Age UK's *fit for the future* Programme

Interim evaluation report

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fit as a fiddle is a programme run by Age UK and funded by the Big Lottery Fund as part of the Wellbeing programme
www.ageuk.org.uk www.fitasafiddle.org.uk

LOTTERY FUNDED

Key Findings

Main characteristics of survey participants

- The average age of Survey One respondents is 75 years.
- Three-quarters (74%) are women and a quarter (26%) are men.
- Nine-tenths (91%) of respondents are White British and 4 per cent are Indian.
- 30 per cent have one and 63 per cent have multiple long-term health conditions.
- 60 per cent consider themselves to have a disability.
- Over one-tenth (13%) are carers.

- 90 per cent of respondents do not smoke.
- 40 per cent drink alcohol, with 90 per cent consuming within the limits recommended by the NHS.
- 60 per cent think physical activity is important and say they are doing something about it, with walking being the most popular form of physical activity.
- Three-quarters think healthy eating is important and say they are doing something about it, with 69 per cent eating at least three, and 26 per cent at least five portions of fruit and vegetables a day.

- Over nine-tenths of respondents feel fully informed about and involved in the management of their long-term health conditions.
- Around half have companions but a third feel isolated some of the time.

Implementing *fit for the future*

- Local Age UKs have adopted a variety of approaches to recruiting or referring older people to the programme. Detailed analysis is required to learn from the different local referral patterns.
- Overall, General Practitioners have been difficult to engage in the referral process. However it emerged from the case studies that referrals from health professionals may be taken more seriously than invitations from voluntary organisations, which suggests that engaging more GPs would benefit the programme.
- Case studies highlighted the importance of older people being informed about the referral process and the activities offered in ***fit for the future.***
- Two models of providing group-based activities have been identified: 'single-' and 'multi-purpose' groups; in some cases 'outreach' services have also enabled frail older people to benefit from the programme in their own homes.
- ***fit for the future*** activities were more affordable and more accessible to older people than mainstream exercise groups, due to more appropriate start times and more convenient locations.

Impact

- Case study participants invited to join ***fit for the future*** groups responded positively to the invitation primarily because they wished to meet new people.
- Participants joining through self-referral were often actively seeking activities outside the home.
- Almost all case study participants felt they had benefitted from the programme.
- Some partner organisations benefitted from the increased number of referrals, while others were unable to meet the increased demand for their services.
- Engaging volunteers was difficult in some areas; further analysis is necessary to unpack the reasons.
- Existing relationships between organisations are becoming stronger, but partnership building has not yet been facilitated by ***fit for the future,*** with some stakeholders unaware of the programme.

The future and sustainability

- Case study participants were satisfied with the programme; the individual attention they received was particularly appreciated.
- The stakeholders who have been interviewed also supported the continuation of the programme.
- Some stakeholders recommended that a small fee should be charged for services, and that costs should be reduced by finding free venues and involving volunteers to contribute to sustainability.
- Stakeholders suggested that ***fit for the future*** should be integrated in the commissioning of non-clinical health and social care services.

Contents

1. Introduction and background

It is widely acknowledged that the UK's population is ageing, with the Department of Health predicting that the number of people aged over 65 will increase by 51 per cent between 2010 and 2030, whilst the number of those aged over 85 is expected to double in the same period. Furthermore, by 2030 more than 40 per cent of households are predicted to be comprised of people living on their own (Jowit, 2013; The King's Fund, 2013). A number of authors (Bardsley et. al., 2011; Victor, 2010; Wigfield et. al., 2013) advise that as people live longer, they are often affected, in later life, by long-term ill health and disabilities. For example, over the next 30 years, the number of people with dementia is expected to more than double (The King's Fund, 2013).

In efforts to maintain and improve the health and well-being of older people, Age UK have developed a portfolio of work, **fit as a fiddle 2013-2015**, supported with £3.6m from the Big Lottery Funded Well-being Programme. The portfolio has emerged as a result of learning from a previous Age UK project, also called **fit as a fiddle**. The portfolio further develops the key elements of the previous project, with a specific focus on older people with long term health conditions; as well as those from groups who are traditionally excluded or overlooked, including older men, Black & Minority Ethnic (BME) and faith communities, and people living with dementia and their carers.

CIRCLE (Centre for International Research on Care, Labour and Equalities), University of Leeds has been commissioned by Age UK to evaluate the fit as a fiddle 2013-2015 portfolio of work which includes three programmes of activity (***fit for the future***; Cascade Training; and Dementia Friendly). This interim report summarises the initial findings of the evaluation, focusing on the ***fit for the future*** element of the portfolio only.

Fit for the future

Fit for the future is a person-centred programme with the overall objective of supporting the physical health and mental well-being of older people living with at least one long-term health condition. The programme aims to achieve this through the provision of holistic, co-ordinated services and activities which improve participants' quality of life and enable them to maintain their independence for longer, while delaying the need for more intensive and costly health and social care interventions. Once an older person is recruited, and prior to any intervention, a trained Age UK staff member or volunteer meets with the older person to develop a tailored personal plan that best suits their health and well-being needs. The programme is being implemented by 11 local Age UK partners: Blackburn with Darwen; Cheshire East; Exeter; Hillingdon; Lancashire; Leeds; Newcastle; Nottingham and Nottinghamshire; Rotherham; Warwickshire; and West-Cumbria.

The overall aim of evaluating ***fit for the future*** is to determine the programme's benefits for older people and the health service, focusing on cost effectiveness and on the impact on statutory bodies. As the evaluation is in an early stage, this interim report provides a

summary of the initial findings on ***fit for the future***, including the benefits felt by older people, and potential impact on statutory bodies in health and social care and the Voluntary, Community and Faith (VCF) sector.

Roadmap to this report

This interim report contains the following sections:

- **Section Two** focuses on the methods used in the evaluation. All stages of the analysis used to evaluate ***fit for the future*** are outlined and the current stage of the evaluation process is reported on.
- **Section Three** describes the characteristics of older people supported by ***fit for the future*** as they emerge from Survey One; and outlines the profile of partner organisations represented by the stakeholders whose views are included in this report.
- **Section Four** describes how ***fit for the future*** is being implemented, analyses and comments on the different practices used by different local Age UK partners. As the analysis of implementation has focussed only on four areas, the findings presented here are both tentative and preliminary.
- **Section Five** focuses on the impact of ***fit for the future,*** exploring how the programme affects participating older people, partner organisations and local partnerships, as well as the broader health and social care system in England.
- **Section Six** discusses both participating older people's and stakeholders' views in relation to the future of the programme and its potential for sustainability.
- **Section Seven** summarises some potential areas for improvement which have emerged from the research so far.
- **Section Eight provides** a summary and some areas for further consideration.
- The **Annex** provides more detailed description of findings emerging from Survey One.

2. Methods

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

Analysis of monitoring data and background documents. Documentary analysis and interrogation of management information data is being undertaken to produce a greater understanding of: the nature of ***fit for the future***; its aims and objectives; how it is being implemented; and how well it is performing against the targets. The analysis of monitoring data and background documents is an ongoing process; this report draws on the expression of interest documents prepared by local Age UK partners and data on referrals to the programme. Following the findings of this interim evaluation report, a review of other interventions aimed at improving the physical and mental well-being of older people will also be conducted.

A three-wave paper-based survey of older people, designed by Age UK, and completed by older people participating in ***fit for the future*** at the start of their involvement in the programme, then three and nine months later. Each local Age UK partner aimed to reach a target of at least 100 older people completing the survey. This interim report summarises findings from the first wave of the survey. Some of the data were supplied by local Age UK partners in the form of completed paper surveys, and some in electronic format (extracted from Charity Log). The data were subsequently entered into statistical software, Statistical Package for Social Sciences (SPSS 21), checked, cleaned and then analysed. As Survey One was conducted when older people first engaged in ***fit for the future***, the findings can be used to outline the profile of participants, but insights into the programme's impact cannot yet be gained (this is expected from the second and third surveys).

Case studies of older people. In addition to the largely quantitative data emerging from the survey, the research team are also conducting 55 case studies of older people to gain a greater and more in-depth understanding of the local operation of ***fit for the future***. This amounts to five case studies of older people in each of the 11 Age UK partner localities. Four of the five case studies in each locality involve carrying out a face-to-face interview with the older person, while one of the five case studies provides more in-depth data. In addition to the face-to-face interview with the older person, the more in-depth case studies involve participants being asked to complete a diary booklet that focuses on their lifestyle and attitudes to healthy living in more detail, as well as interviews with members of their support network, such as friends, family, neighbours or home care workers. Case studies also draw on information supplied about participants' involvement in the programme: the tailored action / support plans developed at the start of the intervention; a summary of the initial assessment and the actions undertaken (up to March 2014); or the initial 'contract' between the participating older person and the local Age UK.

In order to present as much in-depth information as possible in this interim report, the research team have concentrated their initial case studies in four localities: Blackburn with Darwen, Leeds, Nottingham and Nottinghamshire and Rotherham. 16 case studies were completed between May and June 2014 and an additional two in-depth case studies were in progress at the time of writing this report; the data from these case studies have been analysed to inform the findings in this report.

Interviews with older people participants were semi-structured and each lasted between 45 and 60 minutes. All interviews were conducted face-to-face, with the exception of one, which was conducted by telephone, as requested by the interviewee. Each interview focussed primarily on older people's expectations, experiences and opinions about the programme, and explored what may have happened to the older person in the absence of ***fit for the future***. Rather than presenting individual case studies here, extracts of case studies are included to illustrate the findings. It is anticipated that the final report will provide more detailed illustrative case studies of participants' experiences.

The case studies have been conducted so far with 13 women and five men, aged between 63 and 87, living with a range of long-term health conditions and disabilities. The disproportionate amount of women interviewed is a reflection of the larger number of older women accessing the programme overall (see Section Three). The case study interviewees live in a variety of residential settings, some of them come from a BME background and some of them are carers. Names and minor personal details of case study participants referred to this this report and their friends and family have been changed to protect their anonymity.

Qualitative interviews with 55 stakeholders (five in each participating local Age UK partner area) to capture information about their expectations at the beginning of the programme, experiences of the partnership running the programme, suggestions for improvement, lessons learned for themselves and for their organisation, and their assessment about the programme's sustainability. Stakeholders were identified by the 11 local Age UK partners to be drawn from Clinical Commissioning Groups (CCGs); General Practitioners; local authorities; local Age UK Partners; and voluntary sector organisations. The research team will interview each stakeholder twice, once at the beginning of the programme and once towards the end. 35 stakeholders have been interviewed so far and the findings from 26 interviews have been included in the preliminary analysis for this report. Each interview lasted approximately 30 minutes and was conducted by telephone following a semi-structured interview schedule. Stakeholders represented a range of organisations and Table 2.1 below gives a summary of basic information about the stakeholders whose input has been analysed.

Table 2.1 Information about stakeholders

Area	Organisation	Area of expertise
Cheshire East	Local authority	Adult social care
	NHS	Community health
Exeter	CCG	Commissioning services for older people
Hillingdon	Local authority	Health promotion
	Local authority	Sheltered housing
	Age UK	Navigator – primary care services
	Age UK	Fall prevention
	Self-employed contractor	Sports and exercise
Lancashire	NHS	Care for people with long term health conditions
Leeds	CCG	Working with GPs to shape referral practices
	Local authority and voluntary organisation	Sports and exercise
Newcastle	Age UK	Senior member of staff
	Age UK	Services for older people
Nottingham and Nottinghamshire	NHS	Nutrition
	Local authority and voluntary organisation	Signposting to older people's services
Rotherham	Voluntary sector	Campaigning and influencing on behalf of older people
	Voluntary sector	Community organisers
	Local authority	Community centre management
	Voluntary sector	Campaigning and influencing on behalf of older people
	Local authority and CCG	Health and wellbeing
Warwickshire	Age UK	Services for older people
	Age UK	Services for older people
	CCG	Services for older people with long- term conditions
	Private sector	Housing
West Cumbria	NHS	Occupational Therapy
	Housing Association	Community centre management

Presentation of data. Initial findings emerging from Survey One and the qualitative interviews and case studies are presented alongside each other in this interim report. All figures are rounded to the nearest whole per cent. Quotes from case studies and interviews with stakeholders are presented to illustrate findings and add specific detail to the discussion, with the sources identified where appropriate. It is important to note that the sample of participants and stakeholders identified for interviews is not statistically representative, and their opinions do not necessarily reflect the views of all participants and stakeholders involved in ***fit for the future***.

3. Characteristics of participants and partner organisations

3.1. Older people supported by *fit for the future*

Originally it was anticipated that 1650 older people would engage in ***fit for the future*** across the 11 local Age UK partner localities. The monitoring data supplied by the local Age UK partners show that with the exception of three areas the recruitment targets have been met or exceeded, with 1750 older participants recorded in the programme overall (see Table 3.1).

Table 3.1 The number of older people engaged in *fit for the future*

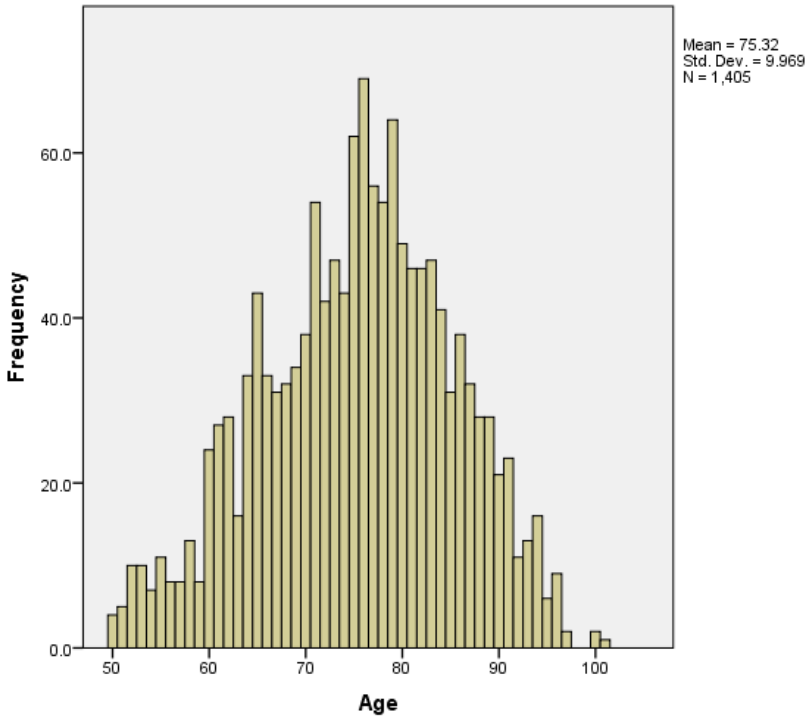
	Planned	**Actual**
Blackburn with Darwen	150	140
Cheshire East	150	151
Exeter	150	110
Hillingdon	150	150
Lancashire	150	171
Leeds	150	116
Newcastle	150	150
Nottingham and Nottinghamshire	150	282
Rotherham	150	136
Warwickshire	150	150
West Cumbria	150	194
Total	**1650**	**1750**

Of the 1750 participants, data from 1520 completed questionnaires were provided to the research team in a format which was suitable for entry into the statistical software. Some of these questionnaires later had to be excluded from analysis because basic information, such as age (year of birth) or gender was missing or incorrect (e.g. birthday: 2014). A few questionnaires were excluded from analysis because the participant was younger than 50 (those who were only a few months younger than 50 when Survey One was completed were included). The final number of surveys included in the analysis presented in this interim report is 1405. The total number of responses may be smaller for some questions due to missing responses. This interim report focuses on the survey questions which are the most relevant at this early stage of the evaluation; the summary of all findings is presented in the Annex.

Gender and age of participants

As alluded to earlier, the vast majority of the survey respondents (74%) are women, with just over a quarter being men. The age of the participants ranges from 50 to 101 years, as shown in Figure 3.1, with the average (mean) age being 75 (standard deviation=10). The average age of female respondents is slightly higher (76 years) than that of males' (74 years).

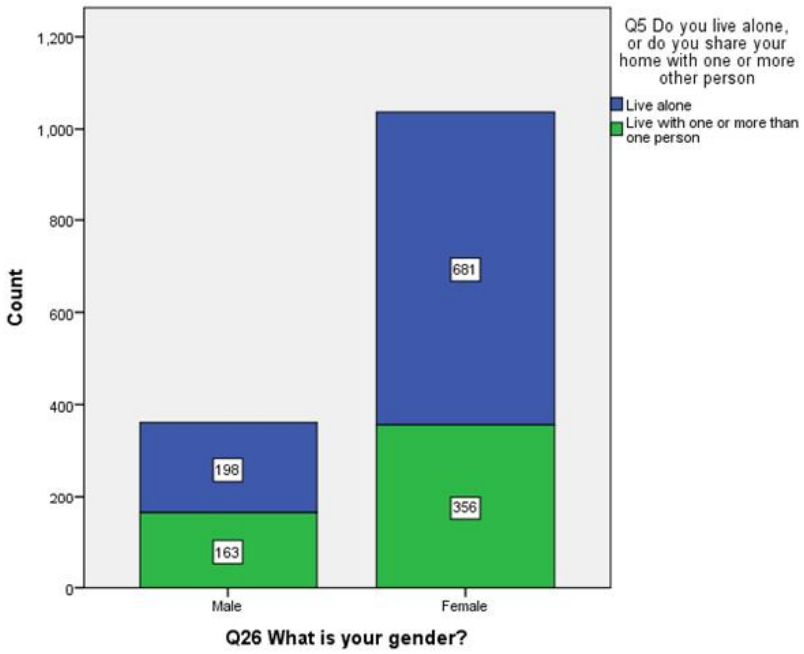
Figure 3.1 Age distribution of participants (n=1405)



Living arrangements

Respondents were asked whether they lived alone or with one or more other person. The majority of the respondents (63%) live alone, and there are important differences between men and women's living arrangements: a larger proportion of older women (66%) than men (55%) live alone (Figure 3.2), reflecting national trends.

Figure 3.2 Participants' living arrangements by gender (n=1398)



Caring responsibilities

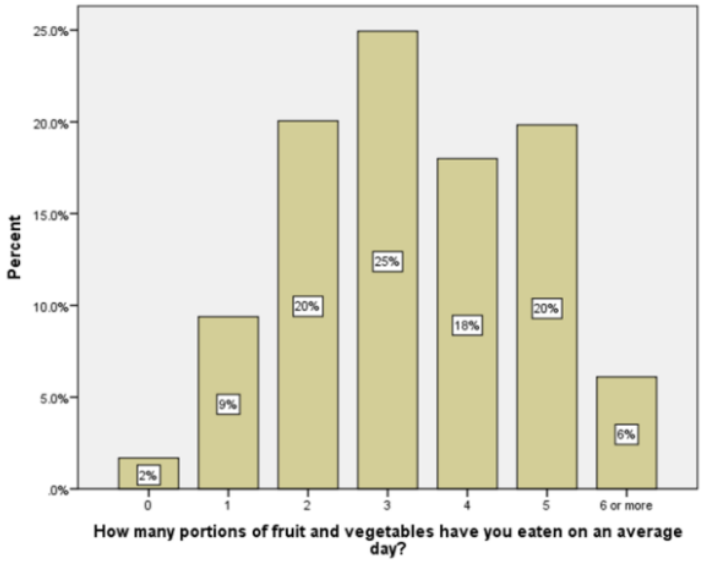
Comparing the caring responsibilities of survey respondents, we do not find a difference between men and women: 13 per cent of both groups look after or support someone who is sick, disabled or frail elderly.

Healthy eating: attitudes and behaviour

The majority (75%) of respondents agreed with the statement *'I think healthy eating is important for my health, and I am doing something about it at the moment'*, and only 3% chose the statement *'I don't think healthy eating is important for my health'*. Almost a quarter of respondents (22%) thought that healthy eating was important for their health, but they said they were not doing anything about it.

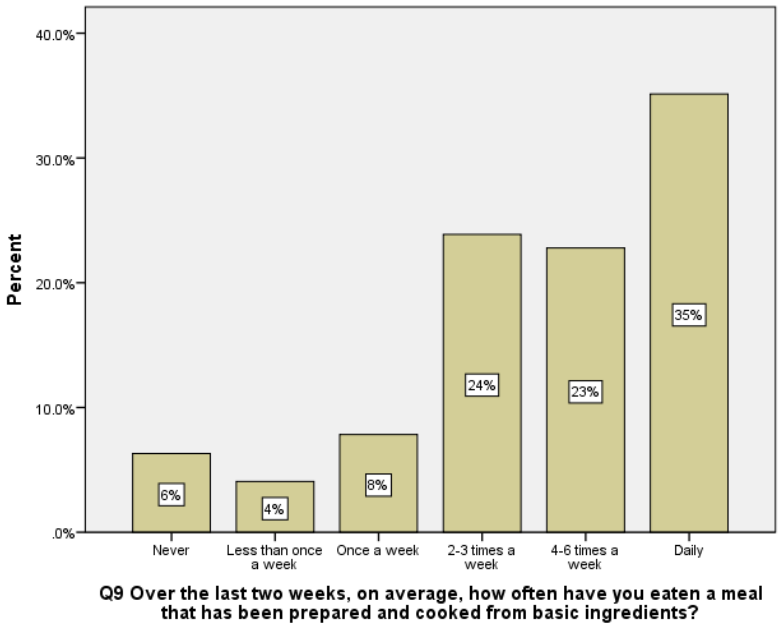
The eating habits of participants were explored further in the questionnaire by asking how many portions of fruit and vegetables respondents eat on an average day. Pictures illustrating portion sizes of different fruit, vegetables and fruit juice were included to help the older people to answer the question. Only a quarter of respondents (26%) said that they eat five or more portions of fruit and vegetables a day (Figure 3.3).

Figure 3.3 Eating fruit and vegetables (n=1311)



To further explore their eating habits, respondents were also asked how many times a week they ate a meal that was prepared and cooked from basic ingredients, either by themselves or by someone else. As Figure 3.4 shows, a third of respondents (35%) eat a cooked meal prepared from scratch every day, and another 23% eat such a meal almost every day (four-six times a week). A quarter of older people completing the survey eat freshly cooked food two to three times a week, and 18% eat such a meal only once a week, or less often (Figure 3.4).

Figure 3.4 Eating a meal prepared from basic ingredients (n=1378)



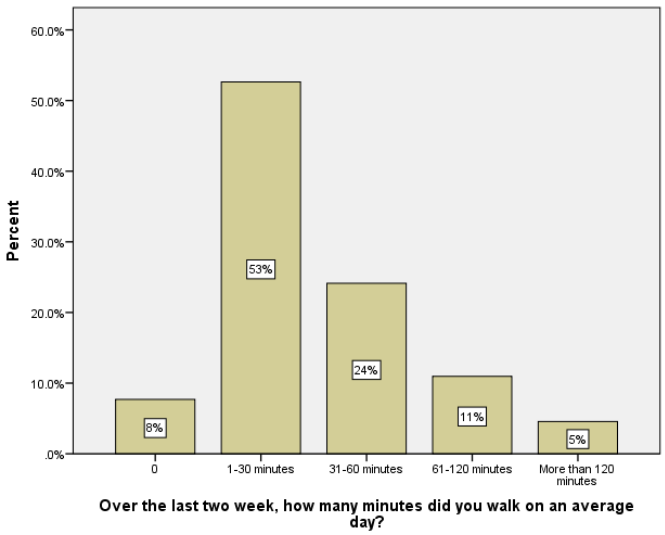
Physical activity: attitudes and behaviour

To explore their attitudes to physical activity, respondents were asked to choose the statement which best represents their attitude to physical activity. 60 per cent of the older people who completed the survey thought that physical activity was important for their health and they were doing something about it, whilst just 3 per cent did not think that physical activity was important for their health. 38 per cent of respondents thought that physical activity was important, but they were not doing anything about it at the time when Survey One was conducted.

The type of physical activity that questionnaire respondents carry out was explored by three specific questions, focusing on three types of exercise: walking; exercise that makes them breathe somewhat harder than normal; and muscle-strengthening exercise. Respondents were then asked to write down the number of minutes they spent doing these forms of exercise a day (walking) or a week (for the others). Individual responses have been grouped into categories and presented in Figures 3.5 – 3.7 below.

Walking is by far the most popular form of exercise: 40 per cent of respondents walked more than 30 minutes a day. However, 8 per cent of respondents could not walk at all, and half of all respondents walked less than 30 minutes on an average day, as shown in Figure 3.5.

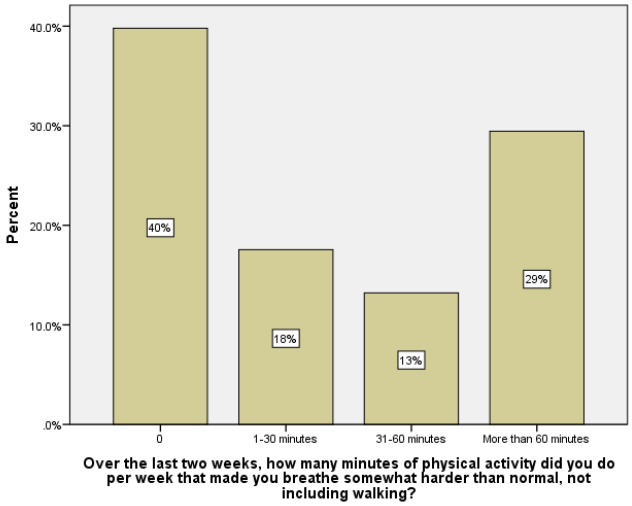
Figure 3.5 Number of minutes spent walking on an average day (n=1313)



A further aspect of respondents' physical activity was explored by asking them how many minutes a week they spent doing exercise that made them breathe somewhat harder than normal, not including walking. A few examples, such as housework, gardening or sports were provided to help them with their answer. As above, individual answers were grouped into categories. The data reveal that 40 per cent of older people completing the survey did

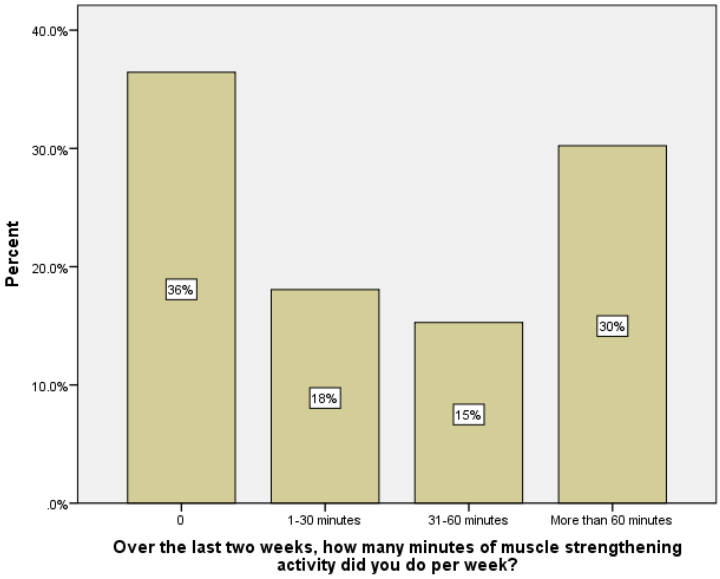
not do any physical activity that made them breathe harder than normal; 31 per cent did less than an hour, and 29 per cent more than an hour a week (Figure 3.6).

Figure 3.6 Number of minutes spent doing physical activity making breathing harder per week (n=1219)



The third question associated with physical activity focussed on muscle-strengthening exercise, and as above, respondents were given some examples (carrying groceries, heavy gardening, walking up and down the stairs) to help them answer the question. The data, shown in Figure 3.7 reveals a similar pattern to the one described in the previous question: 36 per cent do not / cannot do any muscle-strengthening exercise; a third (33%) do less than 60 minutes a week, while about another third (30%) do more than one hour a week.

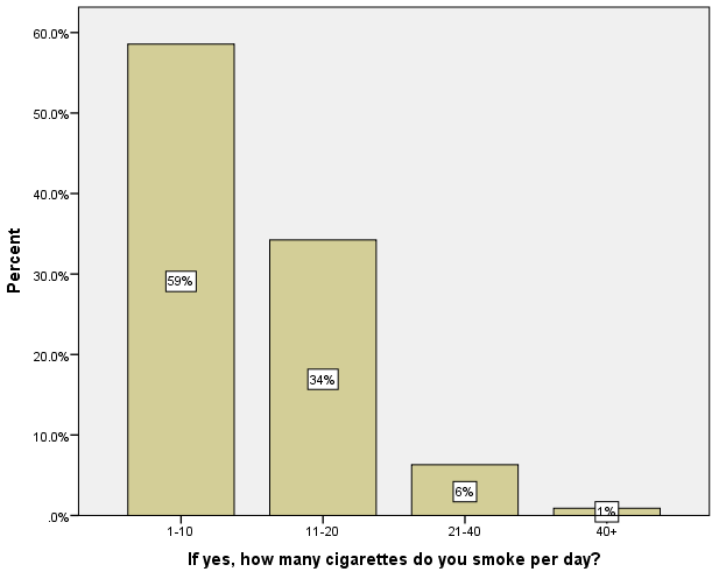
Figure 3.7 Number of minutes of muscle-strengthening physical activity per week (n=1257)



Smoking

Another important aspect of Survey One was mapping the smoking habits of respondents: 90 per cent said they did not smoke, and only 10 per cent indicated that they did (n=1384). Those who said they smoked were asked how many cigarettes they had a day. Slightly less than two thirds of smokers had fewer than ten cigarettes a day (59%), about a third smoked 11-20 cigarettes a day (34%) and the remaining 7 per cent smoked more than two packets of cigarettes a day, as shown in Figure 3.8.

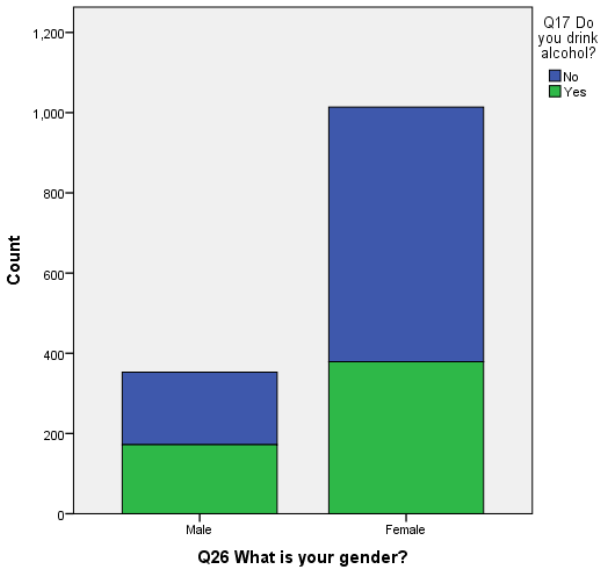
Figure 3.8 The number of cigarettes smoked a day (n=111)



Alcohol consumption

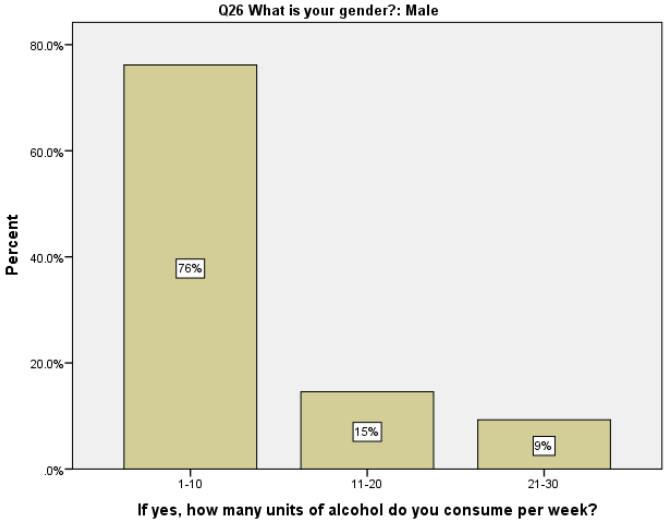
The final question exploring the lifestyle of older people focussed on their alcohol consumption. 60 per cent of respondents said they did not drink alcohol and 40 per cent said they did. The findings show a sizable gender difference: 37 per cent of women but 49 per cent of men said that they drink alcohol, as shown in Figure 3.9.

Figure 3.9 Alcohol consumption by gender (n=1367)



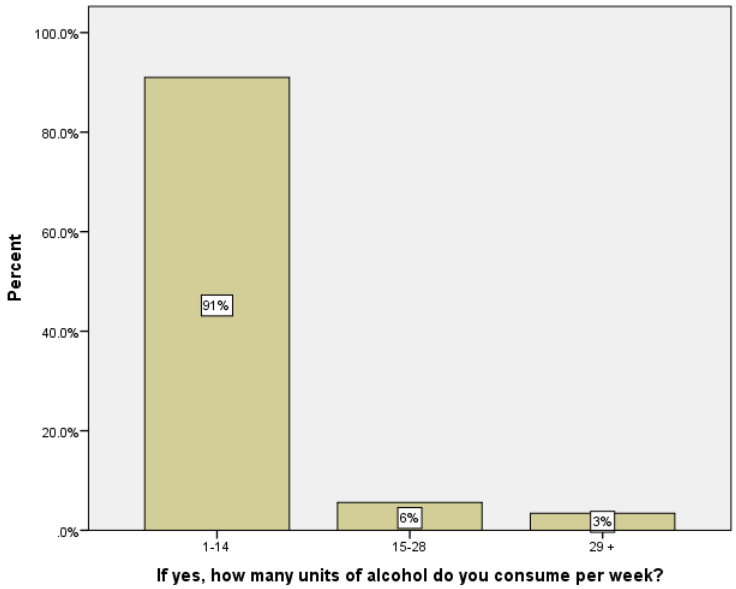
Those who said they drank alcohol were then asked to specify how many units of alcohol they consumed a week, and examples were included to guide the respondents in answering the question. The findings are shown separately for men and women. About three quarters (76%) of men consume fewer than 10 units of alcohol a week, 15 per cent 11-20 units, and 9 per cent consume 21 or more units of alcohol (Figure 3.10). The NHS recommends that men should not regularly drink more than 21 units of alcohol a week, thus 9 per cent of male respondents drink more than the maximum amount.

Figure 3.10 Number of units of alcohol consumed per week: men (n=156)



As the recommended limit for women is 14 units of alcohol per week, the categories presented in Figure 3.11 have been constructed differently. 91 per cent of female respondents consume fewer than 14 units a week; 6 per cent consume 15-28 units (not more than twice the recommended weekly limit); and 3 per cent consume more than 28 units of alcohol per week, as shown in Figure 3.11. In summary, approximately 90 per cent of those men and women who drink alcohol do not consume more than the limits recommended by the NHS.

Figure 3.11 Number of units of alcohol consumed per week: women (n=315)



Long-term health conditions

As ***fit for the future*** aims to improve the physical and mental well-being of older people living with at least one long-term health condition, it was essential to map what type of health conditions participants live with. Older people were asked specifically whether a doctor or other health professional had diagnosed them with: respiratory conditions; arthritis; heart conditions; vascular conditions and stroke; cancer; diabetes, dementia; mental health; and other conditions. They were also given the option to select 'other' health conditions. The most common long-term health condition among respondents is arthritis (51%), followed by heart conditions (29%), respiratory conditions (24%) and diabetes (20%), as shown in Table 3.2. Many respondents indicated that they had been diagnosed with 'other' health conditions, but the design of the questionnaire did not allow all of them to specify what this condition was.

Table 3.2 Respondents reporting being diagnosed with a long-term health condition (percentage)[1]

Long-term health condition	Percentage of respondents
Arthritis	51
Heart conditions	29
Respiratory conditions	24
Diabetes	20
Vascular/Stroke	16
Mental health problem	13
Cancer	10
Dementia	4
Other	43

Many older people who completed the survey questionnaire have multiple long-term health conditions: 30 per cent reported two, 20 per cent three, 10 per cent four, and 4 per cent five or more such conditions (see Table 3.3). Seven per cent of respondents did not report having a long-term health condition.

Table 3.3 Respondents reporting being diagnosed with multiple long-term health conditions (percentage)

The number of long-term health conditions	Percentage of respondents
None	7
One	30
Two	29
Three	20
Four	10
Five or more	4
Total	**100**

[1] The figures presented in this table do not add up to 100 per cent, as many participants lived with multiple long-term health conditions.

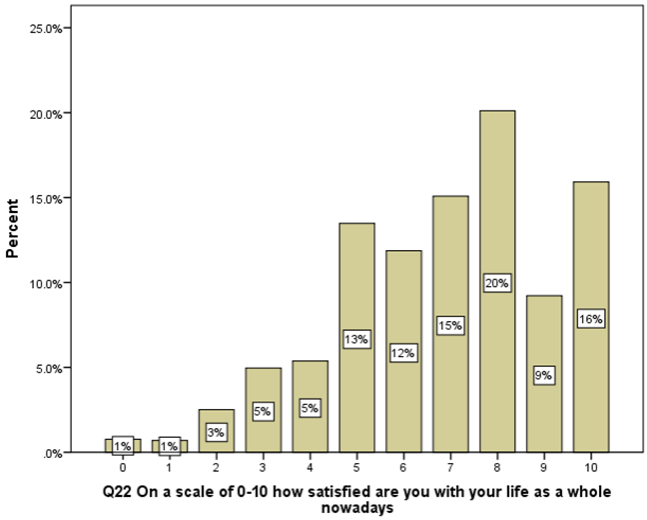
Feelings about the management of long-term health condition

The survey aimed to explore how older people felt about the way their long-term health conditions were managed. Participants were asked to indicate to what extent they agreed with a series of statements, covering four areas: feeling fully informed about issues relating to their long-term health condition; feeling fully involved in decisions regarding managing their condition; feeling fully supported in managing their health condition; and feeling fully in control of the care for their long-term condition. Very similar patterns have emerged in all areas, with the majority either 'agreeing' (36-38%) or 'strongly agreeing' (53-55%) with the four statements. Looking at those who did not agree with the statements, indicating that they had negative feelings about the way their long-term health condition was managed, we find that 12 per cent of respondents felt unsupported and 11 per cent not in control of managing their long-term health condition, a slightly larger proportion than those who felt uninformed or uninvolved in decisions (8%).

Satisfaction with life

Respondents were asked to mark on a scale of zero to ten how satisfied they felt about their lives in general, with zero indicating extremely dissatisfied and ten indicating extremely satisfied. Almost half (45%) of the older people who completed the survey were very satisfied with their lives (choosing eight to ten), and a quarter (27%) were quite satisfied (choosing six to seven). Another quarter (28%) were completely or mostly unsatisfied (choosing zero to five), as shown in Figure 3.12. The average (mean) value on the satisfaction with life scale is 7 (standard deviation: 2.3).

Figure 3.12 Satisfaction with life as a whole (percentages, n=1346)



Mental well-being

The survey included the 'seven-item Warwick-Edinburgh Mental Wellbeing Scale' (WEMWBS), a validated measure of mental well-being. Respondents were asked to rate their feelings over the previous two weeks from 1 (none of the time) to 5 (all of the time) on seven statements: '*I've been feeling optimistic about the future'; 'I've been feeling useful'; 'I've been feeling relaxed'; 'I've been dealing with problems well'; 'I've been thinking clearly'; 'I've been feeling close to other people'; and 'I've been able to make up my own mind about things'.* Ratings were summed up, producing a total score ranging from 7 to 35 for each respondent, and then the individual scores were averaged for the whole sample. The mean value on the scale for all Survey One respondents is 25.8 (standard deviation=5.5, n=1208).

Social networks

Survey One also focused on participants' loneliness, measured by four questions selected form of the Revised UCLA loneliness scale (Hughes et al, 2004): *'How often do you feel you lack companionship?'; 'How often do you feel isolated from others?'; 'How often do you feel left out?'; and 'How often do you feel in tune with the people around you?'.* There were three response options to each question: '*hardly ever or never'*, '*some of the time'*, and '*often'*. Around half of all respondents never or hardly ever or never lack companionship (46%), feel isolated (52%) or feel left out (55%). At the other end of these three scales, 16 per cent often lack companionship, 15 per cent often feel isolated from others and 14% often feel left out. Focusing on the positive question, 45 per cent often feel in tune with the people around them, while 20 per cent hardly ever or never feel in tune with others. Thus, in the *'feeling in tune with other people around'* dimension of loneliness a slightly different pattern has been found than in the other three dimensions.

Ethnicity

Older people who have completed the survey come from 16 different ethnic groups, with the majority from only two groups: 91% White British and 4% Indian (n=1392). These overall figures however hide large differences in the ethnic background of respondents in the 11 areas where ***fit for the future*** is being implemented: local level data are presented in Table 3.4. Proportions below 2.5 per cent are shown together under 'Other'.

Table 3.4 Ethnic background of participants in the 11 areas (percentages)

	White British	Irish	Other White	Indian	Pakistani	Other Asian	Other	Total
Blackburn with Darwen	60			24	9		7	100
Cheshire East	98						2	100
Exeter	100							100
Hillingdon	62	6		21		5	6	100
Lancashire	97						3	100
Leeds	94		3				3	100
Newcastle	94			4			2	100
Nottingham and Nottinghamshire	95						5	100
Rotherham	99						1	100
Warwickshire	97						3	100
West Cumbria	99						1	100

Disability

59 per cent of older people who have responded to this question of the survey (n=1311) consider themselves to live with a disability. Within this group, people mentioned several different disabilities, as shown in Table 3.5.

Table 3.5 Respondents with different types of disability[2]

Disability	Percentage
Chronic illness	60
Physical disability	39
Deafness / serious hearing impairment	7
Blindness / serious visual impairment	7
Serious mental health condition	5
Substantial learning disability	1
Substantial learning difficulty	1
Other disability	38

3.2. Profile of partner organisations

As explained in Section Two and Table 2.1, the partner organisations who were spoken to through the stakeholder interviews represented a range of organisations, including CCGs, GPs, local Age UK partners, local authorities and voluntary sector organisations. Many, if not all, partner organisations represented through the stakeholder interviews are already engaged in providing services to older people, though not exclusively through ***fit for the future***. The services that they provide include: information on support options; signposting to specialised health services, such as hearing clinics or neurologists; activities and initiatives to combat social isolation; exercise and sports instruction; campaigning, influencing and lobbying on behalf of older people; transport; and statutory social care and health services. The stakeholders stated that the organisations they represent support different groups of older people, for example the 'younger' and the 'older' old; those with multiple health conditions; those living in a range of different residential settings; those living in disadvantaged areas or belonging to BME groups.

[2] The percentages in Table 3.5 do not total 100%, as many respondents have more than one type of disability.

3.3. Summary: Main characteristics of the sample population

- The average age of Survey One respondents is 75 years.
- Three-quarters (74%) are women and a quarter (26%) are men.
- Nine-tenths (91%) of respondents are White British and 4 per cent Indian.
- 30 per cent have one, and 63 per cent have multiple long-term health conditions.
- 60 per cent consider themselves to have a disability.
- Over one-tenth (13%) are carers.

- 90 per cent of respondents do not smoke.
- 40 per cent drink alcohol, with 90 per cent consuming within the limits recommended by the NHS.

- 60 per cent think physical activity is important and say they are doing something about it, with walking being the most popular form physical activity.
- Three-quarters think healthy eating is important and say they are doing something about it, with 69 per cent eating at least three and 26 per cent at least five portions of fruit and vegetables a day.

- Over nine-tenths of respondents felt fully informed about and involved in the management of their long-term health conditions.
- Half hardly ever lack companionship, although a third do some of the time.

4. Implementing *fit for the future*: plans and current practices

4.1. Referrals to the programme

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

Local Age UK partners planned to recruit participants via health professionals, for example GPs and Community Mental Health Teams (CMHTs); social care; sheltered housing; existing local Age UK services; friends and families; and self-referrals (see Table 4.1). According to recent monitoring data collected from local Age UK partners, most older people have been referred to ***fit for the future*** from other Age UK services; by self-referral; and by 'other' health professionals, but, overall, less so by GPs. Two local Age UK partners, Nottingham and Nottinghamshire and Leeds have recruited a large proportion of participants via GPs as Table 4.1 shows. Rotherham and Warwickshire have had particular success with referrals from sheltered housing.

Table 4.1 Planned and actual referral routes to *fit for the future*

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

The importance of health professionals and GPs in the referral process emerged in some of the detailed support / action plans and also in case study interviews with the older people who were participating in ***fit for the future***. Some of the older people inferred that they sometimes took referrals from health professions more seriously than from other organisations, as the example in Box 1 illustrates.

Box 1: The importance of GP referrals

An older person in Nottinghamshire stated that he had received a letter from his general practice inviting him to join an exercise group as part of the programme. He said that he would not have opened the letter had it been sent by Age UK or another voluntary organisation, saying that *"there is so much rubbish mail these days."*

(Ron, Nottinghamshire)

Case studies with older people participating in the programme have also revealed that clarity about their referral to ***fit for the future*** is important. The exact reason for being referred to the programme by their GPs and the process of the referral was sometimes unclear and somewhat puzzling for some participants, as the examples in Box 2 illustrate:

Box 2: The importance of clarity of communication about referrals

Ron and Kate in Nottinghamshire mentioned that they did not understand why they were *'selected'* by their GP to be referred to the programme and this puzzled them even several weeks after they had completed the course:

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

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

Although the above examples demonstrate that some GPs are getting involved in referrals to ***fit for the future***, as well as highlighting the importance of encouraging GPs and other health professionals to refer older people to the programme, some stakeholders also indicated that involving GPs in ***fit for the future*** was a challenging task, with some GPs reluctant to engage. This reluctance, often due to time constraints, is something that has been found in research elsewhere, for example in the identification and provision of support to carers (Wigfield et al, 2012). Indeed, some potentially missed opportunities for referrals / social prescribing were identified from the case study interviews with older people as described in Box 3.

Box 3: Example of missed opportunities for referral

During a routine health check it was discovered that Tajinda had slightly elevated cholesterol levels and blood pressure, and although she was given advice about lifestyle changes, she was not referred to an exercise group. It was by chance that she found out about a walking club, run by Age UK, which was the first step towards becoming more active, losing weight and having lower blood pressure and cholesterol levels:

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

The stakeholders mentioned that the system of referring older people to ***fit for the future*** meant that parts of the health and social care system were becoming more 'joined up', with examples of referrals to the programme from the health sector. Examples cited included district nurses and General Practices who provided older people with information and advice about available services and promoted the programme; referrals from General Practices or hospitals (social prescribing); social prescribing as a form of prevention, when a referral was made to prevent a health condition deteriorating; and CCGs discussing ways in which the programmes' scope could be widened (see section 5.4 for a more detailed discussion).

4.2. Nature and delivery of services and activities

In this section we focus especially on the four localities (Blackburn and Darwen; Leeds; Nottingham and Nottinghamshire; and Rotherham) where the completed case studies allow us to reflect on how the local Age UK partner plans for ***fit for the future*** have been implemented and enable us to analyse participants' experiences of the activities.

The types of services and activities offered

Local Age UKs offered a variety of services and activities in the framework of ***fit for the future***.

- **Improving physical activity**
  Exercise groups: Yoga; Zumba; Tai Chi; led walks; Trampolining; swimming, and Aqua Mobility.

- **Healthy eating**

  *Courses on healthy eating***:** nutrition course
  Workshops on healthy eating: these workshops were integrated into the activities of 'multi-purpose' groups (discussed below in more detail)

- **Social engagement activities**

  The activities and services in this category aimed to improve participants' social networks, reduce isolation and thus improve their mental well-being.

  *Arts and crafts***:** making cards using various techniques, origami, knitting, crocheting.
  Games and quizzes: cards, dominoes, bingo, quizzes (designed by the facilitator, participants forming groups).
  Befriending service: visits and telephone calls from Age UK staff and volunteers (also offered to Age UK clients who do not participate in ***fit for the future***).
  Internet/digital skills training: courses on using the internet and tablets, also provided in the form of one-to-one tuition. These services are included here, because case study participants explained that they primarily used the internet to keep in touch with friends and family.

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

The collection of services, listed above, aim to improve participants' well-being in the broadest, most holistic sense. The different ways in which this support is being provided and delivered are listed here:

1) *Signposting***:** participant older people are sent information about services available for them to access, this includes: a) information about local services provided by other organisations, such as the Breathe Easy Group and Ear Foundation leaflet (Nottingham and Nottinghamshire); and b) information material produced by Age UK, such as the Healthy Eating Guide, Save Energy, Pay Less Guide, Home Safety Checker Guide, and Winter Wrapped Up Guide. The support / action plans devised for the participant older people indicate that this kind of signposting took place after the needs assessment, and thus only the relevant guides were given to the participants.
2) *Referrals*: participant older people are also referred to other appropriate services, following their initial assessment in ***fit for the future***. Some of the services that they have been referred to include: Age UK Benefit Check; Age UK Debt Advice; Age UK Advice and Information Outreach; Green Doctor (a voluntary organisation making homes more energy efficient); Library at Home service; home care providers; Vision Consortium; local organisations which run groups for older people (bingo, lunch club); local charities organising home care services; Adult Social Care services at the local authorities; Fire Service (for safety check, fitting fire alarms).

3) *Practical help:* Some participant older people have been provided with practice help following their assessment, for example, Age UK staff / volunteers have made arrangements to: have a water metre fitted; get boilers and heaters repaired; get rebates from utility service providers; set up insurance for household items; and contacted the local authority to arrange for assisted refuse collection.
4) *Personal support and encouragement***:** many case study participants received regular phone calls from Age UK as a result of participating in the ***fit for the future*** programme. Age UK staff / volunteers also supported older people to improve their well-being, for example: they accompanied Tajinda to exercise classes until she was confident enough to go independently; encouraged Peter to go for a short walk every day; encouraged Rachel to join groups and attend activities out of the home rather than staying at home where she is visited and telephoned by Age UK staff and the volunteers of the befriending service; advised Kate about care home options and accompanied her to visit potential care homes for her husband.

The group-based activities (mentioned above) were organised differently by local Age UKs and their partner organisations. Based on the case study interviews with participants so far, we have identified two models of providing services to older people:

- Organising new, 'multi-purpose' ***fit for the future*** groups with the intention of engaging older people in social activities, and improving physical activity and healthy eating (this model is evident in Rotherham);
- Encouraging ***fit for the future*** participants to join 'single purpose' groups (either existing or newly developed ones), focusing on physical activity or nutrition (Blackburn with Darwen, Leeds, Nottingham and Nottinghamshire).

These models are not necessarily reflected in the expressions of interest that the Age UK partners submitted but appear to have emerged once the programme implementation has commenced. The two contrasting examples in Boxes 4 and 5 illustrate how two older people engaged in the two types of group:

Box 4: 'Multi-purpose' groups

Sue joined the special ***fit for the future*** group that was organised by Age UK Rotherham in her village. She describes the group activities in this way:

"[We do] exercise and we always do a quiz. Play games and dominoes because we have a couple of men who come and like cards and dominoes. Scrabble. There's always a craft table. … This is it, you see, because [another group member] has very bad arthritis, and she's been crocheting to keep her fingers going."

(Sue, Rotherham)

Box 5: 'Single-purpose' groups

Sarah has attended three different groups organised by Age UK Leeds, including a ***fit for the future*** Zumba Gold class:

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

(Sarah, Leeds)

Participants reported that they received complex, highly personalised support in all locations, regardless of the model adopted in the delivery of group-based activities. It emerged from the case studies that Age UK staff / volunteers paid specific attention to ensuring that individual needs were at the centre of their provision. In Rotherham for example, one participant was offered tailored help through a 'multi-purpose group' when she was discharged from hospital. Another participant attended a 'single-purpose' group focusing on nutrition in another local Age UK locality, and was given help with choosing a new care home for her husband. This therefore reflects an additional unexpected outcome, and highlights the holistic nature of the programme.[3]

The tailored support/action plans and the follow up notes have revealed that Age UK staff and volunteers view supporting participants with complex needs as a gradual process. This is most evident in the case studies of older people who were in poor health at the beginning of their engagement with the programme: their support started with arranging personal and housekeeping services and reducing their social isolation. These steps were thought to prepare the older person for going out more and becoming involved in activities designed to increase their physical activity.

Accessibility of services and activities

According to case study interviewees, some older people found ***fit for the future*** attractive because the services were easy to access: in terms of time, location, transport options and fees. These factors can be separated for analytical purposes, but they all come together and influence the decisions of individual participants. Some interviewees mentioned that ***fit for the future*** groups were run at times that best suited them, whereas 'standard' exercise classes in gyms or community centres were often run at inappropriate times, sometimes starting too late.

[3] These types of unplanned interventions are hard to formulate as targets and quantifiable outcomes of a specific programme, but they are very important for the participant and also take up the time of Age UK staff, and are thus important elements of the report.

Box 6: Providing activities at appropriate times

One case study participant explained that older people may have more free time than those who are employed, but they do not necessarily have the energy later in the day:

"I was looking for an exercise class but everything was so expensive. And … most classes are in the evening and I'm tired."

(Sarah, Leeds)

Offering activities at suitable times was particularly important for the participant older people who are also carers, as they often have a very strict daily routine, limited by the availability of formal care services that they can draw on to enable them to go out and leave the person being cared for. Even those carers who have a relatively light care load may be restricted in terms of their ability to leave the home (see Box 7, for example).

Box 7: The importance of appropriate activity start times for carers

Kate in Nottinghamshire was interested in joining ***fit for the future*** exercise classes, but they were in the afternoon, when Kate visits her husband in a care home:

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

(Kate, Nottinghamshire)

The overall cost of accessing services was mentioned by many of the interviewees. They said that they were more likely to access the services if they were free of charge or relatively cheap. The cost that they were referring to included the fees they paid for the services, the room hire and the cost of transport to the venues. Some participants mentioned that the cost was often kept down through ***fit for the future***, particularly if the venue was provided free of charge, which sometimes happened as a result of a special arrangement with the local authority.

The example in Box 8 illustrates how the low cost and convenient location contributed to and an older person's decision to choose ***fit for the future*** services over mainstream exercise classes.

Box 8: The importance of the low cost of activities

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

(Sarah, Leeds)

The location of the group sessions was particularly important for older people who were carers or who had limited mobility, as the example in Box 9 illustrates.

Box 9: The importance of the location of the activities

Adam and his wife use a car to go into the town centre from their sheltered accommodation as Adam walks very slowly and his wife is in a wheelchair. The 'multi-purpose' group meets only a hundred meters from their bungalow, and has been their main source of social contact apart from their family in the last couple of months.

Feeling accepted by other group members was particularly important to some participants, as the examples in Box 10 illustrate.

Box 10 The importance of feeling accepted and welcome by others in the group

Anne (Blackburn with Darwen) suffered from an impaired sense of balance and facial palsy as consequence of brain surgery. Physical exercise was vital in helping her to learn to walk again and improve her sense of balance, but Anne was at first embarrassed about her appearance. Others in her Zumba and walking groups were understanding and supportive, and the regular exercise helped her to recover remarkably fast.

Tajinda (Blackburn with Darwen) felt comfortable with joining first the walking group then the swimming and aqua mobility classes because there were several other Asian women in the groups and the activities were tailored to their needs.

4.3. Summary: Implementing *fit for the future*

- Local Age UKs have adopted a variety of approaches to recruiting ***fit for the future*** participants. Detailed analysis is required to learn from the different local practices.
- Overall, GPs have been difficult to engage in the referral process. However it emerged from the case studies that referrals from health professionals may be taken more seriously than invitations from voluntary organisations, which suggests that engaging more General Practices would benefit the programme.
- Case studies highlighted the importance of older people being informed about the referral process and the activities offered in ***fit for the future*** groups***.***
- Two models of providing group-based activities have been identified: 'single-' and 'multi-purpose' groups; in some cases 'outreach' services have also enabled frail older people to benefit from the programme in their own homes.
- ***fit for the future*** activities were more affordable and more accessible to older people than mainstream exercise groups, due to more appropriate start times and more convenient locations.

5. Impact of Fit for the future

In this section we draw on the case studies with older people, and the interviews with stakeholders to provide a preliminary assessment of the programme's initial impact on participating older people, individual organisations, including local Age UK partners, local partnerships and the wider health and social care system in England.

5.1. Impact on participants[4]

The programme's impact on older people's lives cannot be discussed strictly according to the three outcome areas of the Well-being Programme of the Big Lottery Fund (physical health; healthy eating; and mental well-being), as participants and stakeholders talked about their expectations, experiences and perceptions of the programme's impact in an interconnected way.

When talking about their **expectations** of Fit for the future, older people who were interviewed in the case studies most often mentioned socialising and making new friends. Expectations varied depending on how they became involved in the programme: older people who joined the programme through self-referral appeared to have better defined objectives and they were often actively seeking activities outside the home. They also had a clear idea of what they wanted in terms of the kinds of activities that they wanted to access and were prepared to be on a waiting list for their preferred group / activity (Box 11).

Box 11: Self referrals often have clearly defined objectives

Louise, who attended three different exercise groups in ***fit for the future***, was consciously looking for ways of becoming more physically active and having fun:

"I promised myself that when I retire it's not going to be boring. … I signed up while I was still working, and by the time I retired I had a place in the groups."

(Louise, Leeds)

Many of those who were invited by Age UK to participate in the programme said that although they were not actively seeking activities outside the home, they responded positively to the invitation to get involved because they wanted to meet new people, as the following example in Box 12 illustrates:

[4] As only 18 case studies have been completed, these are tentative findings and the findings outlined here may be modified later.

Box 12: Avoiding isolation and meeting new people

"We didn't really know, we just went across and they said we were going to chat and you know do crafts and quizzes. I love quizzes, they keep your brain going and I do like crafts. … They said they would be organising little trips out, so I just thought, it's something different. And also, meeting different people. See, I missed that. Because in my job I was travelling up and down the country, meeting different people every day, you do tend to miss it later."

(Sue, Rotherham)

A group of older people engaging with the programme, who spoke about their expectations of it in relation to reduced isolation and loneliness, was carers. This included older carers who had recently ceased caring due to the death of the person being cared for, and who were currently experiencing transition from an intensive and stressful time (Box 13).

Box 13: The importance of social interaction for current and past carers

Barbara only alluded to how difficult caring for her late husband had been, but her best friend explained that Barbara had lost a lot of weight and suffered from anxiety, and had also been *'tied to the house'* while caring for her husband who suffered from Alzheimer's disease. She benefitted from joining a fit for the future group, in her friend's words:

"She's more outgoing. She's out and about. … She's got something to look forward to."

(Barbara's friend, Rotherham)

The most often mentioned improvement was increased social engagement (Box 14).

Box 14: The importance of social interaction

"My Mondays have changed." (Sue, Rotherham)

"This group has been a lifeline." (Joanna, Rotherham)

Older people participating in ***fit for the future*** often perceived the programme's impact on their well-being in a holistic way and emphasised the connections between improved physical and overall well-being (see for example Box 15).

Box 15: Improving physical activity and overall well-being

"Zumba makes me happier because I enjoy it. I don't think it does much for anything else (laughs). It makes me breathe a bit harder. Meeting people that you know, having a chat, having a coffee."

(Sarah, Leeds)

"The main benefits of the programme? Hmm, learning new things, going out and having a laugh."

(Louise, Leeds)

Sarah and Louise, who were quoted above mentioned *'having a laugh*' and *'having a chat, having a coffee'* as part of the positive experience of joining an exercise class. The relationship between physical exercise and overall well-being also worked the other way round, as Barbara's example illustrates (Box 16):

Box 16 Benefits of social interaction and physical activity

Barbara joined a Fit for the future group primarily to meet new people and improve her low moods, but she is now feeling the benefits of physical exercise as well:

"I feel better because I go out more, and because I'm feeling more fit, I can cope better"

(Barbara, Rotherham)

Expectations of learning about healthy eating have so far been less common in the case study interviews. This may be explained by the fact that, of the case study interviews carried out to date, only older people living in Nottingham and Nottinghamshire mentioned groups focused solely on nutrition. However, a few participants have reported that they had developed healthier eating habits as a result of their participation in ***fit for the future*** (Box 17):

Box 17: Healthy eating

Anthony thought that the nutrition course he had attended was useful:

"I've learnt a few new recipes on the course. Our favourite is the cheese and chive bread, everybody loves it."

(Anthony, Nottinghamshire)

Sue, who attended a 'multi-purpose' group, benefitted from a short activity focussing on healthy eating:

"I wouldn't say [my diet] has changed but there are certain things that I became aware [of], things you let slip a little bit and it brought it back to the forefront. I mean we had a thing the other day, all different fruit, and I thought, you know, I like all those, so why do I only buy bananas, apples and pears, why not other types of fruit? So I started buying blueberries."

(Sue, Rotherham)

However, the following example from a case study illustrates that these positive changes can easily be lost, and that continued support to reduce stress is sometimes needed (Box 18)

Box 18 Learning about healthy eating and mental well-being

"I did change the way I cook until a couple of weeks ago, and then it just all went… I was worried about my husband and I was on the go all the time, so I just can't be bothered. I mean I do things and then I freeze them. It's boring to cook for yourself."

(Kate, Rotherham)

Case studies with older people participating in ***fit for the future*** have also revealed that, in some cases, expectations were unmet, particularly when the details of the activity or group had not been fully explained, as the following example illustrates (Box 19).

Box 19: The importance of providing an accurate description of the activities

Ron was then invited to a group focusing on healthy eating and nutrition, which did not meet his expectations:

"I didn't really know what it was going to be. I went to the four sessions. I suppose it wasn't many of us, only eight people. We talked about food. They got us cooking something. I thought it was going to be more like a lecture. It wasn't what I expected. I did learn something I suppose. I expected a more detailed discussion about food."

(Ron, Nottinghamshire)

Impact on older people – from stakeholders' point of view

When asked about the impact of the ***fit for the future*** programme on the older people participants, some stakeholders said that it was too early to comment or to point to specific examples where they had experienced an impact. Others felt that older people had already experienced a positive impact and pointed to positive feedback they had heard from participants, and one stakeholder mentioned positive feedback from General Practitioners. At this stage, the two main positive impacts of the programme on older people that have been highlighted by the stakeholders are: the engagement of older people who had not previously been involved in other local Age UK activities; and the creation and provision of new activities which had not previously been available to older people. Some examples of the benefits in both these areas are provided in both Box 20 and Box 21.

Box 20: Fit for the future engaging with a wider range of older people

*'There is one client that's really benefitted from involvement in **fit for the future**. A lot has been done to engage this lady and take her to social groups, which she loves. It's been really positive'.*

(Stakeholder in Hillingdon)

We have some who are very isolated. One is a lady in her 90s. She was referred by her doctor. She had depression, never went out. She's now got a befriender, she's linked into the door to door service to shops, lunch clubs, [and] she does exercise. She had nobody, now she's got a much more active life. I could see a different woman.'

(Stakeholder in Newcastle)

Box 21: The benefits of activities resulting from *fit for the future*:

'Some specific falls prevention efforts have helped particular clients'

(Stakeholder in Hillingdon)

'I've seen activities, people are doing physical things, … it improves confidence.

(Stakeholder in Rotherham)

Differences between participants benefitting from the programme:

The evidence so far from the case studies shows that participants have not necessarily benefitted from the programme in the same way or to the same degree. One of the main reasons for the different experiences that the older people have had in relation to the programme can be attributed to the health of the participating older person.

As already alluded to in Section Four, some older people participating in ***fit for the future***, were aware of the exercise classes available to them, but felt that these were beyond their abilities, and therefore they engaged in and benefitted only from the social engagement aspect of the programme (Box 22):

Box 22: Benefits of the programme may be limited by poor health

Marie (Blackburn with Darwen) participated in Knit and Natter, benefitted from debt advice and her mental health has improved a great deal as she made new friends. However, she felt that walking and other forms of exercise offered in the programme were difficult for her, because of her arthritis, which contributed to her undergoing knee and hip surgeries.

Gender is another important factor influencing how older people benefit from ***fit for the future***. Firstly, this relates to the way men and women deal with their long term health condition, and to the way they react when they are approached and being offered help. Two of the five older men who participated in case studies so far mentioned jokingly that they were *'supported by women'*, referring to staff at Age UK and other voluntary organisations and befriending volunteers. It was also clear from these interviews that they had difficulty coming to terms with their health conditions. Secondly, gender is an important factor when influencing group dynamics. Case study participants explained that some men found it difficult to engage in groups where there were more women. In a group in Rotherham, for example, women participants thought that the only man dropped out exactly because he was the only man in a group of women. Remaining group members were aware of this and were planning to invite other men. Thirdly, gender / masculinity construction may not only

affect how men participate in the programme, but also contribute to their willingness to join the programme in the first place.

5.2. Impact on individual partner organisations

Stakeholders were asked about the impact of their involvement in the programme on their own organisation. Many stakeholders indicated that it was too early to state what the impact had been in this respect, however, some stakeholders stated that there were positive effects being experienced already. Stakeholders representing parts of the NHS or local authorities mentioned that they had increased the number of referrals that they make by referring older people to the ***fit for the future*** programme. Those stakeholders representing Voluntary, Care and Faith (VCF) sector organisations, on the other hand, mentioned a series of slightly different benefits. Some said that their organisations experienced more referrals of older people to the activities that they are offering as a result of the programme. A couple of the stakeholders who were interviewed actually stated that the organisations they represent had been *'a victim of their own success'*, experiencing an increase in referrals which they were unable to always accommodate. They stated that they had been unable to increase supply of services to match the increased demand that had been generated as a result of the programme.

Some of the stakeholders representing the VCF sector indicated that the increase in referrals had wider benefits for the organisation, including: developing new voluntary roles within the organisation; raising the awareness of organisation amongst the wider health and social care system; assisting the participating VCF sector organisation to reach a wider range of older people; increasing their organisations lists of potential service users; increasing the usage of local community centres and venues, which in turn brings additional income into the organisations as users spend money on refreshments and other products and services.

5.3. Impact on local partnerships

Stakeholders were asked about their expectations in relation to partnership working for the ***fit for the future*** programme and the extent to which those expectations had been realised. Initial expectations were listed as including: successfully engaging with GPs; gaining access to more and a wider range of older people than individual organisations have done; working with older people on a one-to-one basis and providing appropriate, tailored support; an increase in the use of community centres and venues; providing services / organising activities which are beyond medical intervention and enabling older people to get 'out and about'; and improving older people's mental health**.**

When asked if expectations about partnership working has been realised, the views of stakeholders were somewhat mixed. Many felt that their expectation had been realised or were in the process of being realised. Examples of positive benefits included some new

partnerships that have been developing and/or existing partnerships which are being built upon as a result of the programme. Just under half of those stakeholders who have been interviewed so far, for example, said that they had developed or strengthened links with the NHS. One stakeholder mentioned links they have established with emergency services.

However, there was a general consensus among stakeholders that the ***fit for the future*** programme has not yet facilitated the process of partnership building as much as it could have and that further work in this direction is desirable. In addition, a significant minority of the stakeholders who were interviewed thought that there was not any real partnership working as part of the programme.

Some of the stakeholders also outlined other areas where they felt that their expectations of the programme had not been met. These included difficulties accessing GPs in some localities, and for some partners; some difficulties engaging with volunteers, in particular recruiting volunteer buddies; and the inability to meet demand for services in areas where the programme has been particularly successful in engaging large numbers of older people.

5.4. Impact on the wider health and social care system

Stakeholders were also asked about the way in which ***fit for the future*** was having an impact on the wider health and social care system but most were unable to answer this question. This is partly because the programme is at an early stage of development and partly because some of those stakeholders who have been interviewed do not feel that they have the knowledge to answer this question. This reiterates the need for stronger partnership working between health, social care and the voluntary sector and a need to raise awareness of the programme across the health and social care system.

Nevertheless, many stakeholders said that they had started to see improvements in local level integration of health and social care as a result of ***fit for the future***, such as wider knowledge of the services available elsewhere in the system; and the growing number of referrals across the health and social care system, although it is clear that these improvements are still at a fairly early stage of development.

5.5. Summary: Impact

- Case study participants invited to join ***fit for the future*** groups responded positively to the invitation because they wished to meet new people.
- Case studies joining through self-referral were often actively seeking activities outside the home.
- Almost all case study participants said they had benefitted from the programme.
- Some partner organisations benefitted from the increased number of referrals, while others were unable to meet the increased demand for their services.
- Engaging volunteers was difficult in some areas, further analysis is necessary to unpack the reasons.
- Existing relationships between organisations have become stronger, but partnership building has not yet been facilitated by ***fit for the future,*** with some stakeholders unaware of the programme.

6. The future and sustainability

Older people who were attending ***fit for the future*** groups when the case study interviews were conducted said that they liked the groups and wanted them to continue. Participants in the 'multi-purpose' ***fit for the future*** groups in Rotherham have directly experienced and reflected on the issue of sustainability, and although they were sorry about not meeting Age UK staff every week, they were keen to 'keep' their groups, as the following quote illustrates (Box 23):

Box 23: Fit for the future groups becoming 'self-funding'

"Age UK has finished now and the Lions have taken over. It's a shame because they had these groups going, but they couldn't continue, they had only so many weeks. I think they have to move on and have to start groups in different areas. Now we are self-funding. The local council have just given us £400 to pay for a day trip."

(Sue, Rotherham)

As the groups in the Rotherham area became self-funded, one participant was concerned about the cost of the room hire, while others were concerned that the group may dissolve and they would lose their newly formed links.

The stakeholders who were interviewed were overwhelmingly in agreement that ***fit for the future*** is an important programme and should be continued beyond the existing funding that is available through the Big Lottery. The key reasons given were that beyond the importance of the programme in terms of improving health and well-being, the programme provides a programme of support which facilitates prevention and helps combat social isolation and promote independence. One stakeholder said, for example (Box 24):

Box 24: Combatting social isolation

*"It [**fit for the future]** gets people out of the house, combats social isolation, people learn new skills, it helps to keep them healthy, it is good for their health"*

(Stakeholder, Nottingham and Nottinghamshire)

Another reason given for the need to continue the programme was that it supports integration across service provision, as a stakeholder involved in social prescribing as part of ***fit for the future*** said (Box 25):

Box 25 Fit for the future contributing to integrated service provision

It's probably the single most important thing that could be delivered. I can't imagine not having social prescribing as part of the offer, …. and Fit for the future is [a] model of social prescribing. It's inconceivable that social prescribing shouldn't exist in some form.'

(Stakeholder in Newcastle).

Discussions were had with the stakeholders about the ways in which the project can be sustained beyond the current Big Lottery funding and some suggestions included:

- Supporting and encouraging the wider use of volunteers to run the services and activities to facilitate lower costs;
- Charging a small fee for using the services, where they are not already doing so;
- Collecting evidence, if possible, about the cost savings in the system as a result of the programme, for example avoided hospital admissions;
- Integrating ***fit for the future*** in the commissioning process used by local authorities and Clinical Commissioning Groups. This strategy is currently being adopted by organisations involved in working towards improving the identification and support of carers (Wigfield et al, 2012).

Summary

- Case study participants were satisfied with the programme; the individual attention they received was particularly appreciated.
- Stakeholders interviewed also supported the continuation of the programme.
- To make the programme sustainable, some stakeholders suggested charging a small fee for the services or reducing costs by using free venues and involving volunteers
- Some stakeholders suggested that ***fit for the future*** should be integrated in the commissioning of non-clinical health and social care services.

7. Potential areas for improvement

At this early stage of the programme's development it was felt important, as part of the evaluation, to ask both participants and stakeholders how the programme could be improved. This will help ensure that early lessons from the programme can be disseminated to local Age UK partners and considered during the next phases of the programme's delivery.

Very few case study participants mentioned areas for improvement, apart from some very specific issues such as more convenient times for specific activities to commence and one person who mentioned that the range of activities available was too limited at present.

Issues mentioned by stakeholders included setting out in a clearer way the outcomes expected as a result of the programme; raising awareness of the programme amongst a wider group of organisations, including amongst GPs (despite the known challenges); increasing publicity through adverts in newspapers, newsletters to stakeholders; avoiding duplication but signposting to and building on existing classes and activities rather than setting up new ones offering identical services; and getting a better match between assessing the need of individuals and providing the activities that best meet those needs. This does not always occur currently but is not always easy either, due to capacity and funding constraints. It was suggested that consideration should be given to the involvement of volunteers: some stakeholders thought that more volunteers should be involved, while others thought that there should be a greater reliance on paid staff. Finally, one stakeholder suggested that it was important to collect 'hard' evidence rather than anecdotal comments about the impact of the activities, at the same time warning against asking intrusive questions.

8. Summary and conclusions

This interim report aimed to provide a summary of the initial findings on the ***fit for the future*** programme, including the benefits felt by older people and its potential impact on: statutory bodies in health and social care and the Voluntary, Community and Faith sector.

Focussing on the processes through which participants were recruited or referred to the programme we found that the recruitment targets had been met in most of the 11 areas, albeit through different approaches and methods. Referral routes were somewhat different from those originally planned, which highlights the challenges of engaging health professionals in the programme. More detailed analysis is necessary to unpack the reasons behind the locally specific referral patterns and the divergence from plans.

Data emerging from the case studies suggests that older people joined the programme primarily to expand their social networks, though some self-referrers were also seeking physical activity. Looking at ***fit for the future*** groups, two models of service provision have been identified: 'single-purpose' groups focus on promoting healthy eating or increasing physical activity; while the 'multi-purpose' groups observed so far primarily focus on social engagement, with physical activities and healthy eating workshops included.

Considering the accessibility of activities, ***fit for the future*** activities were more accessible than mainstream services to older people, due to more appropriate start times and more accessible locations. ***Fit for the future*** groups were also more affordable. Although 'hard to reach' groups of older people, such as carers and those with limited mobility, could access the group activities, or benefit from services in their own homes, further attention to their specific needs is essential in order to ensure that they are successfully engaged in the programmes.

The programme's impact has been analysed by focusing on older people and on individual organisations and local partnerships involved in the delivery of the programme, from the point of view of participants and stakeholders. Both participants and stakeholder reported improved overall well-being among participants, attributing this primarily to more intensive engagement in social activities. One stakeholder observed that the physical activity of participants had increased, and a few stakeholders mentioned that new groups of older people had been successfully engaged in activities and new types of activities were offered. Benefits in terms of increased physical activity and improved healthy eating practices were also illustrated by case studies. Further analysis is needed to explore how different groups of older people, such as carers, men, and those in poor health and/or living with disabilities experience the programme's impact. Although a few case studies drew attention to unmet expectations, older people were satisfied with the programme in general and with the person-centred approach in particular.

Findings on the impact on organisations and on local partnerships involved in the programme have highlighted improved social prescribing practices, and the strengthening of existing relationships between organisations in some areas. Areas of concern were also

identified, however: it was challenging to engage new volunteers, and there was consensus among the interviewed stakeholders that ***fit for the future*** had not met their expectations of facilitating partnership building. Despite the criticism, the stakeholders interviewed so far, and most case study participants, supported the continuation of the programme, with some expert stakeholders recommending that the programme be integrated into local-level commissioning of community-based health and social care services.

9. References

Bardsley, M., Billings, J., Dixon, J., Georghiou, T., Lewis, G.H., Steventon, A. (2011). "Predicting who will use intensive social care: case finding tools based on linked health and social care data", *Age and Ageing*, Vol. 40 No.2, pp.265-70.

Hughes ME, Waite LJ, Hawkley LC, Cacioppo JT. (2004) "A short scale for measuring loneliness in large surveys: Results from two population-based studies", *Aging Research Reviews*; Vol 26 No 6, pp. 655–672.

Jowit, J. (2013). "Britain's ageing population: the impact on families and services", *The Guardian*, Sunday, 24 February, available at: www.guardian.co.uk/society/2013/feb/24/ageing-population-impact-familiesservices (accessed 1 July 2013).

The King's Fund (2013). *Co-ordinated Care for People with Complex Chronic Conditions* [online]. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf (accessed on 27 August 2013).

Victor, C. (2010). *Ageing, health and care*. Policy Press

Wigfield, A., Moore, S., Buse, C. and Fry, G. (2012). *Workforce development for Assisted Living Technology: Understanding Roles, Delivery and Workforce Needs*. CIRCLE, Leeds.

Wigfield. A., Wright, K., Burtney, E. and Buddery, D. (2013). "Assisted Living Technology in Social Care: workforce development implications", *Journal of Assistive Technologies*, Vol 7. No 4: 204-218.

10.Annex

Survey One Frequency Tables: All areas

List of tables

Table A 1 Age: computed using Q3 'What is your date of birth?' and Q1 Today's date (years)

Mean	75.3 (10.0)
Median	76
Range	52
Minimum	49
Maximum	101
N	**1405**

Table A 2 Age groups

		Frequency	**Percentage**
Valid	50 - 54	37	2.6
	55 - 59	48	3.4
	60 - 64	128	9.1
	65 - 69	173	12.3
	70 - 74	224	15.9
	75 - 79	305	21.7
	80 - 84	229	16.3
	85 - 89	157	11.2
	90 +	104	7.4
	N	**1405**	**100.0**

Table A 3 Q5 Do you live alone, or do you share your home with one or more other person?

		Frequency	**Percentage**
Valid	Live alone	879	62.9
	Live with one or more than one person	519	37.1
	N	**1398**	**100.0**

Table A 4 Q6 Is there anyone sick, disabled or elderly whom you look after or give special help to?

		Frequency	Percentage
Valid	No	1212	86.9
	Yes	182	13.1
	N	**1394**	**100.0**

Table A 5 Q7 Which of the following best represents your attitude to healthy eating?

		Frequency	Percentage
	Not important	44	3.2
	Important, but not doing anything	297	21.5
	Important and doing something	1038	75.3
	N	**1379**	**100.0**

Table A 6 Q8 How many portions of fruit and vegetables have you eaten on an average day?

		Frequency	**Percentage**
Valid	0	22	1.7
	1	123	9.4
	2	263	20.1
	3	327	24.9
	4	236	18.0
	5	260	19.8
	6 +	80	6.1
	N	**1311**	**100.0**

Table A 7 Q9 Over the last two weeks, on average, how often have you eaten a meal that has been prepared and cooked from basic ingredients?

		Frequency	**Percentage**
Valid	Never	87	6.3
	Less than once a week	56	4.1
	Once a week	108	7.8
	2-3 times a week	329	23.9
	4-6 times a week	314	22.8
	Daily	484	35.1
	N	**1378**	**100.0**

Table A 8 Q10 Which of the following best represents your attitude to physical activity?

		Frequency	**Percentage**
Valid	Not important	37	2.7
	Important, but not doing anything	522	37.9
	Important and doing something	820	59.5
	N	**1379**	**100.0**

Table A 9 Q11 Over the last two weeks, how many minutes did you walk on an average day?

		Frequency	**Percentage**
Valid	0	101	7.7
	1-30 minutes	691	52.6
	31-60 minutes	317	24.1
	61-120 minutes	144	11.0
	More than 120 minutes	60	4.6
	N	**1313**	**100.0**

Table A 10 Q12 Over the last two weeks, how many minutes of physical activity did you do per week that made you breathe somewhat harder than normal, not including walking?

		Frequency	**Percentage**
Valid	0	485	39.8
	1-30 minutes	214	17.6
	31-60 minutes	161	13.2
	More than 60 minutes	359	29.5
	N	**1219**	**100.0**

Table A 11 Q13 Over the last two weeks, how many minutes of muscle strengthening activity did you do per week?

		Frequency	**Percentage**
Valid	0	458	36.4
	1-30 minutes	227	18.1
	31-60 minutes	192	15.3
	More than 60 minutes	380	30.2
	N	**1257**	**100.0**

Table A 12 Q14a Confidence - walking around the house

		Frequency	Percentage
Valid	1	53	3.8
	2	103	7.4
	3	212	15.3
	4	299	21.6
	5	720	51.9
	N	**1387**	**100.0**

Table A 13 Q14b Confidence - doing light housekeeping

		Frequency	Percentage
Valid	1	166	12.1
	2	125	9.1
	3	219	16.0
	4	222	16.2
	5	635	46.5
	N	**1367**	**100.0**

Table A 14 Q14c Confidence – doing simple shopping

		Frequency	Percentage
Valid	1	243	18.0
	2	129	9.5
	3	175	12.9
	4	204	15.1
	5	601	44.5
	N	**1352**	**100.0**

Table A 15 Q14d Confidence - preparing a meal

		Frequency	Percentage
Valid	1	168	12.3
	2	119	8.7
	3	184	13.4
	4	220	16.1
	5	679	49.6
	N	**1370**	**100.0**

Table A 16 14e Confidence - getting myself up in the morning

		Frequency	Percentage
Valid	1	73	5.3
	2	106	7.6
	3	172	12.4
	4	240	17.3
	5	795	57.4
	N	**1386**	**100.0**

Table A 17 Q15a Height (in metres, computed)

		Frequency	Percentage
Valid	1.40-1.49 m	31	2.9
	1.50-1.59 m	308	28.6
	1.60-1.69 m	445	41.4
	1.70-1.79 m	222	20.6
	1.80 + m	70	6.5
	N	**1076**	**100.0**

Table A 18 Q15b Weight (in kilograms, computed)

		Frequency	Percentage
	< 50 kilos	42	4.5
	51-60 kilos	137	14.6
	61-70 kilos	259	27.6
	71-80 kilos	195	20.8
	81-90 kilos	153	16.3
	91-100 kilos	86	9.2
	101-110 kilos	38	4.1
	111-120 kilos	12	1.3
	121+ kilos	15	1.6
	N	**937**	**100.0**

Table A 19 Q15c Waist circumference: inches

		Frequency	Percentage
Valid	<69 cm	34	6.2
	70-89 cm	213	38.6
	90-109 cm	237	42.9
	110-129 cm	57	10.3
	130+ cm	11	2.0
	N	**552**	**100.0**

Table A 20 Q16a Do you smoke?

		Frequency	Percentage
Valid	No	1250	90.3
	Yes	134	9.7
	N	**1384**	**100.0**

Table A 21 Q16b If yes, how many cigarettes do you smoke per day?

		Frequency	Percentage
Valid	1-10	65	58.6
	11-20	38	34.2
	21-40	7	6.3
	40+	1	.9
	N	**111**	**100.0**

Table A 22 Q17a Do you drink alcohol?

		Frequency	Percentage
Valid	No	816	59.7
	Yes	551	40.3
	N	**1367**	**100.0**

Table A 23 Q17b If yes, how many units of alcohol do you consume per week? Men

		Frequency	Percentage
Valid	1-10	115	76.2
	11-20	22	14.6
	21-30	14	9.3
	N	**151**	**100.0**

Table A 24 Q17c If yes, how many units of alcohol do you consume per week? Women

		Frequency	Percentage
Valid	1-14	290	90.9
	15-28	18	5.6
	29+	11	3.4
	N	**319**	**100.0**

Table A 25 Q18a Has a doctor or a health professional diagnosed you with any of the following conditions? Respiratory conditions

		Frequency	Percentage
Valid	No	1063	75.7
	Yes	342	24.3
	N	**1405**	**100.0**

Table A 26 Q18b Has a doctor or a health professional diagnosed you with any of the following conditions? Arthritis

		Frequency	Percentage
Valid	No	689	49.0
	Yes	716	51.0
	N	**1405**	**100.0**

Table A 27 Q18c Has a doctor or a health professional diagnosed you with any of the following conditions? Vascular / stroke

		Frequency	Percentage
Valid	No	1181	84.1
	Yes	224	15.9
	N	**1405**	**100.0**

Table A 28 Q18d Has a doctor or a health professional diagnosed you with any of the following conditions? Cancer

		Frequency	Percentage
Valid	No	1272	90.5
	Yes	133	9.5
	N	**1405**	**100.0**

Table A 29 Q18e Has a doctor or a health professional diagnosed you with any of the following conditions? Diabetes

		Frequency	Percentage
Valid	No	1128	80.3
	Yes	277	19.7
	N	**1405**	**100.0**

Table A 30 Q18f Has a doctor or a health professional diagnosed you with any of the following conditions? Dementia

		Frequency	Percentage
Valid	No	1343	95.6
	Yes	62	4.4
	N	**1405**	**100.0**

Table A 31 Q18g Has a doctor or a health professional diagnosed you with any of the following conditions? Mental health

		Frequency	Percentage
Valid	No	1217	86.6
	Yes	188	13.4
	N	**1405**	**100.0**

Table A 32 Q18h Has a doctor or a health professional diagnosed you with any of the following conditions? Other

		Frequency	Percentage
Valid	No	798	56.8
	Yes	607	43.2
	N	**1405**	**100.0**

Table A 33 Q19a I am fully informed about issues relating to my long term health conditions

		Frequency	Percentage
Valid	Strongly agree	467	38.3
	Agree	649	53.2
	Disagree	89	7.3
	Strongly disagree	15	1.2
	N	**1220**	**100.0**

Table A 34 Q19b I am fully involved in decisions regarding managing my long term health conditions

		Frequency	Percentage
Valid	Strongly agree	448	37.2
	Agree	662	54.9
	Disagree	76	6.3
	Strongly disagree	19	1.6
	N	**1205**	**100.0**

Table A 35 Q19c I am fully supported in managing my long term health conditions

		Frequency	Percentage
Valid	Strongly agree	432	35.7
	Agree	641	52.9
	Disagree	116	9.6
	Strongly disagree	19	1.6
	N	**1211**	**100.0**

Table A 36 Q19d I am fully in control of the care for my long term health conditions

		Frequency	**Percentage**
Valid	Strongly agree	433	36.2
	Agree	633	52.9
	Disagree	107	8.9
	Strongly disagree	23	1.9
	N	**1196**	**100.0**

Table A 37 Q20a Number of days of unplanned GP visits

		Frequency	Percentage
Valid	0	864	75.9
	1	163	14.3
	2	83	7.3
	3+	29	2.7
	N	**1139**	**100.0**

Table A 38 Q20b Number of days of unplanned hospital visits

		Frequency	Percentage
Valid	0	961	90.8
	1	70	6.6
	2	17	1.6
	3+	10	1.0
	N	**1058**	**100.0**

Table A 39 Q20c Number of days of unplanned visit to other health professionals, e. g. nurses

		Frequency	Percentage
Valid	0	937	92.7
	1	49	4.8
	2	19	1.9
	3+	6	.6
	N	**1011**	**100.0**

Table A 40 Q21 In the last month have you experienced a fall or loss of balance?

		Frequency	Percentage
Valid	No	954	70.3
	Yes	403	29.7
	N	**1357**	**100.0**

Table A 41 Satisfaction with life scale (Q22 On a scale of 0-10 how satisfied are you with your life as a whole nowadays?)

Mean	6.9
Std. Deviation	2.3
Range	10
Minimum	0
Maximum	10
N	**1346**

Table A 42 Q23 Seven-Item Warwick-Edinburgh Mental Wellbeing Scale

Mean	25.8
Std. Deviation	5.5
Range	28
Minimum	7
Maximum	35
N	**1208**

Table A 43 Q24a How often do you feel you lack companionship?

		Frequency	Percentage
Valid	Hardly ever	635	46.2
	Some of the time	518	37.7
	Often	221	16.1
	Total	**N**	**100.0**

Table A 44 Q24b How often do you feel isolated from others?

		Frequency	Percentage
Valid	Hardly ever	707	51.8
	Some of the time	451	33.0
	Often	207	15.2
	N	**1365**	**100.0**

Table A 45 Q24c How often do you feel left out?

		Frequency	Percentage
Valid	Hardly ever	745	55.4
	Some of the time	417	31.0
	Often	182	13.5
	N	**1344**	**100.0**

Table A 46 Q24d How often do you feel in tune with the people around you?

		Frequency	**Percentage**
Valid	Hardly ever	263	19.6
	Some of the time	478	35.7
	Often	598	44.7
	N	**1339**	**100.0**

Table A 47 Q25 What is your ethnic group?

		Frequency	Percentage
Valid	White British	1265	90.9
	Irish	20	1.4
	Gypsy or Irish Traveller	1	.1
	Other White	8	.6
	Indian	56	4.0
	Pakistani	9	.6
	Chinese	1	.1
	Other Asian	9	.6
	Mixed white and Black Caribbean	3	.2
	Mixed white and Black African	5	.4
	Mixed white and Asian	1	.1
	Other mixed background	1	.1
	Caribbean	8	.6
	Other Black, African, Caribbean	1	.1
	Arab	1	.1
	Any other ethnic background	3	.2
	N	**1392**	**100.0**

Table A 48 Q26 What is your gender?

		Frequency	**Percentage**
Valid	Male	362	25.8
	Female	1043	74.2
	Total	**1405**	**100.0**

Table A 49 Q27a Do you consider yourself to have a disability?

		Frequency	Percentage
Valid	No	535	40.8
	Yes	776	59.2
	N	**1311**	**100.0**

Table A 50 Q27b If yes, what is the nature of your disability? Deafness, or severe hearing impairment

		Frequency	Percentage
Valid	No	739	87.8
	Yes	103	12.2
	N	**842**	**100.0**

Table A 51 Q27c If yes, what is the nature of your disability? Blindness, or severe vision impairment

		Frequency	Percentage
Valid	No	745	88.5
	Yes	97	11.5
	N	**842**	**100.0**

Table A 52 Q27d If yes, what is the nature of your disability? A physical disability

		Frequency	Percentage
Valid	No	301	35.7
	Yes	542	64.3
	N	**843**	**100.0**

Table A 53 Q27e If yes, what is the nature of your disability? A substantial learning disability

		Frequency	Percentage
Valid	No	832	98.9
	Yes	9	1.1
	N	**841**	**100.0**

Table A 54 Q27f If yes, what is the nature of your disability? A substantial learning difficulty

		Frequency	Percentage
Valid	No	824	97.9
	Yes	18	2.1
	N	842	100.0

Table A 55 Q27g If yes, what is the nature of your disability? A serious mental health condition

		Frequency	Percentage
Valid	No	767	91.0
	Yes	76	9.0
	N	**843**	**100.0**

Table A 56 Q27h If yes, what is the nature of your disability? A chronic illness

		Frequency	Percentage
Valid	No	610	72.4
	Yes	232	27.6
	N	**842**	**100.0**

Table A 57 Q27i If yes, what is the nature of your disability? Another disability

		Frequency	Percentage
Valid	No	775	92.0
	Yes	67	8.0
	N	**842**	**100.0**

Table A 58 Q28 Sexual orientation

		Frequency	**Percentage**
Valid	Heterosexual	1123	99.3
	Gay or lesbian	4	.4
	Bisexual	1	.1
	Other	3	.3
	N	**1131**	**100.0**

Table A 59 Q29 Religion or belief

		Frequency	Percentage
Valid	Christian	876	71.0
	No religious affiliation or belief	157	12.7
	Other	121	9.8
	Hindu	32	2.6
	Muslim	27	2.2
	Sikh	11	.9
	Buddhist	8	.6
	Jewish	2	.2
	N	**1234**	**100.0**

Table A 60 Q30a Is your gender identity the same as your were assigned at birth?

		Frequency	Percentage
Valid	No	43	4.0
	Yes	1035	96.0
	N	**1078**	**100.0**

Table A 61 Q30b Do you live full-time in the gender role opposite to that assigned at birth?

		Frequency	Percentage
Valid	No	673	85.7
	Yes	112	14.3
	N	**785**	**100.0**

Table A 62 Q30c Do you feel able to discuss your gender identity with anyone?

		Frequency	Percentage
Valid	No	104	13.6
	Yes	662	86.4
	N	**766**	**100.0**