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Title: Benefits and impacts of Active Lives groups for older people living in the community

Amelia Bell (MSc, PG Cert LSHE, BSc (Hons), Dip HE, RGN)

Senior Lecturer

Faculty of Health and Social Care, Edge Hill University, St Helens Road, Ormskirk,

Lancashire, L39 4QP, UK

bellam@edgehill.ac.uk 01695 657014

Amelia Bell is a senior lecturer with the Faculty of Health and Social Care at Edge Hill University. She is a qualified Registered General Nurse with a clinical background in women's health. Her research interests primarily involve public health concerns, sexual health and loneliness and social isolation amongst older adults

Rob Gandy (PhD, MSc, BA (Hons), FIS, MIHM, Dip HSM)

Visiting Professor, Liverpool Business School, Liverpool John Moores University, and Honorary Senior Lecturer, Edge Hill University

Rob Gandy is a Visiting Professor with Liverpool Business School, at Liverpool John Moores University. He is a professional statistician with a PhD in Business Information. His research interests primarily involve healthcare-related subjects, and include commissioning, procurement, end-of-life services, dementia and migration. Much of his research has a particular focus on quantitative and cost-benefit analysis.

Professor Brenda Roe (PhD, RN, RHV, FRSPH)

Professor of Health Research, Evidence-based Practice Research Centre, Faculty of Health and Social Care, Edge Hill University, St Helens Road, Ormskirk, Lancashire, L39 4QP, UK

Brenda Roe is Professor of Health Research at Edge Hill University and Honorary Fellow at PSSRU, University of Manchester. She is also Editor of the Journal of Advanced Nursing and Non-Executive Director Mersey Care NHS Mental Health Trust. Her work focuses on older people, ageing, quality of life, evidence based practice and policy, long term conditions, service delivery and arts for health

Abstract

There are an increasing number of older people globally and nationally. However this rise in life expectancy is not always paralleled with a good quality of life. Within the north west of England Age UK Lancashire was awarded three-year funding by the Big Lottery to undertake an Active Lives programme. This programme delivered a range of local activity groups aimed at promoting the health, activity, lifestyle and wellbeing of older people living within the community. This paper reports the findings of a three-year descriptive study which evaluated older people's experiences of participating in the activity groups. The study identified the impact on their health, quality of life and wellbeing, use and benefits of the groups and suggestions for future service developments. Data were collected in three phases utilising focus groups and self-completed questionnaire surveys. Qualitative data were analysed by content analysis to identify key themes. Standard descriptive analysis was used for quantitative data. Key findings were benefits with general improvements in participants' physical and mental health, their wellbeing and quality of life. It was concluded that Active Lives groups in the community presented an effective means of maintaining and improving older people's health and social wellbeing.

Key Words: Quality of life, active ageing, older people, health and social wellbeing

Benefits and impacts of Active Lives groups for older people living in the community

Introduction and background

Like many developed countries, the United Kingdom (UK) has an increasing number of older people, with these cohorts growing fastest (Brown et al, 2004; Office of National Statistics (ONS) 2012; Teater and Baldwin, 2014). The 2011 census reported that 9.2 million residents of England and Wales were aged 65 years and over (ONS, 2013). By 2013 the population of the UK aged 65 years and over was estimated to be 11.1 million (ONS, 2014). Globally, the population of people over 60 years of age will reach two billion by 2050 (World Health Organisation (WHO), 2012a).

In response to the challenges of an ageing population there has been an emphasis within Europe on the development of ‘active ageing’ policy (Foster and Walker, 2015), as well as a global focus on active ageing (Annear et al, 2014). It is apparent that there is a lack of consensus on what constitutes active ageing (Boudiny, 2012) with some putting emphasis on continued employment and physical activity and others suggesting a more holistic approach. Arguably, active ageing should refer to more than just employment-related or physical activity; it should encompass all meaningful pursuits that improve an individual’s wellbeing (Foster and Walker, 2015). The application of active ageing to economic or physical activities alone can lead to the exclusion of those older people who have physical restrictions (Walker, 2002). Boudiny (2012) recognised the need for active ageing policy to focus on older people engaging with life in general rather than concentrating on economic engagement and highly physical activity. An over-emphasis on physical activity is of particular relevance

to this population group due to the number of older people living with co-morbidities. There is an increased prevalence of long-term health conditions among older people which can be a major health burden for them, their carers and health and social care services (Stern and Konno, 2009; Coulter et al., 2013). Approximately 80 per cent of those aged over 65 years are affected, with many having more than one condition (Stern and Konno, 2009; Coulter et al., 2013). These conditions can make taking part in physical and social activities difficult, thereby emphasising the need for a more holistic approach to active ageing and for policies that reflect the needs of the ‘young’ old and the ‘old’ old (Foster and Walker, 2015). Active ageing policy should consider the heterogeneity of the older population and apply an inclusive definition. The WHO (2002:12) suggest that active ageing is ‘the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age’. They further define ‘active’ as being able to continue to participate in ‘social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour market’. There is a need to develop initiatives that promote inclusion and allow all older people to engage in activities that promote positive health and wellbeing, a fact supported by The European Year of Active Ageing 2012, which recommended international, national and local policies be developed that support older adults, promote their independence and wellbeing, and encourage physical exercise (WHO, 2012b).

Within the north west of England a charity (Age UK Lancashire) aims to support the needs of older people within the population of two towns (Ormskirk and Skelmersdale) and surrounding rural communities in West Lancashire. It was awarded three-year funding by the Big Lottery to undertake the Active Lives programme (January 2012 to December 2014). The Big Lottery Fund provides community groups and health, education and environmental

projects with funding from the UK's National Lottery (Gov UK, 2016). Within the geographical area Age UK Lancashire serves, many older people live in areas of deprivation, are isolated, and lack support and access to services (Age UK, 2011; Bidmead et al 2012). Bidmead op cit. also highlight the potential for social isolation of those within Skelmersdale as great and indicate that the potential for loneliness amongst older people is very apparent. The delivery of the Active Lives project in West Lancashire had a focus on reducing this risk of loneliness and enabling older people to continue to be part of their community. The Active Lives programme aimed to promote the activity, lifestyle, physical and mental health, and wellbeing of older people living in the local community and was intended to benefit people aged over 50 years, particularly those isolated due to age-related illness or disability. The programme involved preventative community support through the delivery of a range of activity groups that were otherwise not available from local social care providers. It has been recognised that developing active preventative programmes plays an integral part in supporting the success of the ageing population (Teater and Baldwin, 2014).

Although the participation in physical activity can help improve health and wellbeing (Angevaren et al., 2008; Yeom et al., 2009; Reimers et al. 2012; Chase, 2013; English et al., 2014) the Active Lives groups that were offered reflected the WHO (2002) recommendation, ensuring that a range of activities were available rather than a focus on physical activities only. The groups ran at two Age UK Lancashire centres and rural locations on various days of the week with the exception of Sundays. There were no restrictions on who could attend each group and there was a minimal charge to attendees, dependant on the nature of the activity. The WHO (2016) acknowledge that the ages of 60 and 65 years are often used when defining the start of old age. However, this evaluation includes those aged 50 years and above, in line with the age that individuals can access Age UK Lancashire support services.

For the purpose of this evaluation the groups were divided in to five categories and Table 1 lists the different activity groups for each headline category.

<Insert Table 1 here>

An evaluation of the benefits and impact of the programme was required as a condition of funding and was undertaken as a partnership between Age UK Lancashire and Edge Hill University. This paper presents the findings of the evaluation in relation to experiences, health, wellbeing and quality of life. Findings on the organisation of groups, facilities, locations and frequency are reported elsewhere (Gandy et al., 2016).

Methods

Aim

The aim of this study was to evaluate older people's experiences of participating in the Active Lives groups, and to identify the impact that attending had on their health, quality of life and wellbeing.

Design

The evaluation was pragmatic and comprised a descriptive cross-sectional study that used mixed methods to collect qualitative and quantitative data by focus groups and self-completed survey questionnaires. It was undertaken in three phases, from April 2012 until December 2014: Phase 1 data collection (September to December 2012); Phase 2 data collection (June to August 2013); and Phase 3 data collection (April to June 2014).

Sample

Convenience samples of participants were recruited for each phase from service users who attended the Active Lives groups in all locations. There were no set exclusion criteria and the study welcomed participants that attended either one or more groups. The samples comprised of participants aged 50 years or above, reflecting eligibility and inclusion criteria of Age UK Lancashire.

To avoid coercion by the research team, ensure good research practice and assure inclusivity all potential participants who attended the groups for each phase of the study were identified by the Active Lives programme co-ordinator. Utilising a gatekeeper to access potential participants ensures that individuals are not coerced to participate and do so willingly (Cronin et al., 2015). The programme co-ordinator approached all members accessing the Active Lives groups to avoid any selection bias. All those attending the groups were provided with a project summary and invited to participate in the evaluation. Potential samples for the focus groups and surveys were identified separately but comprised all participants attending one or more of the groups. All participants were sent a covering letter, a project information sheet and a consent form to allow them to fully consider participating prior to attending the groups. Potential samples from across the full range of Active Lives groups were invited in order to gain information across all activities, centres or sites and locations served although those willing to participate in the research were ultimately ones of convenience and self-selecting.

Focus group sample sizes ranged between six and fifteen participants for each of the focus groups conducted on two occasions across the three phases (6 focus groups in total), in accordance with recommended methodological practice (Krueger 1994, Morgan 1997).

The samples required for the quantitative surveys were constructed so that each activity group by site combination was capable of being separately surveyed, i.e. five x three = 15 potential surveys. Using anticipated activity levels, the number of responses required for surveys to be deemed satisfactory, was projected as ranging between 75 and 180. People could attend a range of activities at different sites, and could complete surveys for each combination. However, because of survey anonymity it was not possible to calculate multiple responses within and between phases. The number of people that attended each activity and site reflected the nature of the activity and the physical constraints of the site; some activities were for set time periods (e.g. education courses) whilst others were ongoing (e.g. lunch clubs). As not all groups operated every week a pragmatic decision was taken to survey all individual sessions within the survey period of each phase, which meant that it was not possible to establish a uniform sample. Therefore the sample size reflected those sessions actually surveyed and the numbers attending those sessions on the day (Gandy et al., 2016).

Data Collection

Qualitative data on the experiences of those attending the Active Lives groups were collected via two focus groups undertaken in each phase. Focus groups are a flexible data collection method (Barbour, 2005) commonly used in health and social care research (Freeman, 2006); however, there are recognised strengths and disadvantages of the method. Within the group there may be dominant participants whose views predominate (Holloway and Wheeler, 2010; Finch et al., 2014). This difficulty can be managed by an experienced facilitator who can encourage and give opportunities to contribute to more reluctant participants (Grbich, 2003; Goodman and Evans, 2006; Robson, 2011; Roe et al., 2011a; Finch et al., 2014). The groups were moderated by a member of the evaluation team and a second member acted as a note-

taker to capture additional contextual information, about the dynamics of the group and to validate aspects of group consensus or disagreement.

Discussion topics included: activity groups they attended; their experiences; and the impact participating in the groups had on health and wellbeing. Further data were obtained following the focus groups using a self-completed questionnaire to obtain information on participants' age and gender, standardised measures on health status (overall, generational and temporal) (Sargent-Cox et al., 2010), and quality of life and wellbeing (Bowling, 2005).

Overall-current health status at the present time was measured on a 1 to 5 item scale (1 being excellent and 5 being poor); temporal health status scored by indicating if their health was better, about the same or not as good as 12 months ago; and generational, their health was better, about the same or worse than people their age (Sargent-Cox et al., 2010). Quality of life used the standardised measure for overall quality of life using a 7 items descriptor =, so good it could not be better, very good, good, alright, bad, very bad, so bad it could not be worse (Bowling, 2005). Both standardised measures have been developed and used in national research programmes (Bowling, 2005, Sargent Cox et al., 2010). Participants' views, and suggestions for service developments based on their experiences were also obtained using three local indicator open questions (Roe et al., 2011b). The local indicator open ended questions have been used previously in Innovations Forum and Partnerships in Older People Projects research (Roe et al., 2011b) and comprise 1) experience of service/group, 2) Have the groups helped you, if so how? If not, why? And 3) How could we improve what we do, do you have any suggestions?

For the surveys, quantitative data were collected across each phase using anonymous self-completed structured survey questionnaires. Each survey recorded a person's gender and age (in specific age groups of "under 65 years", "65-74 years", "75-84 years" and "85+ years")

and sought people's experiences at key stages of programme delivery. No data were available for numbers of people that 'dropped out' from the programme; however Age UK Lancashire suggest anecdotally these numbers were small (Gandy et al., 2016). The results provided contemporary feedback: Phase 1 concentrated on facilities and organisation; Phase 2 obtained data on frequency of attendance, enjoyment, impact of the groups on health and wellbeing, and whether they would recommend the activities to friends and family; and Phase 3 focussed on availability and frequency of groups, and perceived changes in health, wellbeing and social isolation. Each survey involved no more than seven questions and each survey utilised a 5-point Likert scale, there was also an option to decline to answer. Age UK Lancashire identified the activity sessions in which the surveys would be administered. The session co-ordinator ensured that all attendees were given the opportunity to complete the survey.

Ethical considerations

Ethics approval for the Active Lives evaluation was obtained from the University Faculty of Health and Social Care Research Ethics Committee (FOHSC - LRC32). Potential participants were provided with a project summary and information sheet by a person independent of the evaluation team and those wishing to participate were advised of the date, time and venue of the focus group or survey. Utilising a gatekeeper to assist in recruitment ensured participant's personal data was restricted to an individual who already had access. Written informed consent was obtained following an overview of the study at the time of data collection. When utilising focus groups there is less confidentiality due to the number of participants (Robson, 2011) however participants were asked to refrain from mentioning individual names. To assure confidentiality and anonymity all transcribed data from the focus groups and self-completed questionnaires were anonymised. The surveys were

anonymised and confidentiality was maintained as no data could be located back to participants. All electronic and transcribed data were stored securely on a password protected system. Written consent forms were stored in a secure cabinet. Participants were made aware of their right to withdraw from the study at any point.

Data analysis

Focus groups were digitally recorded and transcribed. The transcriptions were verified as accurate recordings by comparing the accuracy of the transcription with each of the respective digital recordings for each focus group. Content analysis was undertaken to allow for the identification of key themes within the data (Miles and Huberman, 1994).

Conventional content analysis was utilised as the aim of the study was to describe a particular phenomenon (Hsieh and Shannon, 2005), which in this case was the experiences of older people participating in the Active Lives groups. Using an inductive approach data were examined without preconceived notions or categories noting key words and themes that were then used to formulate categories (Kondracki et al., 2002). Analysis was performed independently by two members of the research team and the themes identified were discussed and agreed (Graneheim and Lundman, 2004). Data relating to background information, health status and quality of life were collated using summary statistics. It was not possible to identify participants who participated across all three phases and so matched pairs analyses could not be performed. Quantitative data were analysed using standard descriptive methods, mean difference tests, correlations and multiple correspondence analysis (MCA). (All analyses used Excel software, except MCA which utilised SPSS). The use of MCA allowed for the detection and representation of underlying structures within data sets (Sourial et al., 2010) and detailed MCA results have been reported elsewhere (Gandy et al., 2016).

Reliability and Validity

A semi-structured guide was utilised in the focus groups to prompt and initiate conversation and this assisted with assuring consistency and increasing validity. Confidentiality and anonymity was assured during the process to increase openness and honest discussion and assist in increasing reliability and validity. Two members of the project team undertook analysis of the focus group data and reached consensus on agreed emerging themes. This supported reliability with data saturation occurring when no more themes were identified. Standardised reliable and valid measures on health status (Sargent-Cox op cit), quality of life and wellbeing (Bowling op cit.) were used as intended, with standardised questions and responses used as per the researchers prescribe.

Quantitative data were obtained using a survey design developed following a pilot study to ensure its suitability for the population group. Use of the pilot study enabled any required modifications to be made so instructions and questions were clear and suitable and that the survey was fit for purpose. The surveys were anonymous to ensure answers were more likely to be open and honest. Data were held on a secure database.

Findings

Samples

The majority of participants in the focus groups and surveys across all three phases were women with most or all Active Lives groups sampled (Tables 2 & 3). The response rates for the surveys were acceptable, ranging from 48% to 63% (see Table 2).

<Insert Tables 2 and 3 here>

Sixty-seven participants attended the focus groups with seven being involved in two or more focus groups; a total of 58 individual participants once duplicates were removed across the three phases (see Table 3). Their mean ages were 73 years for Phase 1 (range 62-89), 74.5 years for Phase 2 (range 56-82) and 77 years for Phase 3 (range 67-85). This slight increase in mean age could be attributed in part to those who participated in focus groups in all phases. The majority of survey respondents were within the 65-74 and 75-84 years age ranges. Only a minority were 85 years and above or aged under 65 years (see Table 4). As the surveys used tick boxes for the four age categories, it was not possible to calculate the specific means and standard deviations of survey respondents' ages.

<Insert Table 4 here>

Key themes identified from the focus groups reoccurred across the three phases. They included: benefits of the groups; restrictive factors; suggestions for promoting groups and their development; appreciation of staff/support at times of need; and intergenerational activities. Findings from these themes and the suggestions highlighted by participants on the short local indicator questionnaire are reported and direct quotations cited. Results on health status, wellbeing and quality of life from focus groups and surveys are also reported.

Benefits to health and wellbeing attending the groups

A key theme which emerged from the data was the obvious positive benefits of attending the Active Lives groups on participants' health and wellbeing. There was general agreement that participants valued the impact the groups had on their social wellbeing, physical health and mental health. Across all phases the most prominent theme appeared to be social factors and this was often discussed in relation to building friendships and avoiding loneliness. The

Active Lives groups appeared to be a way in which the participants could form friendship networks. One participant stated,

'Yeah, from like one seed of actually first coming to Age UK, cause I came here, I knew nobody; nothing. I started – it was first Tuesday keep-fit. Through that I met friends. I do lots now, I don't stay in now, but if I'd have never made the first step to Age UK I'd probably been old and lonely now' (Focus Group Six).

And another explained that attending groups regularly allowed people to see each other consistently, and this was a positive point:

'I think the social side is mostly what people want, regardless of what the actual thing is, they just love to come and see the same people every week' (Focus Group Two).

One of the participants in Phase 1 summarised the positive impact that the groups had on their social wellbeing by expressing their concerns should the groups end,

'My family live a long way away, I've got very good friends, but if the thing closed down I would have blank weeks, those weeks when there was nothing on' (Focus Group Two)

There were some participants in Phase 3 who suggested that although the social impact of the groups was appreciated, the impact on physical health was equally as important and of benefit. In Phases 1 and 2 there was also discussion about the impact on physical health and the opportunity to exercise and keep fit.

Throughout the three phases it was evident that participants felt that physical activities had a positive impact on their mental health and wellbeing. 'Line dancing' and other dance related

activities kept participants both mentally and physically active, because of the need to concentrate and recall steps, thereby aiding their memory.

'Mentally, you've got to remember steps, so it's arithmetic' (Focus Group One)

The quantitative results supported the qualitative findings in relation to health and wellbeing benefits. Within Phase 2 of the study 87% (142) stated that they 'agree' or 'strongly agree' that the Active Lives groups had helped their health and wellbeing. Furthermore, the quantitative data from Phase 2 indicated that 95% (156) 'agreed' or 'strongly agreed' that the Active Lives groups had helped their social wellbeing. 84% (172) of participants in Phase 3 felt they had become less socially isolated since attending the groups.

Restrictive factors

The participants indicated that although the Active Lives groups were greatly appreciated there were certain factors that may have restricted some individuals from attending. This was a reoccurring theme in all phases with concerns centred on car parking facilities at one venue and disabled access at another. Whilst lack of parking impacted on group attendance, there was recognition that alternative parking was available nearby. Also, despite the concerns about disabled access, participants indicated the benefits of the venue's building outweighed such issues, and they were aware that Age UK Lancashire were addressing access problems.

Suggestions for promoting and developing the groups

One aim of the evaluation was to establish suggestions in relation as to how the services provided by the programme could be developed. Participants were consistently complimentary about the Active Lives groups and Age UK Lancashire, and the main issue raised was a need for more advertising of the activities and groups available. There was a recognition across all phases that the main method of advertising was through 'word of

mouth'. However, it was suggested more direct publicity, for example in local newspapers, would attract new members. One participant stated;

'I think we should do more advertising of,.....I know that we, we pass on word of mouth, but I think we need to do more advertising and get people who are a little bit younger than the majority of us now' (Focus Group Two)

Participants appreciated that increased advertising would be expensive and discussed other available means, such as centre notice boards and information leaflets. There were some suggestions for additional groups, for example, a half-day option for day trips, yoga, Tai Chi, lip-reading classes, cooking classes and a holiday club. There was also a request that in some groups, such as the IT and computer sessions, more one-to-one support would be appreciated. Participants also highlighted that they would welcome activities on a Sunday as this was considered to be a lonely day for people. As discussed, those attending focus groups within each phase demonstrated great appreciation in relation of Age UK Lancashire and its staff. This would appear to be supported by quantitative data highlighting that 99% (162) of participants in Phase 2 would recommend their activity group to family and friends.

Intergenerational Activities

An interesting theme emerged from the Phase 2 and Phase 3 focus groups. This related to the participants of the Active Lives groups working with 13- and 14-year olds. Participants appeared to greatly value the opportunity to participate in intergenerational activities. The qualitative findings indicated that the participants primarily found it enjoyable to spend time with the younger generation and also interestingly viewed this time as an opportunity to address any negative images of older people that were present amongst younger generations:

‘They get more involved and they can see us what we are, you know, not little old ladies, we fight our cause, you know’ (Focus Group Five)

Health status, quality of life and wellbeing

Across all six focus groups 63 participants returned either completed or partially completed standardised health status, quality of life and wellbeing questionnaires. Within Phase 1 19 (86%) returned questionnaires, 24 (100%) in Phase 2, and 20 (95%) in Phase 3. The number of participants was small, and matched pairs sample analysis was not possible.

When considering overall health status of participants at the present time it was evident that the majority of participants rated their overall health as being a three – mid range (one being excellent and five being poor). A small minority of participants indicated their health to be excellent, and a small minority indicated their health to be poor (see Table 5).

<Insert Table 5 here>

The participants were asked to compare their current health status to 12 months ago and whether it was better, about the same or not as good. The majority of participants reported their health the same as 12 months ago at Phase 2 and Phase 3 compared to those at Phase 1. More than a quarter (range 26% to 47%) reported their health was better. Minority percentages at all three phases reported their health as being not as good as one year ago which suggests a temporal decline (see Table 6).

<Insert Table 6 here>

Participants were asked if they considered their health better, about the same or worse than most people their age. Within Phase 3 none of the participants judged their health better than most people their age with a majority of participants, proportionally more than in Phase 2 and Phase 1, reporting their health about the same as other people their age. However proportionally more judged their health worse than others at Phase 3, compared to Phase 1 and Phase 2 (see Table 7).

<Insert Table 7 here>

Participants were asked to rate the quality of their life from a range of ‘so good, it could not be better’ to ‘so bad it could not be worse’ (Bowling, 2005) (for all categories, see Table 8). The majority of participants rated their quality of life as being either ‘good’ or ‘very good’

<Insert Table 8 here>

These findings would appear to be supported by the quantitative results from Phases 2 and 3. The quantitative data from Phase 3 indicated that 83% (162) of participants considered that attending the Active Lives groups had ‘improved’ or ‘greatly improved’ their social wellbeing and quality of life, and 17% reported no change. In Phase 2 of the study 87% (142) of participants ‘agreed’ or ‘strongly agreed’ that the activity programme had helped their health and wellbeing. However, in Phase 3 when asked how much their health and wellbeing had changed through attending the groups 62% (118) indicated it had ‘improved’ or ‘greatly improved’ but over a third indicated ‘no change’.

Discussion

One of the main aims of the study was to identify the impact that participating in the Active Lives programme had on the health, wellbeing and the quality of life of participants. It is evident from the findings that participants did feel that the Active Lives programme had an overall positive impact for participants. The findings indicate that attending the groups allowed them to experience physical, mental and social benefits to their wellbeing which would appear to meet the aim of the earlier discussed WHO (2002) definition of 'active ageing'. Participants attended a range of groups which allowed them to become more engaged in life and their community, a point of importance also highlighted by Boudiny (2012).

A key concern of the targeted population was the increased risk of loneliness and isolation and the impact this may have on health and wellbeing. Matthews et al. (2014) indicate older adults who engage less in social and cultural activities have poorer aging outcomes. It is important to encourage older adults to engage in social activities and become involved in their community. Our findings emphasise that social wellbeing was viewed by participants as one of the main reasons for attending and the greatest benefit. Forming friendships was a key factor for participants, a fact that is of importance when considering that older adults with a solid social network can expect a 50% boost to their longevity (Hunter, 2012). Fewer men than women accessed the groups indicating a need to consider the range of activities available. Gendered environments are of importance when trying to enhance the health and well-being of men (Wilson and Cordier, 2013).

Even those that felt the social impact of attending the groups was greater recognised that there had also been improvements to their physical health. It is clearly evident within the literature that the health and wellbeing of older adults is improved through participation in physical activity (Angevaren et al., 2008; Yeom et al., 2009; Reimers et al., 2012; Chase, 2013; English et al., 2014). Increased activity can reduce the risks of coronary heart disease and other chronic diseases including depression and type 2 diabetes (American Heart Association, 2003) and will assist with the prevention of stroke (Howard and McDonnell, 2015). It was encouraging to see that evaluation participants appeared to enjoy the physical element of the programme particularly as the 2014 English Longitudinal study of ageing (ELSA) report indicated that only 30-40% of older adults in 2012-2013 took part in only low level physical activity (Steptoe et al., 2014).

This evaluation demonstrated that those older people attending the programme indicated that participating in physical activity also improved their mental health. The link between physical health, mental health and wellbeing is documented within the wider literature which suggests that increasing the leisure activities and physical activities of older adults can prevent or forestall cognitive decline (Angevaren et al., 2008; Stern and Konno, 2009; Plooij et al., 2012). Indeed Sprange et al. (2013) argue that healthy active ageing will encourage good mental wellbeing, and it has also been suggested that certain activities decrease levels of depression (Pinneger et al, 2012).

An important consideration when providing services such as the Active Lives groups is the accessibility of the facilities. The wider literature suggests that difficulty in accessing services and the appropriateness of a venue have been identified as significant barriers to older people attending services (Greaves and Farbus, 2006; Hennessy, 2014). In general, participants felt that the facilities used by the programme were appropriate and they did not

create a barrier to their attendance. An issue consistently highlighted by focus group participants was the lack of public transport in the more rural areas, which was felt to adversely influence attendance. This is consistent with the ELSA report's finding that access to transport had a significant impact on older people's ability to engage in social activity (Steptoe et al., 2014), and as such is an important consideration when providing community groups for older people.

Strengths and limitations of the evaluation

It is argued that the cross-sectional nature of data collection across the three phases of the three-year project, and the use of multiple sampling, as well as the mixed methods approach, are clear strengths of this pragmatic evaluation. A longitudinal design might have improved robustness but this was not possible due to resource constraints, the need for anonymity (to maximise the number of responses to the quantitative surveys), and the different focus of each phase.

Furthermore, use of a longitudinal approach was restricted by nature of the population group and that not all participants attended the same groups regularly across the three-year period. Response rates for the focus groups and surveys for each phase of the study were acceptable, but as convenience sampling was utilised the possibility of some sample bias cannot be excluded.

Conclusion and recommendations

It is evident that the vast majority of older people who participated in the Active Lives groups said they experienced multi-dimensional benefits to their health, wellbeing and quality of life. The groups also positively impacted on people's social wellbeing, with particular reference to reduced feelings of loneliness and isolation, and helped older people to form networks of

friends. Loneliness has a significant, adverse impact on health and wellbeing and is therefore a key public health issue both nationally and globally. It was evident that the Active Lives groups assisted in addressing this at a local level.

Whilst the evaluation was positive, there were some suggestions for improvements to services. These focused primarily on access (transport, car parking and disabled access), **which are key** to any successful service of this kind; it has to be accessible to the population it serves to maximise its impact. Additional groups were also suggested by participants. These included yoga, Tai-Chi and cooking.

Shaping services and groups to meet the needs of older people should improve attendance and participation now and in the future and ensure sustainability; those older adults involved clearly wished to see the Active Lives groups continue. More women than men were accessing the groups and it may be that future groups offered could be made more relevant to men. **It is recommended that consideration be given to the introduction of further groups to increase variety and the possibility of attracting more men**

Only a minority of people aged 85 years and above attended the Active Lives groups, but as this is an age group that will grow in numbers in the future, careful thought needs to be given to how to maximise their access to services. **To encourage attendance of those aged 85 and above there is a need to review available groups to ensure inclusivity. Efforts could also be made to specifically target the ‘oldest old’ when planning future advertising campaigns.**

When considering the transferability of the Active Lives Project to a similar population, commissioners and service providers should note the positive impact on health and wellbeing

that attending the groups appeared to have on participants. In an era of fiscal austerity such programmes can aid the prevention of these long-term conditions, thereby helping address some of the largest cost areas for the NHS (Gandy et al. 2016).

In conclusion the Active Lives programme had a multifaceted positive impact on those older adults that attended and appears to represent a positive approach to encouraging active aging and improving the health, wellbeing and quality of life of older people.

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Table 1. Categories of activity groups for evaluation

Activity Group Category	Individual Activities Covered By Headline Category
Education/ Informative	Arts & Craft Group; Big Band; Craft Group; German Group; Spanish/ French Group; Information & Advice
IT/Communications	Computer classes; Mobile telephone use; Internet shopping
Physical/ Exercise	Chair-based exercise; Health Walks; Indoor Bowling; Keep Fit; Line Dancing; On Tap Performers Group; School of Dance; Tap & Tone Group; Tea Dance; Yoga; Zumba;
Social/ Engagement	Bridge Club; Coffee Morning; Lunch Club; Rural Club; Senior Citizens meeting
Support Group	Alzheimer's Support Group; Day Care Services; Foot care Surgery;

Table 2. Response rates for surveys

Survey	Number of activity groups	Response rates*	Men	Women
Phase 1	9/15	48% (158 from 329)	37 (23%)	121 (77%)
Phase 2	11/15	63% (166 from 263)	26 (16%)	140 (84%)
Phase 3	15/15	58% (205 from 352)	45 (22%)	160 (78%)

***The number of completed survey forms returned as a percentage of the number of survey forms handed out.**

Table3. Summary information on samples per focus group and overall totals

Phase	Focus group	Total participants	Men	Women
Phase 1	FG1	14	2	12
	FG2	8	2	6
Phase 2	FG3	11	2	9
	FG4	13	4	9
Phase 3	FG5	6	2	4
	FG6	15	3	12
Overall Totals	6	67*	15	52
Number of individuals		58	13	45

*Note Overall total includes 1 participant(woman) who participated in data collection for phases 1 and 2 only, 1 participant (woman) phases 2 and 3 only, and 7 participants (5 women & 2 men) who participated in all 3 phases.

Table 4. Age range and totals of survey respondents

Age range	Phase 1	Phase 2	Phase 3
Under 65	32 (20%)	20 (12%)	18 (9%)
65 - 74 years	57 (36%)	55 (33%)	53 (26%)
75 - 84 years	32 (20%)	49 (30%)	87 (42%)
85 years and above	16 (10%)	19 (11%)	29 (14%)
Prefer not to say	21 (13%)	23 (14%)	18 (9%)
Total	158 (100%)	166 (100%)	205 (100%)

Table 5. Overall health responses

Overall health	Phase 1	Phase 2	Phase 3
1 excellent	0	0	2 (10%)
2	3 (19%)	7 (30%)	5 (26%)
3	10 (63%)	13 (57%)	11 (59%)
4	1 (6%)	1(4%)	1 (5%)
5 poor	2 (12%)	2 (9%)	0
Total responses	16	23	19
No response to question	3 (16%)	1 (4%)	1 (5%)
Total returned questionnaires	19	24	20

Table 6. Temporal health responses

Health compared to 12 months ago	Phase 1	Phase 2	Phase 3
Better	8 (47%)	8 (35%)	5 (26%)
Same	4 (24%)	12 (52%)	11 (58%)
Not as good	5 (29%)	3 (13%)	3 (16%)
Total responses	17	23	19
No response to question	2 (11%)	1 (4%)	1 (5%)
Total returned questionnaires	19	24	20

Table 7. Generational health responses

Health compared to others same age	Phase 1	Phase 2	Phase 3
Better	6 (35%)	10 (43%)	0
Same	9(53%)	11 (48%)	14 (78%)
Worse	2 (12%)	2 (9%)	4 (22%)
Total responses	17	23	18
No response to question	2 (10.5%)	1 (4%)	2 (10%)
Total returned questionnaires	19	24	20

Table 8. Overall quality of life

Indicator	Phase 1, Number of participants	Phase 2, Number of participants	Phase 3, Number of participants
So good, it could not be better	2 (11%)	0	1 (5%)
Very Good	4 (22%)	11 (46%)	7 (37%)
Good	7 (39%)	9 (38%)	7 (37%)
Alright	3 (16%)	3 (13%)	4 (21%)
Bad	1 (5%)	1 (3%)	0
Very Bad	1 (5%)	0	0
So bad, it could not be worse	0	0	0
Total responses	18	24	19
No response to question	1 (5%)	0	1 (5%)
Total returned questionnaires	19	24	20