prescription

To minimise the risk of falling for older adults with postural instability, a functional assessment by qualified, experienced instructors prior to participating in any form of physical activity is recommended. Emphasis should also be placed on tailored and adapted exercise programmes that take account of functional limitations and an appropriate level of supervision should by given. These cautionary steps should contribute to better outcome measures for these participants[xxxii xxxiii].

The use of hip protectors

An important method of reducing injury risk during supervised and unsupervised sessions is the use of hip protector underwear which has been shown to be effective in the prevention of hip fracture[xxxiv]. The pads give both teacher and participant confidence during an exercise session[21]. However, it is known that compliance among older people is poor.

Motivation to take part in strength and balance programmes

Some people reject the idea that they are at risk, either because they are genuinely confident (sometimes over confident) of their capabilities, or because they feel that to accept they are "at risk" may stigmatise them as old and frail.

Some people who have fallen do not accept that they are likely to do so again, and could therefore benefit from advice, because they attribute their falls to momentary inattention or illness rather than to a persisting vulnerability.

Rather than focusing on the risk of falls – the very mention of which can be anathema to older people – and the possible consequences, it is better to stress the benefits of improving strength and balance? Activity carried out to improve balance is likely to be seen as socially acceptable and relevant by a wide range of older people, whereas hazard reduction, which many older people take to mean restricting activity, is not.

Many older people are receptive to messages about the positive benefits of exercises that improve balance, strength and mobility. They are likely to welcome support and encouragement to help them make this kind of exercise an enjoyable, habitual part of daily life, especially if they are given explanations for the advice offered.

The benefits of physical activity extend above and beyond falls prevention. Disease prevention and amelioration, maintenance of independence and prevention of disability and improved mental health are added bonuses to those who take part in regular physical activity. (Yardley et al 2005)

Reference Yardley et al (2005) Encouraging positive attitudes to Falls prevention in Later Life. Help the Aged, London

For more information on motivating older people, click here to go to Working paper 2 – Overcoming the barriers to physical activity for older people.

Summary of key issues

- falls and fall-related injuries amongst adults in later life are a major public health issue
- the tendency to fall increases with age. Risk factors for falling tend to increase in prevalence with age, leading to more frequent falls
- some of the risks factors for falling are modifiable with exercise
- an appropriate exercise programme which helps to reduce the age related decline in fitness, and particularly training to improve strength, balance and coordination, is highly effective in reducing the incidence of falls among people in later life
- even those who take up exercise in later years and frail older people with multiple pathologies and disabilities can reap significant functional, mental and social benefits from regular physical activity
- multifactorial interventions, including tailored exercise programmes, have been recommended in evidence-based guidelines for the prevention of falls in older people
- any workforce development plan for the promotion of physical activity in later life should address the need for knowledge, awareness and skill development in relation to the prevention and management of falls as a key component.

Key websites and resources for further information

www.helptheaged.org.uk for details of National Falls Day (June), resources for professionals and older people.

www.nice.org.uk for details of The NICE Guidelines on the assessment and prevention of falls in older people.

www.profane.eu.org an online community and an active working group of Health Care Practitioners, Researchers and Public Health Specialists dedicated to the prevention of falls in Europe and beyond.

www.laterlifetraining.co.uk for details of exercise training courses for preventing falls among frailer, older people, resources and research articles.

Tai Chi Finder for classes, videos, workshops and events.
Telephone 0845 890 0744 Website: ***www.taichifinder.co.uk***

www.nos.org.uk for the National Osteoporosis Society,
Camerton, Bath BA2 0PJ Tel 01761 471771

www.rospa.co.uk for the Royal Society for the Prevention of Accidents (ROSPA),
Edgbaston Park, ROSPA House, 53 Bristol Road, Edgbaston, Birmingham B5 7ST Tel 0121 248 2000.

UK PAPOFF c/o ISPAPOFF Secretariat, Postgraduate Education Centre, Nottingham City NHS Trust, Hucknall Road, Nottingham NG5 1PB Tel 0115 962 7758.

UK PAPOFF is the UK branch of the International Society of Physical Activity for the Prevention of Osteoporosis, Falls and Fractures. It is a multi-disciplinary scientific society encouraging research in the field of osteoporosis, falls and fractures. It produces a newsletter which includes research updates, and hosts an annual conference.

Educational materials

Active For Life Falls Prevention Programme

This consists of:

- a falls prevention programme strategy for the primary care organisation or hospital, on CD ROM
- two 90-minute videos specifically produced to promote fall prevention and management among frail older people
- Active for Life Falls Prevention – a booklet which includes advice on home assessment and adaptation to prevent falls, diet and regular physical activity and family and carer support
- Active for Life posters for display in GP surgeries and hospital waiting rooms.

Available from: Classroom Multimedia Ltd, PO Box 1489, Bristol BS99 4QJ. T 0117 940 6409. W ***www.active-for-life.com***

Golden Ball Tai Chi Video

Master Lam Kam Chuen The Gentle way to health and well-being. Published by The Lam Associates 2002 ISBN 0-9543084-0-9. Available from Jane Ward, Flat 4, 53 Tollington Park, London N4 3QP. E-mail: janeward@gn.apc.org

Step to the Future Exercise Video and DVD

Step to the Future is a new programme of exercises from Help the Aged. Presented by Seona Ross, and advised by postural stability experts Sheena Gawler and Susie Dinan, this programme of aerobic endurance and strength exercises is designed to keep older people active into later life. The DVD is also available in Hindi. The VHS and DVD is available to order through Help the Aged Home Shopping 0870 7700441 for £12 each (plus p&p). Quote product codes N2701 (VHS) or N2702 (DVD). It can be ordered by internet from ***www.helptheaged.org.uk***

Be Strong, Be Steady

Strength and balance exercises for healthy ageing by Help the Aged. This video contains a programme of chair-based and standing exercises devised specifically for older people. The programme is introduced by people who describe the important role exercise plays in their lives. Each exercise is demonstrated by a specialist and then performed in real time by older people. To obtain this video visit ***www.helptheaged.org.uk*** or telephone 0870 770 0441. Translations of the video in Bengali, Punjabi and Cantonese are also available.

Books and reports

Encouraging Positive Attitudes to Falls Prevention in Later Life by Professor Lucy Yardley and Professor Chris Todd (2005). Published by Help the Aged ISBN: 1-904528-87-2. Date of publication: 2005.

Falls, Fragility and Fractures. National Service Framework for Older People: The Case for and Strategies to Implement a Joint Health Improvement and Modernisation Plan for Falls and Osteoporosis by C Cryer and S Patel. Published by the Alliance for Bone Health, London, 2001.

The Construction of the Risks of Falling in Older People: lay and professionals perspectives. Scottish Health Feedback (1999), a research project commissioned by HEBS.

National Service Framework for Older People: Modern Standards and Service Models. Published by the Department of Health, London, 2001.

Physical Activity and the Prevention and Management of Falls and Accidents among Older People: Guidelines for Practice by P Simey and B Pennington. Published by the Health Education Authority, London, 1999. available at ***http://www.hda-online.org.uk/documents/physical_activity_prevoffalls.pdf***

Fall Proof ! by Debra J.Rose. A comprehensive balance and mobility training programme. Available from Human Kinetics ISBN 0-7360-4088-9. Tel: 0113 255 5665. Email: hk@hkeurope.com Website: ***www.HumanKinetics.com***

Selected journal articles

'Effectiveness and economic evaluation of a nurse delivered home exercise programme to prevent falls. 1: Randomised controlled trial and 2: Controlled trial in multiple centres' by MC Robertson, MM Gardner, N Devlin, R McGee, AJ Campbell. Published in 2001, in the British Medical Journal; 322: 1-5 and 697-701.

'The effect of Tai Chi Chuan and computerized balance training on postural stability in older subjects' by SL Wolf, HX Barnhart, GL Ellison, CE Coogler. Published in 1997, in Physical Therapy; 77 (4): 371-81.

'The effects of exercise on falls in elderly patients. A preplanned meta-analysis of the FICSIT trials' by MA Province, EC Hadley, MC Hornbrook. Published in 1995, in the Journal of the American Medical Association; 273: 1341-47.

Randomized controlled trial of a general practice programme of home based exercise to prevent falls in elderly women by Campbell AJ, Robertson MC, Gardner MM et al. 1997. British Medical Journal; 315: 1065-69.

Tailored group exercise (Falls Management Exercise — FaME) reduces falls in community-dwelling older frequent fallers (an RCT) 2005 by Skelton, DA, Dinan SM, Campbell MC and Rutherford OM. Age & Ageing, Oxford Journals Vol 34, No.6 Pp 636-639 (Online).

'Exercise, falls and injury prevention in older people' by D Skelton and S Dinan. Published in 2001, in Osteoporosis Review; 9 (4): 1-5.

'Exercise for falls management: Rationale for an exercise programme to reduce postural instability' by DA Skelton and SM Dinan. Published in 1999, in Physiotherapy: Theory and Practice; 15: 105-20.

'Guidelines for managing falls among elderly people' by JM Simpson, N March, R Harrington. Published in 1998, in the British Journal of Occupational Therapy; 61 (4); 165-168.

'Guidelines for the prevention of falls in older persons' by the American Geriatrics Society, British Geriatrics Society and American Academy of Orthopaedic Surgeons on Falls Prevention. Published in 2001, in the Journal of the American Geriatrics Society; 49: 664-72.

'Guidelines for the prevention of falls in people over 65' by G Feder, C Cryer, S Donovan, Y Carter. Published in 2000, in the British Medical Journal; 321: 1007-11.

'Risk factors for serious injury during falls by older persons in the community' by M Tinetti, J Doucette, E Claus, R Marottoli. 1995. Published in 1995, in the Journal of the American Geriatrics Society; 43: 1214-21.

Training and education for falls prevention

Training qualifications for those working with older people are listed in the Training section of the Information directory. However, a limited number of courses have been designed specifically to address the needs of frailer older people and falls prevention and management. These are described below.

Exercise for the prevention of falls and injuries – Training for Postural Stability Instructors – Later Life Training Ltd

An Exercise for the Prevention of Falls and Injuries session is an appropriate onward referral option for people who have participated in a hospital-based physiotherapy rehabilitation class or for people living in the community with a history of falls or fear of falling. The sessions include dynamic balance training, floor work and coping strategies as well as core components of strength and endurance. These sessions are effective at reducing trips and falls.

This is a seven-day course, post NVQ Level 3, of 100 hours including contact time. It is designed for qualified, experienced health and exercise professionals working with frailer older people. It has an inter-disciplinary approach and includes: the prevalence and consequences of falls and fractures; costs, demographic trends, and the implications for independence and quality of life; management of medical conditions; medications; and exercise programming related to participants with a history or fear of falling. The course is older person specific but the practical programming principles can be widely applied.

For further details: Later Life Training Ltd. Mountgreenan, Strath Fillan, by Crianlarich, Stirlingshire FK20 8RU
Tel 01838 3000310 email info@laterlifetraining.co.uk and website ***www.laterlifetraining.co.uk***

The Otago Exercise Programme Leaders Award – Later Life Training Ltd

This is a training course and qualification for health and exercise professionals in the delivery of the evidence based Otago strength and balance exercise programme (OEP) for frailer, older people.

The Course consists of the original 24 OTAGO Exercise Programme exercises, designed to prevent falls and improve balance, strength and confidence, that made up the original OTAGO Exercise Programme home exercise study design. There are some additional warm up and cool down exercises to ensure current international guidelines are followed. The specific order and progressions for each exercise is predetermined for OEP.

The course runs over four full days (9 am - 5 pm). Three course days followed by one day assessment. This course runs over a minimum of four weeks to allow task oriented practice before the assessment. Participants are provided with a "How to Lead" Manual developed by Later Life Training. The qualification has been aligned with NVQ Level 2 in Care and Level 2 in Exercise and Fitness.

It is anticipated that successful candidates will deliver sessions either working within the therapies in a hospital-based programme or leading falls and injury prevention sessions in community settings as part of a local health improvement plan or onward referral from the Falls or Care of the Elderly rehabilitation setting. Successful candidates will receive a Later Life Training Qualification Certificate (OTAGO Exercise Programme Leaders Award).

For further details: Later Life Training Ltd. Mountgreenan, Strath Fillan, by Crianlarich, Stirlingshire FK20 8RU
Tel 01838 3000310 email info@laletrlifetraining.co.uk and website ***www.laterlifetraining.co.uk***

Chair-based Exercise Leadership – Leicester College

A chair-based exercise class can improve many risk factors for falls (eg, strength and flexibility) but does not include dynamic balance training and is not the most effective form of exercise for falls prevention. However, it is appropriate in nursing, residential and sheltered housing settings, or for those people who have very low levels of strength and endurance and need a level of training appropriate at that time.

Leicester College offers a 32-hour course (four days plus contact hours) designed for health care and other professionals wishing to deliver 17 chair-based exercises to frailer older people. It is also appropriate for qualified exercise teachers holding a Level 2 NVQ in Exercise and Fitness, and wishing to undertake specific evidence-based exercises with chair-based, frailer older participants. The course is older person specific and is designed for those working under the supervision of a multi-disciplinary team.

For further details: Leicester College, Freeman's Park Campus, Aylestone Road, Leicester LE2 7LW
Telephone: 0116 229 5555. Email: jlicata@lec.ac.uk or s4b@leicestercollege.ac.uk
Web: ***http://www.leicestercollege.ac.uk/s4b***

Extend Diploma in Movement to Music for the over 60s and Disabled People of All Ages – Extend Exercise Training

Extend sessions vary widely in their settings and in the functional level of participants. Seated exercise sessions are appropriate in nursing, residential and sheltered housing settings but will improve risk factors only. Where prevention of falls is the focus, people living in the community with mild deficits of strength and balance can be appropriately referred into the more active community-based Extend sessions. It is not appropriate to send a person with a history of falls and injury to an Extend session unless the instructor is qualified to take Exercise for the Prevention of Falls and Injuries classes.

Extend Exercise Training offers a progressive programme to promote quality of life for the over 60s and for less able people of any age. The Extend Diploma in Movement to Music for the Over 60s and Disabled People of all Ages is a 12 day training course (100 hours including contact time). The training is older person specific. It is currently being aligned with NVQ3.

For further details: Extend Exercise Training, 2 Place Farm. Wheathampstead, Hertfordshire AL4 8SB ENGLAND.
Tel 01582\ 832760. Email: admin@extend.org.uk Web: ***www.extend.org.uk***

Mature Movers Seated Exercise Certificate – Keep Fit Association

A 60 hour seated exercise course designed for health care and other residential setting professionals.
The course is aligned to NVQ2 Health Care. Assessment takes place in the workplace.

For further details: Keep Fit Association, Astra House, Suite 1.05, Arklow Road, London SE14 6EB.
Tel 020 8692 9566. Email: Kfa@keepfit.org.uk Web: ***www.keepfit.org.uk***

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WORKING PAPER 12

WORKING WITH ETHNIC MINORITY ELDERS

This working paper is divided into two sections and provides

1. **A summary of evidence relating to elders from ethnic communities, including:**
   - **the size, age structure and location of ethnic minority populations**
   - **the health of ethnic minority populations, with an emphasis on the older population**
   - **levels of physical activity among ethnic minority populations, with an emphasis on the older population.**
2. **Guidance on the practical aspects of promoting physical activity among ethnic minority populations.**

PART 1 – Summary of evidence

The profile of ethnic minority populations

This section summarises national research conducted on the largest of the ethnic minority populations, namely Indians, Pakistanis, Bangladeshis, African-Caribbeans and Chinese. With respect to other large groups such as Black Africans we provide merely the size of the population. Little information exists on their health needs at national level as Black Africans are not an ethnic group per se but aggregates of very diverse communities based solely on geographical origin and skin colour. Similarly other large communities, such as Arabs, Somalis and Turks, are not included as national data about them are not available.

The size of the ethnic minority populations

The 1991 Census identified just over 3 million people (5.5 per cent of the population of Great Britain) as belonging to one of the ethnic minority groups. More recent estimates from the 1997 Labour Force Survey (Schuman, 1999) show that this figure has grown to 3.6 million people (6.4 per cent of the population). Table 5 shows the size of the different groups.

Table 5 – The ethnic composition of the population of Great Britain

	Number (000s)	Percentage of total population
White	52,936	93.6
All ethnic minority groups	3,599	6.4
African-Caribbean	526	0.9
Black African	352	0.6
Black Other	307	0.5
Indian	925	1.6
Pakistani	587	1.0
Bangladeshi	209	0.4
Chinese	157	0.3
Other Asian	192	0.3
Other	344	0.6

Source: Labour Force Survey, 1997 (Schuman, 1999)

The largest ethnic groups are Indians, African-Caribbeans, Pakistanis, Bangladeshis and Chinese. South Asians (Indians, Pakistanis and Bangladeshis) form about half of the ethnic minority population. Black groups make up a further quarter of the population. Just under a half of the ethnic minority population were born in the UK. This figure increases to 90 per cent for those aged below 35.

Within the South Asian groups, males generally outnumber females. This is due to specific migration patterns in these communities, where men tend to come to settle first and are later joined by their relatives. In all other populations females generally outnumber males, as is the case with the general population.

The age structure of the ethnic minority populations

Table 6 – Age structure of the ethnic minority populations

Ethnic group	0-24 years (per cent)	25-49 years (per cent)	50-74 years (per cent)	75+ years (per cent)
White	32	35.2	25.4	7.4
African-Caribbean	36.8	38	24.2	1.2
Indian	44.7	39.7	14.4	1.2
Pakistani	60	29	10.5	0.4
Bangladeshi	64.8	23.5	11.5	0.2
Chinese	41.2	45.6	12.2	1

Source: 1991 Census (Warnes, 1996)

Census data reveal that the age structure of ethnic minority groups differs significantly from that of the general population (Warnes, 1996).

Ethnic minority populations generally have a much younger age profile, with a far higher proportion aged 0-24 years than the general population. This reflects both a tendency for ethnic minorities to have larger families (which is particularly the case with South Asians), and migration patterns since migrants tend to represent the younger, economically active members of the population.

A quarter of the general population is aged between 50 and 74 years. A similar proportion is found among the African-Caribbean population with just over 24 per cent of this population aged between 50-74 years. However, a much smaller proportion is found among the other groups: 14 per cent of Indians, 10 per cent of Pakistanis, 11 per cent of Bangladeshis, and 12 per cent of Chinese are aged between 50-74 years.

The differences between the general population and ethnic groups are greater still when one considers those aged 75 years and over. While just over 7 per cent of the general population is aged 75 years and over, the equivalent figure for the ethnic minority populations is 1 per cent or below.

It is important to note that the above figures are based on 1991 census. The number of older people (aged 50 years and over) will have increased significantly over the last ten years. In 1991, there were 12 per cent of Indians, 8 per cent of Pakistanis, 6 per cent of Bangladeshis, 12 per cent of Chinese and 9 per cent of African-Caribbeans aged between 40-49 years. Most of them will now be in the 50 years plus age group.

The location of ethnic minority populations

The ethnic minority population is largely concentrated in a few geographical areas (Schuman, 1999). Nearly half (44.8 per cent) of all ethnic minority groups live in the Greater London area, compared with one in ten of the white population. A further quarter of the ethnic population lives in the West Midlands, West Yorkshire and Greater Manchester areas.

There are significant variations in the concentration of individual ethnic groups. The Black population is heavily concentrated in the Greater London area, with 85 per cent of Black African and 60 per cent of the Black-Caribbean population residing there. Among the South Asian groups, about half of the Indian and Bangladeshi and a fifth of the Pakistani population live in the Greater London area. In contrast, 60 per cent of Pakistani, 20 per cent of the Black-Caribbean and only 5 per cent of the Black-African population live in the Greater Manchester, West Yorkshire and West Midlands areas.

The health of the ethnic minority populations

This section summarises the key findings from research on health conditions for which physical activity is known to be beneficial and from which ethnic minority populations suffer disproportionately. When there are reliable national data specifically about the older members of ethnic minority groups, we provide these data. However, it is often the case that no such data are available because the sample sizes are too small to allow for meaningful comparison between age groups. Therefore, when it is not possible to offer a breakdown in terms of age, we provide general findings for all age groups. It should be borne in mind that, as with the general population, the severity of the conditions is likely to increase with age.

Coronary heart disease

Among South Asians, the mortality rate from coronary heart disease (CHD) is 38 per cent higher among men and 43 per cent higher among women compared with the population of England and Wales (Balarajan, 1996). The pattern shows some variations between the groups, with the highest rates among Bangladeshi men (with rates 47 per cent higher than the general population), followed by Pakistani men (42 per cent higher) and Indian men (37 per cent higher). The African-Caribbean population has lower rates of coronary heart disease than the general population (Balarajan, 1995), as do the Chinese (Harland et al, 1997).

Mortality rates from CHD among South Asians have not declined as fast as in the general population (Wild and McKeigue, 1997). The mortality rates from CHD for those aged between 65 and 74 years indicate a similar pattern: South Asians suffer more than the general population from CHD, while African-Caribbeans are less affected (Balarajan, 1995).

Stroke and hypertension

Significantly higher rates of mortality from stroke are found across all ethnic minority groups, compared to the general population. The highest rates are found among Bangladeshis (2.5 times the national average) followed by African-Caribbeans (1.8), Pakistanis (1.7) and Indians (1.3) (Balarajan, 1995).

A similar pattern is found among those aged 65 to 74 years, with significantly higher mortality rates from stroke in Bangladeshis, followed by African-Caribbeans, Indians and Pakistanis (Balarajan, 1995).

Between 1988 and 1992, mortality from hypertension (high blood pressure) among African-Caribbeans was 3.5 times greater than for the general population of England and Wales. Among South Asians the rate was 1.5 times the national average (Raleigh, 1997).

It is estimated that between 25 per cent and 35 per cent of African-Caribbeans are hypertensive, compared to 10-20 per cent of the general population (Beevers et al, 1993).

Diabetes

Rates of diabetes are much higher among all ethnic minority groups than in the general population. Among ethnic minority men aged over 55 years, 18 per cent of African-Caribbeans, 19 per cent of Indians, 39 per cent of Pakistanis, 31 per cent of Bangladeshis and 16 per cent of Chinese men are reported to have diabetes, compared with 7 per cent among men aged over 55 in the general population (Erens et al, 2001). Among ethnic minority women aged over 55 years, 26 per cent of African-Caribbeans, 15 per cent of Indians, 28 per cent of Pakistanis, 26 per cent of Bangladeshis and 12 per cent of Chinese women have diabetes, compared with 5 per cent among women aged over 55 in the general population (Erens et al, 2001).

Mortality data from diabetes show that when compared with the general population Bangladeshis have a 6.5 fold excess, Pakistanis a four-fold excess, and Indians a three-fold excess. African-Caribbean men exceed the national average by 3.6 fold; while among African-Caribbean women the excess is six-fold (Raleigh et al, 1997).

Twenty per cent of South Asians aged between 40-69 years are known to have non-insulin dependent diabetes, compared with 5 per cent of whites (McKeigue and Sevak, 1994). The condition remains undiagnosed for 40 per cent of South Asians (Simmons et al, 1989).

Psychosocial health

This section reports on some key social and psychological factors that are assumed to correlate with health. In particular, it addresses reported stress and worries, anxiety levels, and severe lack of social support (ie, the amount of support and encouragement people receive from family and friends) for all major ethnic minority groups.

About one in ten (9 per cent) of the general population report that stress and worries at home have a bad effect on their health. Higher rates are found among ethnic minorities with 12 per cent of African-Caribbeans, 11 per cent of Indians, 16 per cent of Pakistanis and 17 per cent of Bangladeshis stating that stress and worries at home affects their health (Health Education Authority, 1994). Breakdown by age group is not available.

Anxiety levels among those aged 55 years and over do not seem to vary significantly in relation to ethnicity. Some 12 per cent of people aged over 55 years in the general population report two or more symptoms associated with anxiety such as: heart racing or pounding; hands sweating or shaking; difficulty getting breath; butterflies in the stomach; dry mouth; and nausea. This compares with 9 per cent for African-Caribbeans, and 10 per cent for both Indians and Pakistanis. Data for Bangladeshis and Chinese are not available due to the small sample size (Nazroo, 1997).

Figures on social support among those aged over 50 differ significantly both in terms of gender and across ethnic groups. Generally, men suffer more than women from severe lack of social support. Among the general population, 17 per cent of men are classified as severely lacking social support. Among ethnic minority men, 19 per cent of African-Caribbeans, 35 per cent of Indians, 35 per cent of Pakistanis, 29 per cent of Bangladeshis and 55 per cent of Chinese are classified as having a severe lack of social support (Erens et al, 2001).

The equivalent figures for women aged 50 years and over are as follows: 11 per cent of women in the general population experience a severe lack of social support, compared with 8 per cent for African-Caribbeans and 34 per cent for Indians. Data for both the Bangladeshis (26 per cent) and the Chinese (34 per cent) are tentative and must be interpreted with caution due to small sample sizes. No data for older Pakistani women are available due to the very small sample size (Erens et al, 2001).

Falls and accidents among ethnic elders

There are no specific data relating to the prevalence of falls and accidental injuries among ethnic elders. Check with Help the Aged.

Levels of physical activity among ethnic minority populations

Among men aged 55 years and over, 20 per cent of African-Caribbean, 22 per cent of Indian, 15 per cent of Pakistani, 7 per cent of Bangladeshi and 13 per cent of Chinese people do enough physical activity to benefit their health (30 minutes of moderate activity on at least 5 days a week). This compares with 18 per cent for the male general population aged over 55 years (Erens et al, 2001).

Among women aged 55 and over, 14 per cent of African-Caribbeans, 2 per cent of Indians, 6 per cent of Pakistanis, 1 per cent of Bangladeshis and 14 per cent of Chinese people do enough physical activity to benefit their health. This compares with 11 per cent for the female general population aged over 55 years (Erens et al, 2001).

Sedentary levels – doing less than half an hour of physical activity a week, providing no health benefits at all – are very common among ethnic minority groups. Among men aged 55 and over, 57 per cent of African-Caribbeans, 67 per cent of Indians, 73 per cent of Pakistanis, 85 per cent of Bangladeshis and 68 per cent of Chinese are sedentary. This compares with 57 per cent for the male general population (Erens et al, 2001).

Sedentary levels among women aged over 55 years are 59 per cent for African-Caribbeans, 78 per cent for Indians, 85 per cent for Pakistanis, 92 per cent for Bangladeshis and 64 per cent for Chinese. This compares with 62 per cent for the female general population (Erens et al, 2001).

Regardless of their ethnic background, people cite the same key barriers to engaging in physical activity. As for the general population these consist of lack of time, energy, or an appropriate companion, or a self-perception of not being sporty (Health Education Authority, 2000).

Awareness of the association between physical activity and health is very low among ethnic minority groups generally. When asked which serious illness or health problem may result from not taking enough exercise, less than a third mentioned heart disease and less than one in 20 mentioned stroke or high blood pressure (Health Education Authority, 2000).

PART 2 – Promoting physical activity among ethnic minority elders

This section provides background information on the life conditions of older members of various ethnic communities. It:

- highlights the scarcity of services targeted directly at the older segment of the ethnic minority population
- discusses perceptions of physical activity among ethnic minority groups and the main reasons invoked for lack of physical activity
- suggests ways to design culturally appropriate activities and centres.

In discussing issues of concern to older members of ethnic minority groups, one inevitably resorts to a degree of generalisation. However, each community is characterised by much internal diversity. These dimensions of diversity are identified wherever possible.

Ethnic minority elders in Britain: some commonalities

The vast majority of ethnic minority elders were not born in the UK. Often they arrived here as adults. Culturally and linguistically, therefore, their roots are elsewhere. The sense of identity and way of life of elderly members of the various ethnic minority groups are also rooted in different social worlds, where people prepare and eat different foods, dress differently, follow different patterns of social interaction, worship different gods, rejoice and mourn following different customs. Old age brings into sharp relief the loss of one's country and culture. All older people, but members of ethnic minority groups perhaps more intensely, relish in the opportunity to engage and reminisce with others who share a common background and implicit understanding. They crave being simply accepted on their own terms.

This is particularly important since a significant proportion of older people from all ethnic communities do not use English as their main language of communication (except the African-Caribbeans, for whom English is the mother tongue). In fact, many hardly speak English at all despite years of living in Britain. This lack of fluency in English often correlates with poor education, though this is not necessarily the case.

Religion is also very important in the lives of most ethnic minority elders. One of the main motivations to venture out of the house is to attend places of worship. Religious celebrations are of course occasions for social contact, something which older people across all ethnic groups lack and desire.

Older people generally, and ethnic minority elders even more acutely, experience economic deprivation on a disturbingly large scale.

Finally, the burden of isolation and loneliness, so common among all older people, affects ethnic elders even more seriously. These feelings are fuelled by anxieties about safety on the streets, as well as by fears of racism.

Overcoming barriers and increasing access to physical activity

Two inter-related types of barriers combine to reduce the uptake of physical activity by ethnic minority elders:

- the lack of provision of culturally appropriate services
- the perceptions of physical activity and services currently on offer among the older sections of various ethnic minority groups.

The first of these is by far the more important. The second is partly influenced by the first.

Provision of culturally appropriate environments

The most significant barrier to fuller participation in physical activity by ethnic minority older people is the lack of culturally adequate services catering for their specific needs. Ethnic minority older people do not feel at ease when using services designed for and attended mainly by white people. As a result, they avoid them altogether.
Their main sources of anxiety are:

- general anxiety about something unfamiliar
- fears about not 'fitting in'
- fears about racism
- inability to communicate in English
- concerns about the inadequacy of provisions (eg, the food not being halal or vegetarian).

Therefore, for ethnic minority older people to participate in physical activity, or any other activity, it is a basic requirement that the overall social and cultural context in which they conduct these activities must reflect the specificity of each ethnic group. Once this is achieved, many of the barriers to participating in physical activity are similar to those for older people in the general population.

The following key dimensions of culture and ethnicity need to be considered when devising activities for ethnic minority elders.

Language

Most older members of ethnic minority groups (except African-Caribbeans for whom English is the native language) feel more comfortable speaking in their mother tongue than in English. In fact, some hardly speak English at all. Language is not only essential for effective communication; it is crucial for social identification. It is therefore imperative that group activities be run in the main language of the specific communities that they target.
The main languages spoken by people according to their area of origins are shown below.

Main languages and religions of ethnic minority groups

Area of origin	Main languages spoken	Main religions
India (and East Africa)	Punjabi, Hindi, Gujarati	Hindu, Sikh
Pakistan	Urdu, Punjabi	Muslim
The Caribbean	English	Christian
Bangladesh	Bengali, Sylheti	Muslim
China (and Chinese diaspora)	Cantonese, Mandarin	Confucian, Taoist, Buddhist

Religion

Another key cultural dimension which intersects, but does not totally overlap with language is religion. Activities should be targeted to specific groups, as Hindus, Sikhs and Muslims, for example, frequently have different needs and priorities even though they may originate from the same country. The main religions practised by people according to their area of origins are shown in the table above.

Religious prescriptions and proscriptions do not impact per se on the types of physical activity deemed acceptable, but they do affect the manner in which the activities are organised and delivered. They also impact on the total environment within which these should be conducted.

The only group for whom religion has a more immediate impact on the provision of services is Muslims:

- for Muslims, it is not acceptable to engage in mixed-gender activities. Activities should be segregated between men and women. Also, activity leaders should be of the same sex as the participants
- many elderly Muslims pray five times a day (Namaz). Providers should take this into account, acknowledge that Namaz is itself a form of physical activity and build further activities around prayers
- most elderly Muslims fast from dawn to sunset during the Holy Month of Ramadan. Friday is the day of assembly for Muslims. This should be taken into account when planning activities.

For all other groups, mixed gender does not offend religious principles, although women and men might prefer to socialise separately.

Leadership skills

Ideally, staff leading activities should be of the same background as participants. This is particularly important for the South Asian and Chinese populations. The ethnic, religion and gender matching of staff and participants instils confidence and creates ease, in turn, increasing the likelihood that people will participate.

The issue of staff-participant 'matching' is particularly important in the early stages. Once a core group of older ethnic participants from any one community has been recruited, the initial reluctance is overcome. People have developed trust in the service providers and so the relative importance of 'matching' decreases. Group members rely on each other and in fact enjoy their growing autonomy. Often, they will also become receptive to doing physical activity – such as going for walks – with members of other groups. However, this will only work if there is a small group of 'regulars' from one community.

It should be noted that there is a chronic shortage of skilled staff from ethnic minority backgrounds. The problem is particularly acute among the Bangladeshi, Black African and Chinese populations.

Recommendations for action

Organisations could consider:

- developing leadership and organisational skills among representatives of a range of communities activities and giving them proper reward for running activities
- involving a range of community members in running activities that require no specific training
- developing multicultural awareness among all staff.

Food

Food is one of the most basic dimensions of culture. It is a direct tie with one's family and country. It is therefore essential that providers offer the foods most familiar to the specific ethnic groups targeted. Particular attention should be paid to religious prescriptions.

There is a limited recognition of the contribution made by diet in maintaining a healthy lifestyle. The difference in South Asian and Chinese diets in relation to fat and sugar content is cited as an example of this.

Ease of access and safety

Elderly people tend to feel rather anxious about their social environment. Fear of crime is widespread. The problem is compounded among ethnic minority elders, who also fear racially motivated attacks. Although service providers cannot do much themselves about that, they can allay some of the fears by providing enhanced safety, for example by ensuring that activities are held during daytime, that the immediate surroundings of day centres are well lit, or that door-to-door transport is provided (this is particularly important since many elderly people have reduced mobility).

General lack of resources and strategic planning

Organisers complain of an acute shortage of money and staff to run activities with ethnic minority people in general. The problem is compounded, of course, when the level of specificity increases and one tries to target elders and to focus on physical activity. Short-term funding and general lack of strategic planning are often identified as the main barriers to setting up proper services.

Recommendations for action

- develop a strategic framework based on consultation with ethnic minority groups
- evaluate the service provision
- protect the funding of successful initiatives for at least three years.

A myth about the supportive role of the extended family

People working with ethnic minority groups have challenged common assumptions about both the prevalence and the positive role of the extended family system. They reject these assumptions as unfounded and argue that such assumptions might serve to legitimise the current lack of provision.

Recommendations for action

- challenge mistaken assumptions about the extent and role of the extended family.

Cultural differences in attitudes to physical activity

There do not appear to be any significant differences in the attitudes people hold towards physical activity between older members of various ethnic minority groups and the general population.

There are no cultural or religious reasons that would actually prevent ethnic minority elders from engaging in physical activity. However, the kind of activities preferred and the manner of participation are partly dependent on culture.

There are few cultural differences in the types of activities preferred.

Compared with the general population, very few members of ethnic minority groups have pets. Activities that revolve around them (such as dog walking) are therefore unlikely to be attractive to this population.

Some examples of cultural differences in the types of activities preferred are:

- for African-Caribbeans, music is an important component of social and physical activities
- for Chinese people, Tai Chi is a favourite activity, and gardening is very popular.

However, as with all groups of older people, beware of stereotypes and be prepared to offer choices.

Recommendations for action

- encourage members of all ethnic and religious groups to engage in physical activity
- use music with African-Caribbean elders and promote Tai Chi and gardening among elderly Chinese people
- beware of stereotypes and be prepared to offer choices and new ideas.

There is little knowledge or agreement about what constitutes the recommended level of physical activity eg, responses can range from 30 minutes and up to two hours per day to 30 minutes per week and 10,000 steps per day.

Perceptions of physical activity and of the services on offer

Most people associate physical activity with sport and strenuous exercise. This may not be explicitly stated as a reason for not engaging in physical activity, but it may account for the exceedingly high levels of sedentary behaviour found across all ethnic minority elders. Taking up physical activity so perceived must seem a daunting prospect for most.

Many people seem to think of physical activity as an (unpleasant) means to an end, rather than as an end in itself. They believe they must dutifully engage in physical activity because it is good for one's health, but do not seem to think that the process itself could be fun and pleasurable.

However, differences between how sport and physical activity were perceived arise in relation to the 'organised' nature of many sports (the exception was participation in organised walking groups), the sense that sports were either done as part of a team/group (defined as two or more participants) or in a more competitive environment, ie, beating your opponent/s or improving individual/team performance.

There is consensus that sport is somehow 'more energetic' and 'intensive' in nature. In contrast, physical activity in general was seen as something that is engaged in on an individual basis, whether pursuing an interest as part of a larger group or as a lone participant. Physical activities carried out as part of a daily routine, eg, housework, shopping or gardening, are also cited as activities an individual would do themselves.

To overcome the association of physical activity with sporting activities, some organisations conduct physical activity sessions under more appealing and less threatening names, such as 'stress reduction', 'gardening', 'exercise to music' (rather than aerobics) or 'dancing' classes.

Perceived benefits of physical activity

There is high awareness that physical activity can enhance health. Together with non-smoking and a healthy diet, physical activity is identified as one of the main factors associated with good health.

Any form of physical activity is understood to result in positive outcomes with group participants citing better physical and mental well-being both immediately and in the longer term, alleviating social isolation and fostering a sense of being more connected with the wider community whether this was within one's own community, ie, ethnic group, or with the community at large. Importantly, for some, undertaking regular physical activity was also seen as a means of imposing structure and discipline in what could be an otherwise unstructured lifestyle.

However, there is a lack of awareness of the specific illnesses or health problems that may result from insufficient levels of physical activity. Moreover, physical activity may not have much relevance in people's lives. Many seem to think that the net benefit to them, considering all the effort put into actually doing the activity, is marginal.

Ideas for action

- emphasise improvement in overall quality of life
- promote more specific knowledge of the health benefits of physical activity.

Reasons invoked for lack of physical activity

In common with all older people, members of ethnic minority groups will not engage in physical activity on their own initiative and in isolation. They need encouragement and social support. The principal reason for not taking up physical activity is lack of a proper companion or culturally adequate environment or there not being an activity where people can meet fellow members of their community.

Other reasons include: lack of relevance in their lives ("I'm already so old…"), lack of energy, and a self-perception of not being 'sporty'.

Ideas for action

- conduct physical activity sessions within a broader programme of social activities
- use word-of-mouth: entice those already involved to encourage fellow community members to take part in physical activities
- distinguish between physical activity and sport: make it a part of everyday life
- emphasise improvement in overall quality of life.

Lack of awareness among ethnic minority elders about existing provision

It is extremely difficult to reach out to many ethnic minority elders. A large proportion of them do not go out, except for very short shopping trips and, occasionally, to attend places of worship. Not surprisingly, information about existing services often fails to reach those who most need them.

There is no single or best means to communicate information. A combination of approaches is required to be effective in reaching ethnic elders and communicating information.

Ideas for action

Combine different strategies to inform ethnic minority elders about existing provision:

- leaflets and audio-cassettes in appropriate ethnic minority languages (at GPs' surgeries, community centres, places of worship, etc)
- encounters with social services personnel
- ethnic radio networks
- road shows
- through friends, relatives and neighbours.

WORKING WITH ETHNIC MINORITY ELDERS CONTINUED

Summary of recommendations

- **offer training to lay representatives of a range of communities and give them proper reward for running activities**
- **involve a range of community members in running activities through the development of leadership and organisational skills**
- **involve a range of community members in running events that require no specific training**
- **develop multicultural awareness among all staff**
- **develop a strategic framework based on consultation with ethnic minority groups.**
- **evaluate the service provision**
- **protect the funding of successful initiatives to ensure programmes can be sustained for at least three years**
- **challenge mistaken assumptions about the extent and role of the extended family**
- **recognise that:**

  - all ethnic and religious groups can engage in physical activity

  - there are few cultural differences in the types of activities preferred
- **use music with African-Caribbean elders and promote Tai Chi and gardening among elderly Chinese people**
- **emphasise improvement in overall quality of life**
- **promote more specific knowledge of the health benefits of physical activity**
- **conduct physical activity sessions within a broader programme of social activities**
- **use word-of-mouth: entice those already involved to encourage fellow community members to take part in physical activity**
- **combine different communication strategies to inform ethnic minority elders about existing provision.**

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WORKING PAPER 13

WORKING WITH OLDER MEN

Introduction

Older men face particular problems that are often overlooked. Besides having a shorter life expectancy than women, with particular differences for disadvantaged men, they not only experience a number of male-specific health problems (eg, prostate cancer) but are more likely than women to develop any form of cancer, heart disease and stroke or take their own lives. Older men are more likely than older women to experience significant social isolation, consume alcohol at above recommended levels and to delay seeking help from health and other services (MHF 2007).

It can be argued that service providers have often neglected older men. This may be because there are more older women but also because many men are reluctant users of services. Providers have often argued that if men do not use services, or demand access to different types of services, then that is men's choice and responsibility; providers may not have asked if existing services have been delivered appropriately or how men's needs might be more effectively met. The fact is that services remain female dominated. Eg, While the majority of participants in the Walking the Way to Health programme were over 50, 73 per cent were female (WHI 2006). While these figures are important in that older women have lower levels of physical activity than men, they raise important questions about older men's participation in programmes.

1. Men's participation in physical activity

Surveys consistently report higher participation in physical activity by men and higher scores of functional capacity amongst older men than older women. (Skelton et al 1999).

Those levels of participation decline significantly with age and at each stage, levels of the majority of older men are insufficient for health.

However many agencies report difficulties in recruiting older men to physical activity programmes (Age Concern 2007).

This working paper sets out to raise a number of questions relating to improving opportunities for older men to become physically active and maintain activity throughout the later stages of life.

2. Key issues relating to older men in the population

There are an increasing number of older men in the population. In 1951 there were 77 men aged 50+ per 100 women; by 2003 that figure had increased to 85 and is expected to increase to 90 by 2031.

1.7 million single older men could be living in isolation in the UK. Nearly 400,000 of these are single older men aged 75 and over. It is also estimated that 289,000 single older men are living in poverty. (Age Concern 2005)

In 2003 there were only 40 men per 100 women aged 85 and over, this is estimated to increase to 65 men by 2031.

Within these figures are a number of key issues:

- older men are more likely than older women to be married and to live with their spouses
- older men – particularly those who are bereaved, divorced or never married – are more likely than older women to be excluded from wider social relationships
- grandfathers are less likely to see their grandchildren if they are not married and living with their wife
- men's life expectancy is lower than women's, although there are significant social class differences as well
- older men are major providers of care, with those over 75 providing more intensive care (50 hours or more per week) than women
- in general, male pensioners have higher incomes than females, with the greatest difference between married pensioners. For single, divorced and widowed older men, the differences are much smaller
- older men have more access to cars, mobile phones and the internet than do older women
- older men are more likely than older women to be self-employed
- older men are more likely to smoke and drink than older women
- women are more likely to take part in religious activities than men
- loneliness resulting from the death of a spouse, poor social support and physical illness or disability can lead to self harm and suicide in older age – particularly amongst older men.

"A picture emerges of considerable differences both between older men and older women and between different groups of older men". (Age Concern 2007)

Married men retain significant economic and social advantages over bereaved, divorced or never married men. As the number of older men increase, along with the associated increases in bereavement and divorce, access to services is likely to become even more important and the need to find appropriate services more pressing.

3. Why don't older men use services?

Cultural and social reasons? eg:

Traditional notions of gender emphasise the importance for men of independence and self-reliance, the centrality of employment, the workplace and of "productivity" as contributors to society.

Reality or perception – do older men become "grumpy old men" who are stuck in the past or do they display diminished masculinity "resting on a park bench"?

Are they reluctant to admit to having problems, display emotions or seek assistance from others? In practice they are less likely to recognise or acknowledge conditions such as depression or stressful life events or visit the doctor (seen as a sign of weakness?) or delay appointments until the condition becomes more serious.

Individual reasons? eg:

Personal and family circumstances may also hinder involvement in services – such as emotional problems following bereavement resulting in withdrawal from social contact or problems with health and mobility.

Women tend to maintain wider family, friendship and support networks than men which continue into retirement. Men's more work-based networks tend to dwindle or disappear after retirement. Divorced and single men are more susceptible to social isolation, poor health, and risk behaviours (eg, drinking and smoking) than married older men.

There are also individual differences that are age related. For men at the older end of the age range there is sometimes a sense of "closing down", a gradual withdrawal from social engagement, communication and participation – "they presume that this is their lot in life" (Age Concern 2005). For those in the younger 60 – 75 age range, there is more of a need to remain active and an understanding of the potential of old age.

There is some evidence that these individual level barriers to services are less significant than others.

Service level reasons? eg:

The nature of referrals, organisation and absence of male "front-line" staff.

Are male role models necessary to engage older men in health services eg, exercise class instructors/physiotherapists? Is it that the activities provided are unappealing to older men (eg, cooking, dance, arts and crafts) and that activities with a practical outcome (eg, photography and IT) are more attractive than physical activity opportunities that retain a sense of sport or competition? Perhaps older men prefer to do their own thing rather than participate in formal or organised activities eg, 'working out' by themselves.

Some older men may prefer 'men's groups' or to attend services as volunteers and contributors (as walk leaders, drivers) rather than passive participants, 'doing for others' rather than being 'done to by others' (Arber and Davidson 2006).

Are older men affected by the 'feel' of a service that most members are women or that the services are designed for women, or that they will feel out of place and unsure how to behave in a 'feminised' service?

4. What opportunities are there?

There are significant challenges for those services wanting engage and work with older men. The Age Concern Review (2007) highlights the following areas:

- responding to the key issues for older men
- recruiting older men to services and programmes
- developing appropriate service provision
- improving men's health and well-being
- creating a suitable atmosphere within services
  - as being critical to developing this area of work.

Responding to the key issues for older men

An important starting point is to be clear about what the needs of older men in the local community are. This will require developing sensitive information systems about attendance at programmes, local surveys about services, preferences and interests. These might include:

Key transitions in men's lives, eg, retirement, bereavement or significant health problems.

Sensitivity to different masculinities, eg, from ethnic minority or gay communities, white working class identities.

The centrality of work and war in older men's lives, eg, that masculine identity and work are closely linked and provides the means of judging a man's worth, linked to the possibility of a loss of role, self esteem and worth upon retirement. It is suggested that men often look back at war time as a defining period in their lives, being young, active and part of a collective endeavour.

Recruiting older men to services and programmes

Finding older men, eg, the key locations: pubs, cafes, allotments, bowling greens; key people eg, peer mentors; front line staff eg, volunteer drivers, handypeople; or home visits that may be less threatening and reach isolated older men.

Strengthening referred access routes, eg, exercise referral and social prescriptions from GPs.

Addressing men's lack of awareness of services, eg, printed publicity and information for older men about the benefits of services and their availability in appropriate locations. Media work should be complemented by face to face recruitment.

Addressing the difficulties in rural areas, eg, depending upon car or public transport or developing home based services via male volunteers visiting older men or via internet services.

Developing service provision

Consulting with older men, responding to their wishes and tailoring services accordingly. Service provision 'designed for men' but without their input was less successful. Older men often react best to service provision that is simple and straightforward and protects their right to control and organise their own lives.

Supportive management and coherent strategy – service managers must recognise that engaging older men improves the overall quality of services, not just for older men and that consistency and coherence across a range of services is required linked to strategic aims and objectives.

Designing appropriate service models to ensure that older men have a choice that includes both access to mainstream services and segregated provision. The key is finding a reason why older men would want to come together eg, attendance at sports events.

Developing attractive activities – in general, middle class men may attend activities for educational reasons, whereas working class men are more attracted by social contact. The success of an activity may depend upon the way it is presented to older men, how it is run, whether other men attend or it is perceived as a 'masculine' activity, rather than the activity itself. For men who are isolated, there is a preference for social over skills-based or educational activities.

"Men's groups however are not a universal panacea to the problem of how to engage older men". (Age Concern 2007)

Developing male roles within services – increasing numbers of male staff in face to face services, although not itself essential to attract older men to services, may assist in making older men feel more welcome and comfortable in a female dominated service.

Increasing volunteer opportunities – by recruitment into driving, gardeners and other volunteer roles eg, buddying.

Stimulating support networks – women tend to develop friendships around the home and social groups, whereas men's tend to be workplace related, and more likely to be reduced or disappear in retirement. Widowed men also rely heavily upon family after bereavement. These differences highlight the importance of developing new social networks for men.

Reaching the hardest to reach – most isolated and frailer older men are not reached by services and rarely have visitors. They may also find it hard to accept help.

Issues relating to fatherhood and grandparenting – many older men are isolated from families, including their children, increasing their social isolation. These issues may form the basis for developing new groups for older men.

Improving men's health and well-being

Evidence suggests that it is difficult to engage men (especially older men) around health issues as men tend to delay taking action and 'tough it out'. When men do engage, it is usually around physical activity, and they are less keen to participate around diet/nutrition and mental health. However key learning includes:

Going to where men are – eg, the locations that older men frequent: pubs, allotments, snooker clubs and working men's clubs.

Respecting men's choices – some older men may be open to reviewing and changing risk taking behaviours, but others would retain the right to chose not to do so, even with the understanding of the detrimental impact upon their health.

Communicating with older men – eg, sensitivity as to how older men will receive information and that they are individuals with different backgrounds, histories and attitudes to risk. Older men will respond to different 'triggers' that may elicit positive responses and health and social care professionals will require appropriate skills.

Psychological and mental health – there is evidence that older men are vulnerable to depression and negative health behaviours following bereavement and that it is also related to isolation, loneliness and poor physical and mental health. Older men are less likely than older women to ask for help with problems such as depression.

Creating a suitable atmosphere within services

The 'feminised' atmosphere of some services may operate as a barrier to older men's participation and may be addressed by:

Providing a positive welcome – whilst male staff can be helpful, this is not essential and the support of another participating older man may be very valuable. Engagement with a service may take time.

Male friendly imagery – Promotional; materials, such as posters on walls and reading matter should convey the message to older men that their presence and participation is valued.

Attention to the physical environment – including décor and toilet facilities as well as discreet spaces for men to meet and chat.

"Men's groups however are not a universal panacea to the problem of how to engage older men". (Age Concern 2007)

4. Implications for physical activity

The questions raised in this working paper suggest that in order to ensure that services and programmes involving physical activity are appropriate for older men, providers should include a component of 'gender proofing/sensitivity' by undertaking checks to their planning processes. Such processes will also have implications for the planning of services for older women.

Gender Equality Duty

The Gender Equality Duty introduced as a result of the Equality Act 2006 comes into force in April 2007 and is the biggest change in sex equality legislation in thirty years, since the introduction of the Sex Discrimination Act itself. It has been introduced in recognition of the need for a radical new approach to equality – one which places more responsibility with service providers to think strategically about gender equality, rather than leaving it to individuals to challenge poor practice. For further details of this legislation and it's potential impact upon public bodies and health services for men go to ***www.menshealthforum.org.uk***

Physical activity provision and services for older men

Theme	Components	Actions relating to physical activity
Responding to the key issues for older men	Key transitions in men's lives Sensitivity to different masculinities The centrality of work and war in older men's lives	
Recruiting older men to services and programmes	Finding older men Strengthening referred access routes Addressing men's lack of awareness of services	
Developing appropriate service provision	Consulting with older men Supportive management and coherent strategy: Designing appropriate service models Developing attractive activities Developing male roles within services Increasing volunteer opportunities Stimulating support networks Reaching the hardest to reach	
Improving men's health and wellbeing	Going to where men are Respecting men's choices Communicating with older men Psychological and mental health	
Creating a suitable atmosphere within services	Providing a positive welcome Male friendly imagery Attention to the physical environment	

For other information visit

Men's Health Forum ***www.menshealthforum.org.uk***
And in particular Work Fit: a highly effective workplace-based lifestyle improvement programme developed jointly by Men's health Forum and BT. Men's Health Forum, Tavistock House, Tavistock Square, London WC1H 9HR 020 7388 4449

Malehealth ***www.malehealth.co.uk***
Malehealth is an information service run by the Men's Health Forum with a free independent information line for the 'man in the street'.

Working With Men ***www.workingwithmen.org***
320, Commercial Way, London, SE15 1QN. T 020 7732 9409.

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