Institute for Health Research
Sefydliad Ymchwil Iechyd

'As soon as I get my trainers on I feel like dancing':

AN EVALUATION OF 'AGEING WELL' IN ENGLAND AND WALES

MAY 2007



Age Concern's Ageing Well programme in England and Wales

Final evaluation report 2007

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CHAPTER 1
EXECUTIVE SUMMARY

1.1 INTRODUCTION AND BACKGROUND

This evaluation was commissioned by the Welsh Assembly Government in partnership with Age Concern England to evaluate the Age Concern Ageing Well programme in England and Wales.

Ageing Well is an innovative programme to enable older people to become involved in local initiatives designed to improve physical, social and emotional health and wellbeing. Ageing Well aims to increase the expectation of good health in old age and to encourage people aged over 50 years to maintain, sustain and improve their own health and that of their peers in later life. It aims to promote effective models of healthy ageing in line with national and international strategies. Across England and Wales there are 88 Ageing Well projects.

1.2 RESEARCH DESIGN AND METHODOLOGY

The aim was to assess the impact of the programme on Ageing Well Coordinators, Senior Health Mentors and clients and to make recommendations for the future development of the programme.

The key objectives were to examine:

- The Ageing Well programme in practice.
- Practicability of the Ageing Well core training material and support and supervision for paid and voluntary staff.
- Impact on health and wellbeing of coordinators, volunteers and clients.

Data collection included:

- Four focus groups with 31 Ageing Well project coordinators and two face to face interviews with coordinators unable to attend a focus group (n=33).
- Short postal questionnaire survey of coordinators (n=33).
- Telephone interview survey of Senior Health Mentors (n=101).
- Face to face interviews with clients in six projects (n=31).
- Face to face interviews with Ageing Well managers (n=3).
- Review of documents project evaluations and reports and research reports.

The timetable for the evaluation was November 2006 – May 2007.

1.3 PROFILE OF COORDINATORS, VOLUNTEERS AND CLIENTS

Volunteers and coordinators brought a breadth of skills and experience to the role, with two-thirds of coordinators having been in post for more than two years, suggesting continuity over time. In terms of backgrounds, experience and skills there were similarities in the profiles of coordinators and volunteers, with high proportions of coordinators and volunteers having professional or management backgrounds. On the other hand a quarter of clients came from professional backgrounds. Other clients had retired from skilled or unskilled manual occupations, were housewives, or had been unemployed prior to retirement age. The vast majority of coordinators, volunteers and clients were women. Fifteen per cent of coordinators, 15% of volunteers and 29% of clients were from black or minority ethnic backgrounds.

Volunteering roles within Ageing Well included running or assisting at exercise groups or arts and cultural events, discussions with individuals, giving out information leaflets, providing complementary therapies, leading walks or providing transport or refreshments.

1.4 AGEING WELL PROJECTS AND ACTIVITIES

The evaluation revealed a diversity of project types and differences in experiences for coordinators, volunteers and clients. Since it was created some 14 years ago the programme has developed in breadth and depth from a base of nine projects in the early 1990s to 88 in 2007, with more projects in development in Wales. The projects that participated in the evaluation were developed to provide health promotion activities for people aged over fifty years living in deprived urban communities, or others who lived in isolated rural communities. Some projects targeted hard-to-reach social groups such as people from minority ethnic communities, people living in socially disadvantaged localities, or men. About half of the projects enabled older people to participate in a broad range of physical activities such as walking or exercise classes, complementary therapies, arts and history, reminiscence, healthy eating and other health-related talks. Other projects were focused on single activities, such as exercise, or delivering support to isolated individuals in their own homes. The settings in which activities were delivered varied with some older people attending activities in their local day centre or community hall, and others being visited in their own homes or residential care setting.

Most of the clients who took part in the evaluation joined in Ageing Well activities at least once a week, with about a half of the sample taking part more than twice a week. Clients of projects reported that they enjoyed physical exercise whether seated, keep fit or walking and they also valued the companionship of other people. Talks on health advice, welfare benefits or local history, as well as dancing, IT and crafts were also popular. Men were more likely to join walking groups or exercise sessions or talks provided by external speakers. The number of male participants was small so these findings should be treated with caution. The most requested additional topics included health advice including information for carers, health screening checks, outings and day trips. Clients also suggested that health information should be provided in formats more readily accessible to older people including languages other than English or Welsh (where it was not already available), oral as well as written formats for people who could not read and using terminology that some may be more familiar with, such as imperial measures as well as metric ones.

1.5 FACTORS THAT FACILITATED THE DELIVERY OF AGEING WELL

The enthusiasm and motivation of clients, volunteers and staff at national and local levels were key to the success of Ageing Well. Coordinators and volunteers were motivated by the opportunities that Ageing Well offered to make a difference to the quality of life of older people. Coordinators, volunteers and clients gained mutual advantage from a supportive project environment.

Health gains made by clients also provided motivation for coordinators and volunteers. In turn clients were motivated by the friendliness of coordinators and volunteers. Coordinators and volunteers described being able to use skills acquired in the workplace, such as nursing, complementary therapies or administration, or in other voluntary work.

Good transport links, provision of transport such as 'Dial a Ride', being able to drive or walk to accessible venues enhanced participation. Other clients and volunteers, however, reported difficulties getting to projects where private transport was unreliable or projects were based on busy main roads.

Funding was also mentioned as both a facilitating factor and a barrier to development of Ageing Well. New policy initiatives generated funding opportunities which were welcomed and coordinators benefited from receiving information about the strategic priorities of different health organisations in order to secure funding.

1.6 FACTORS THAT CHALLENGED THE DELIVERY OF AGEING WELL

The short-term nature of some funding streams created uncertainty and instability that preoccupied many coordinators with an inevitable impact on stress levels. Volunteers and clients were not immune from anxiety about the future of their projects. The majority of the clients who were interviewed reported that they would be willing to pay charges where it was necessary to sustain projects. However both volunteers and clients felt charges could deter low income older people from joining in and so their introduction should be approached with caution.

Coordinators identified problems in developing partnerships with the statutory sector, as the role of voluntary initiatives such as Ageing Well in the preventative, active ageing public health agenda was not always fully recognised.

Doubts and anxieties of health professionals about the role of the voluntary sector were mentioned as an obstacle. An understanding of the lay model shows that the key role is in *interpreting* professional information and advice in a way that understands the values and beliefs of the person.

The recruitment and retention of volunteers was also seen as a difficulty by some coordinators and volunteers. As well as the funding issues discussed above, volunteers also mentioned that personal issues such as lack of time, other volunteering or caring commitments impeded their involvement with Ageing Well. Another challenge in developing a lay health approach to healthy ageing involves the difficulty of recruiting the 'right' volunteers or paid workers from deprived communities. The essence of the model lies in involving people who relate to each other's circumstances, and to reach deep into communities to address inequalities. This issue is also relevant for recruiting volunteers into Ageing Well from groups who are under-represented in the programme.

1.7 TRAINING OF VOLUNTEERS

The evaluation found examples of good practice in relation to initial, as well as ongoing, training. The most common model was for coordinators to use elements of the Age Concern England Senior Health Mentor Core Training Pack to supplement local training to meet volunteers' needs. Some coordinators used the whole of the pack and some did not use it at all. The majority of coordinators stated that it was comprehensive, relevant and easy to understand and stated that after training volunteers were prepared for their roles.

The majority of volunteers had received training when they joined Ageing Well and most of these also stated that their training was comprehensive, relevant and easy to

understand. However, it was clear that most were unfamiliar with the idea of a Senior Health Mentor Core Training Pack for volunteer mentors.

Practice in delivering training varied across projects, with some coordinators undertaking most of the training, and others bringing in outside speakers where appropriate, or sending volunteers to local colleges for training.

Coordinators working with minority ethnic communities questioned the Senior Health Mentor Core Training Pack's appropriateness in terms of both language and relevance for different cultures.

Volunteers' main suggestions for changes to training included adapting training to the requirements of the activities that volunteers intended to take part in as well as local circumstances; offering more flexible training depending on the expertise of volunteers and ongoing refresher training that also enabled volunteers to meet together.

1.8 SUPPORT AND SUPERVISION

The evaluation looked at support and supervision from the ActivAge Unit for coordinators, coordinators for volunteers and volunteers for clients. At all levels positive relationships were identified. Ageing Well demonstrated excellent support models for volunteers. Support systems need to be in place for the coordinators who are pivotal to the success of initiatives.

The majority of clients indicated that they received sufficient support from volunteers and commented that they felt motivated, encouraged and sometimes cajoled by volunteers. Some of the volunteers were viewed as friends and it was evident that a warm social environment was fostered.

1.9 IMPACT ON HEALTH AND WELLBEING ON COORDINATORS, CLIENTS AND VOLUNTEERS

The findings indicated that there was a positive impact on the health and wellbeing of all groups, in particular clients, and to a lesser extent volunteers and coordinators.

The majority of volunteers reported a positive health impact, although between a third to a half reported that their knowledge of and levels of exercise and healthy eating had stayed the same mainly because they were interested in these issues before they joined Ageing Well. Maintaining health is an important feature of active ageing programmes.

There was a clear consensus from coordinators, volunteers and the clients themselves that clients had benefited physically, socially and emotionally from participating in Ageing Well activities.

There were marked similarities in the most frequently reported health benefits for clients and volunteers, which were widening social networks and improvements in knowledge and levels of physical activity. Findings indicated that volunteers valued the relationships and friendships they had made through participating in Ageing Well. It has been shown that volunteering provides the opportunity to make friends and to increase social interaction. Over 90% of clients and over 60% of volunteers reported improvements in their knowledge about and levels of physical exercise.

1.10 THE CONCEPT OF 'PEER' HEALTH MENTORING WITHIN AGEING WELL

Findings clearly identified the importance of the positive relationships which had developed between clients and volunteers and between volunteers and their coordinators. These relationships had a beneficial impact on health and wellbeing and helped sustain participation. There was evidence of ambiguity in respect of the title 'senior health mentor'. Some coordinators were unclear about the concept of peer mentoring or that training was a necessary pre-requisite for this role.

Ageing Well offers an opportunity for older people to be engaged in a community-based style of care which may be more appealing than volunteering in mainstream health and care services where the role of volunteers is being marginalised because of growing emphasis on budgets and achieving targets (HM Treasury 2002).

1.11 DEVELOPING THE LAY HEALTH PROMOTION MODEL IN AGEING WELL: A TYPOLOGY OF VOLUNTEER ROLES

Challenges to the implementation of healthy active ageing include the lack of a robust evidence base that demonstrates that using lay health workers or peer mentors can improve health and reduce inequalities. This is primarily because of the lack of large-scale studies, particularly in the UK, and even fewer that specifically involve older people. However, experience in practice, including within Ageing Well, shows that involving lay people from communities to reach their peers with health messages can be successful (Coull *et al* 2004; MacGregor and Sheehy 2004).

Despite the programme being promoted as one that utilised the skills of 'senior health mentors', few volunteers in our study were actually known by this title. Coordinators, volunteers and clients mainly referred to 'volunteers', with a minority reported to be 'senior health mentors'. However interviews with all groups of participants revealed that despite not being called 'senior health mentors' volunteers engaged with clients in a continuum of positive mentoring roles.

Scrutiny of the roles undertaken by Ageing Well volunteers found a variety of roles that enabled the development of a typology of volunteer mentoring including 'volunteers', 'activity leaders' and 'community health volunteers / senior health mentors'. Some project coordinators reported that they were developing 'health trainers' in their projects.

Greater clarity about the volunteer-led activities in Ageing Well has the potential to increase the client base, as well as make Ageing Well more attractive to volunteers. As volunteers grow in confidence they may wish to change and extend their volunteering contributions.

1.12 ADOPTING A GENDER SENSITIVE APPROACH IN AGEING WELL

The evaluation has shown that Ageing Well is predominantly a service populated by women. Examples to increase numbers of men include taking initiatives to where men are (quizzes in pubs or football matches), offering health checks in the workplace for men aged 50 – 65 years; following guidelines reproduced on the Men's Health Forum website to produce health information designed to reach men of all ages.

1.13 INVOLVEMENT OF BLACK MINORITY AND ETHNIC GROUPS

There is also an under representation of BME groups among Ageing Well volunteers. Coordinators working with ethnic minorities acknowledged that speaking the same

language and being from the same community facilitated recruitment of volunteers and enabled Asian Elders to participate in activities that otherwise may not have been possible. Therefore the coordinators and volunteers were able to link into informal and formal networks within the community.

1.14 CONCLUSION

The Ageing Well programme received an extremely enthusiastic response from everyone who took part in the evaluation. Involvement in Ageing Well was seen to have had a very positive impact on the mental and physical health of the majority of participants in particular social wellbeing. The evaluation identifies the valuable contribution that older volunteers make in promoting the health and wellbeing of people aged over 50 years and sustaining broader strategic public health objectives for active ageing.

1.15 RECOMMENDATIONS

The Ageing Well model

- The concept of Ageing Well should be more clearly defined in order to strengthen the model and build on good practice within the programme.

- Age Concern England's ActivAge Unit and Ageing Well in Wales should work with coordinators, volunteers and clients to agree and promote shared definitions of the range of volunteering and mentoring roles within Ageing Well.

- Consideration should be given to revising the 'senior health mentor' title. A title with 'volunteer' included in it may be most appropriate.

- Consideration should be given to revising the Ageing Well membership categories 'active' and 'regular' projects.

- A typology of volunteering roles is suggested that has the potential to increase the client base and make volunteering more attractive to a wider range of people including those approaching retirement, in mid-life, or seeking to increase their job prospects.

- Consideration needs to be given to the age span and differing levels of fitness that Ageing Well currently seeks to bring together as 'peers'.

Recruitment of volunteers

- Recruit more men and people from minority ethnic groups by developing strategies to address their particular needs.

- Work with local employers to increase the pool of volunteers at part of pre-retirement planning.

Training

- A national resource pack should be developed in consultation with coordinators, volunteers and clients, which covers the key principles of Ageing Well as a health mentoring model. The resource pack could be adaptable to meet the requirements of volunteers taking up different mentoring roles. The pack would

supplement the training already offered by local Age Concern volunteering programmes.

- The ActivAge Unit should consider developing training packages for supporting local trainers to deliver the training to their volunteers.

- Consideration should be given to supporting volunteers who wish to extend their role and train as nationally accredited NHS health trainers. The ActivAge Unit may wish to contribute a module to this national model on specific competences for health trainers working with older people.

Support and supervision

- Build on good practice and establish and promote a range of opportunities for coordinators to network and support each other. This may include buddying relationships between coordinators, clustering projects in areas of specific interest such as men, BME communities, or mental health. There should be more opportunities at network meetings to share ideas and examples of practice.

- Ensure that all volunteers have appropriate supervision that meets individual requirements.

- Establish a central database to provide accurate information on volunteers participating in Ageing Well.

- Refine project evaluation forms in partnership with local projects to establish benefit to local projects and ensure better return on information about client outcomes, for example, using questionnaires such as Short Form (SF) 12.

- Collate evaluation forms centrally and provide feedback to the coordinators

Partnership/ funding base

- There is scope for Ageing Well to work more closely with statutory sector providers and community groups to increase the number of projects and to increase numbers of volunteers and clients. Links to the health improvement agenda and active ageing strategies would be particularly beneficial.

- Ageing Well offers distinctive advantages – the contributions of older volunteers to support their peers – and these core features should be retained.

- Long-term funding streams would improve sustainability, with less reliance on grants. For example policy changes to joint commissioning for health and wellbeing may offer a strong lever for statutory funding.

Clientele

- Seek to attract more men into Ageing Well as clients and as volunteers through adopting gender sensitive strategies.

- Ensure transport is available as this is one of the key factors which impedes participation.

- If considering charging for services, these fees would need to be nominal so as not to deter those from lower incomes.

- Consider extending the health screening provision, in particular through the mid-life life checks currently being developed nationally.

CHAPTER 2
INTRODUCTION AND BACKGROUND

This evaluation was commissioned by the Welsh Assembly Government in partnership with Age Concern England to evaluate the Age Concern Ageing Well programme in England and Wales. The key objectives were to examine:

- The Ageing Well programme in practice.
- Practicability of the Ageing Well core training material and support and supervision for paid and voluntary staff.
- Impact on health and wellbeing of coordinators, volunteers and clients.

The research objectives and the broad design were specified by the commissioners.

2.1 WHAT IS AGEING WELL?

Ageing Well was developed by Age Concern England 14 years ago as an innovative programme to enable people aged over 50 years to become involved in local initiatives designed to improve the physical, social and emotional health and wellbeing of their peers. Ageing Well aims to increase the expectation of good health in old age and to encourage older people to maintain, sustain and improve their own health and that of their peers in later life. It aims to promote effective models of healthy ageing in line with national and international strategies.

A centrally-led network of local Ageing Well projects provide support with physical activities and other social events together with health information and advice 'in the context of positive and holistic health'. Some projects provide a comprehensive, generic range of activities promoting physical exercise, swimming and other sports, and complementary therapies such as yoga or Tai Chi, as well as cultural events. Others focus on single activities such as exercise classes. Projects may be developed to appeal to a broad range of client interests, or to work with people with specific health conditions, older people from ethnic minority communities, or with people who experience mental health problems such as anxiety or depression. Activities may be led by trained volunteers or by paid staff. Volunteer 'peer health mentors' are trained to encourage older people on a small group, or individual basis, to increase their levels of physical or social activity.

The programme was developed in response to the government's Health of the Nation targets (DoH 1992), with a focus on coronary heart disease, stroke, accidents, cancer and mental health. It is led by the ActivAge Unit of Age Concern England and Ageing Well in Wales. Local Ageing Well projects may be 'active' or 'regular'. To qualify for 'active' membership groups should recruit and train older people to become volunteer Senior Health Mentors (SHMs). They should run health promotion activities for older people which can be delivered by these volunteers. Once accepted for 'active' membership they should train volunteers using the 'Senior Health Mentor Core Training Pack' developed and provided by the ActivAge Unit, together with any other relevant information to meet local needs. 'Regular' projects run health promotion activities for older people that may be delivered by external speakers such as health professionals and not necessarily by volunteers. Both types of project are expected to reapply for membership annually and provide six monthly written updates. They should also be willing to share information and best practice with the ActivAge Unit and other members of the network and contribute to the programme nationally. There

are currently 33 'active' projects and 38 'regular' projects in England and 17 projects in Wales. In Wales the distinction between active and regular is not made. There are currently six Ageing Well projects in Scotland.

Ageing Well Northern Ireland operates in three ways: an Ageing Well Network and Actively Older Project which provides training, networking and evaluation to over 350 groups that meet criteria for affiliation; Ageing Well through Community Sport that aims to increase levels of participation by older people in physical activity and Actively Ageing Well which provides physical activity programmes and organisational development to support 60 community groups. The latter project ends in June 2007 and will be developed in future through the Ageing Well REACH project that will empower hard-to-reach groups of older people to become agents for positive health change in their communities.

The most important feature of the Ageing Well programme is the role of volunteer SHMs who are trained to be a 'valuable resource to their families, friends, communities and most importantly to each other' (Hawksworth and Robertson 2004). They are expected to act as 'positive role models', as 'normal everyday people'. They should provide support through 'empathy' and challenge 'the perception that health is linked to medical services' (Hawksworth and Robertson 2004).

2.2 DEFINITION OF AN AGEING WELL SENIOR HEALTH MENTOR

'Senior health mentoring, as conceived in the Ageing Well UK programme, is a loose term covering different facets of a relationship from listening to, encouraging and guiding. A mentor is an example – a partner in health: someone to trust and share with' (Hawksworth and Robertson, 2004).

This definition of Senior Health Mentoring is taken from *Developing Active Ageing Programmes Involving Older People,* a resource, edited by Hawksworth and Robertson. Volunteers are not expected to give medical advice, but to 'signpost' older people to appropriate professionals. Such mentoring can encourage self-development through empathic discussion, health advice and information (Coull *et al.* 2004).

The resource book goes on to describe Senior Health Mentoring in the following ways:

- Senior health mentoring involves older people themselves in health promotion activities, thus empowering them to make decisions.
- A SHM is someone who will help their peer group to move into or step up their campaign for healthy living.
- SHMs point people in the right direction, helping them find appropriate information and access services.

SHMs are expected to be trained in the core skills of:

- Health, health promotion and healthy ageing.
- What a SHM is and what a SHM isn't.
- The benefits of senior health mentoring.
- Communication skills.
- Working with groups and working one-to-one.
- Discrimination and acceptance.
- Ethnicity and health.
- Volunteering good practice.
- Introduction to some health issues affecting older people.

The ActivAge Unit provides Ageing Well projects with a Senior Health Mentor Core Training Pack and other resource material to enable projects to be developed.

2.3 DEFINITIONS OF AN 'OLDER PERSON'

Ageing Well aims to engage with people aged over 50 years as volunteers and beneficiaries or clients. However 'older people' are not a homogenous group with the same strengths and abilities. Chronological age is a relative term and is not a reliable indicator of age. The World Health Organisation (WHO 1997) and the NSF for England (DoH 2001) outline three categories of old age:

- 'Entering old age': People who live independently, but may have early indications of disease. People in the group are likely to be aged 50 – 70 years.
- 'Transitional phase': people who may be living independently, but who are losing mobility and some aspects of independence, with reduced involvement in physical or social activities. People in this group may be aged 65 – 80 years.
- 'Frail older people': people in their later years who may have 'limited function' and may have become dependent on others to meet some or all of their needs. They may have multiple diseases or impairments. People in this group are likely to be aged over 75 years.

2.4 ACTIVE AGEING

'Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age' (WHO 2003).

The term 'active' ageing was adopted in the late 1990s by WHO as an alternative to 'healthy ageing'. Policies and programmes based on the active ageing framework emphasise mental health, physical health and social connections. The active ageing approach is based on the principles of independence, participation, dignity, care and self-fulfilment. An active ageing approach may address the challenges of population and individual ageing. When public policies support active ageing there is the potential for

- Fewer disabilities associated with chronic disease in old age
- More people enjoying a positive quality of life as they grow older
- More people participating in society as they age
- Lower expenditure on, and less dependency, on care services and medical treatment (Hawksworth and Robertson, 2004).

The Age Concern England's ActivAge Unit thus anticipates that health promotion for older people based on an active ageing approach should produce the following benefits:

- Enhanced quality of life, improved confidence and self esteem
- Healthy lifestyles
- Increased opportunities to sustain independent living
- Participation in communities
- Greater understanding of the availability of health care services and other resources and
- Improved competence for older people to manage their own health and social care.

Studies of the 'Successful Aging' senior health education programme for older adults in the Netherlands found that the younger old-age groups were most attracted to the

programme, which is significant for the development of prevention strategies (Kocken and Voorham, 1998a). The group most interested in the programme were never married or widowed women with health problems. The programme challenged 'disengagement' theory that suggests that older people withdraw from social activities in later life. Instead there was a positive association between physical exercise and wellbeing, suggesting support for 'activity' theory which states that the needs for social engagement are the same for adults of all ages (Kocken and Voorham, 1998b).

2.5 AGEING AND HEALTH

It is estimated that by 2020 some 20% of the population of England and Wales will be over the age of 65. The life expectancy of men and women at the age of 65 has risen over recent decades to 82 years for men and 85 years for women (ONS 2006a). However healthy life expectancy has increased less – in 2002 a man aged 65 could expect to live 4.2 years in poor health and a woman 5.1 years (ONS 2006b). In 2003 60% of people aged 65 – 74 and 64% of people aged 75 and over were reported to have long-standing illness (ONS 2003). These figures however mask variations by region, social class and ethnic group, with people from socially disadvantaged areas, lower socio-economic groups and ethnic minorities experiencing shorter life expectancy and higher levels of long-standing illness and disability (Social Trends 2007). For example, the percentages of people in Wales with limiting long-standing illness and stating that their general health is 'not good' are 5-10% higher than those for England (National Public Health Service for Wales 2004). The proportion of people reporting long-standing illness or that their general health is 'not good' rises with age (National Public Health Service for Wales 2004).

Of people aged 65 – 74 years, only 18% of men and 14% of women take part in recommended levels of weekly physical activity needed for good health. For people aged over 75 years this falls to 8% and 4% (Department of Health 2005). About 10–15% of people aged 65 have depression (Department of Health 2001) and 40% of older people admitted to hospital are malnourished (Age Concern England 2006).

Physical exercise promotes mental and physical health, reduces the risk of stroke and heart disease and helps maintain healthy weight. Older people are less active than the general population and levels of activity reduce with age, although there is some evidence of a slight improvement in percentages of people aged over 75 years achieving physical activity targets of thirty minutes exercise at least five times a week (Department of Health 2005).

2.6 POLICY CONTEXT

Policy reforms in England and Wales promote active ageing and improvements in quality of life for socially disadvantaged groups to reduce health inequalities. Reforms such as the National Service Frameworks (NSF) for Older People (Department of Health 2001, Welsh Assembly Government 2006) anticipate increased access for older people to mainstream health promotion services, as well as to multi-sectoral approaches to promoting health and wellbeing, such as Ageing Well. *Living Well in Later Life,* a review of progress on the NSF (Audit Commission 2006), found evidence of ageism in all services ranging from patronising treatment to the failure of mainstream services to take account of the needs and aspirations of older people. The reports by Sir Derek Wanless highlighted the need to focus on prevention and the long-term determinants of health (Wanless 2003, Wanless 2004).

2.6.1 Policies in England

Standard 8 of the English NSF 'Promoting an active healthy life in older age' specifies that local health and social care strategic plans should include programmes to promote healthy ageing and to prevent disease. Targets for prevention and after-care in other NSFs for coronary heart disease, cancer, stroke, diabetes and mental health are also relevant to older people. *A New Ambition for Older* Age (Department of Health 2006) sets out the next stage of implementing the NSF for Older People. Key themes include the need to challenge negative attitudes to older people in the health system, the promotion of healthy ageing and improved co-ordination of early support for frail older people.

Choosing Health: Making healthy choices easier (Department of Health 2004) focuses on promoting health through local communities. It marks a shift in public health approaches from 'advice on high to support from next door'. The DoH has recently set up a Healthy Ageing Programme that aims to improve the health and wellbeing of older people. The Health Trainer programme, whilst not aimed at people over 50, offers opportunities for individuals to be trained to support others to make healthy lifestyle choices. The programme is due to be rolled out in 2007 and evidence from Ageing Well has the potential to inform the implementation of this programme.

Targets to tackle variations in life expectancy in socially disadvantaged areas were set out in *Tackling Health Inequalities: A Programme for Action* (Department of Health 2003). It requires that life expectancy should rise more quickly in the most disadvantaged areas by 2010. A key intervention is to make significant impact on the life expectancy of people aged over 50 years.

2.6.2 Policies in Wales

The Strategy for Older People in Wales (Welsh Assembly Government 2003a) sets out a health improvement agenda. Wales has a higher concentration of older people than the rest of the UK population, with just over 17% of the population aged over 64 years, compared to just under 16% of the UK. The Strategy recognises that with increasing numbers of people living a longer life, it is important that added years are accompanied by good health and improved quality of life. It also acknowledges the significant contribution that older people can make in their communities, rather than always being seen as dependent users of services. The Ageing Well initiative has the potential to embrace both these agendas.

The Healthy Ageing Action Plan for Wales (Welsh Assembly Government 2005) identified the need for specific health promotion initiatives for older people and is central to the 'Promoting health and wellbeing' standard in the Welsh NSF. The NSF sets national, evidence-based standards, and aims to improve health and social care services and equity of access for older people across Wales (Welsh Assembly Government 2006a).

2.7 VOLUNTEERING AND OLDER PEOPLE

In general, the participation of volunteers in health initiatives is increasing (Jones 2004). Volunteers add value to health or other care initiatives and in turn may benefit personally in terms of health gain. Five key advantages of older volunteers have been identified

- Maturity – older people are better able to understand the age related problems of others because of their life experience.

- Skills – older people have developed all kinds of work related or social skills.
- Availability – older people who are retired from paid work and have finished raising children may have more time and flexibility to participate.
- Loyalty – older people remain longer with their organization and spend more time than younger people.
- Numbers – older people are a growing proportion of the population (Community Service Volunteers, 2001).

Volunteering has been shown to improve an individual's sense of wellbeing and helps to develop social networks (Davis Smith 1998). Volunteering also helps develop skills and experience that can enhance employment opportunities.

The role of the coordinator has been found to be vital to the success of volunteering projects (Merrell 2000; Taggert et al. 2000). Feeling part of a team is an important reward for volunteers (Gaskin 2003) particularly a flexible and informal support system (Smith 2002). The provision of training contributes to raised levels of confidence and contributes to high retention rates. In addition it reinforces the view that the volunteer role is valuable to the organisation, clients and volunteers (Britton 1999).

2.8 THE LAY HEALTH PROMOTION MODEL

The origins of the Ageing Well peer mentoring approach are to be found in the Age Concern Age Well initiative, the Santa Monica Peer Health Counselling Scheme and a peer counselling model developed by the Beth Johnson Foundation (Nash, 1991; Ivers and Meade 1991; Freeman 1994).

The lay/ peer health promotion model has been growing in popularity in the UK and is one of the corner-stones of public health policy in England. C*hoosing Health: Making healthy choices easier* (Department of Health 2004) offers opportunities for people to access personalised support in order to improve their health through the health trainer model which is now being rolled out across England, particularly in areas of deprivation. People are recruited from local communities and are expected to be in touch with the realities of people's lives. They are seen as 'someone like me', and they work with individuals to support behavioural change.

A review of the evidence to support the health trainer model, carried out by Northumbria University Primary Care Development Centre (Visram and Drinkwater 2005), grouped the lay health model into three main categories. These were lay health advisors or natural helpers, peer educators and advocates. Lay health advisers were defined as community members who work in community settings and serve as connectors between health care consumers and providers in groups that traditionally lack a voice; peer educators involved education or counselling activities in which the educators have similar backgrounds to their clients; advocates refers to the activity of working with individuals to pursue and act on their behalf. The most common examples of the primary function of advocates found in the literature were to be bilingual and simply interpret language (Visram and Drinkwater 2005).

The evidence for this lay health support model tends to come from North America, where numerous interventions are undertaken across the United States and Canada. Research has shown that people are more likely to hear and respond to personalised messages, and thus change their attitudes and beliefs, if they believe the messenger is similar to them and faces the same concerns and pressures (Sloane and Zimmer 1993).

Social cognitive theory suggests that peers can influence others because people are more likely to imitate behaviour if a model appears to be a realistic figure for self comparison (Pervin 1989).

A study by Bishop, Earp, Eng and Lynch (2002) in a breast screening cancer programme in North Carolina, evaluated the approach of engaging African- American women aged 50 and over, as volunteers, to talk to other community women about breast cancer, support women through the process of getting mammography and to broaden community awareness and support for breast cancer. The findings suggest that developing interventions based on this model, built on a community's unique assets and deeply embedded social networks. It highlighted the need for professionals to include community members and participants in all aspects of planning of health promotion initiatives.

In the UK, the work of Tricia Greenhalgh *et al.* (2005) in East London gives some useful insights into its effectiveness with certain client groups. Diabetes support and education in minority ethnic groups was delivered through bilingual health advocates, who were members of the local community and employed by the primary care trust. The conclusions were that local people who understood the community were better able make sense of complex situations and to enable people to know how to act upon medical advice.

A randomised controlled trial of the Braveheart project, an Ageing Well initiative for older people with ischaemic heart disease, concluded that lay health mentoring had a positive impact on diet, physical activity and use of health services (Coull *et al,* 2004). The intervention involved patients joining a mentor-led group for monthly two-hour meetings over a one year period. Volunteer lay health mentors, aged 54-74, had thirty hours of training provided by the project coordinator and health professionals. The coordinator provided ongoing support for mentors. The study concluded that Braveheart provided 'a useful model to achieve measurable health gain' as well as additional benefits to secondary prevention and conventional rehabilitation (Coull *et al.,* 2004, p. 353). Other studies of peer mentoring with older people with cardiac disease and chronic arthritis suggest less significant success rates (Rose, 1992; Lorig *et al.,* 1993).

2.9 PREVIOUS EVALUATIONS OF AGEING WELL

An evaluation of four Ageing Well projects in Lothian (including The Braveheart Project) concluded that the model was viewed positively by most stakeholders including coordinators, mentors and clients. Ageing Well was considered to have 'enhanced the lives of its participants' and to be having a positive impact on health and wellbeing (MacGregor and Sheehy, 2004, p. iii). The Ageing Well model was thought to be an effective one that should be rolled out across Scotland. All participants in the study were complimentary about the enjoyable social interaction that took place between mentors and clients. The peer mentoring approach was a positive feature that appealed to both mentors and clients. But the evaluation concluded that it was unclear whether volunteers were 'using a peer mentoring approach in the strictest sense of the definition' (p. 46). Most mentors preferred to work with larger groups of older people, rather than developing close one to one relationship with clients. They preferred providing an 'enjoyable social environment for group activity' rather than developing close one to one relationships' (p.47). Key factors that enhanced the effectiveness of a project were the commitment and

enthusiasm of coordinators and mentors and support from statutory providers including the NHS and local authorities. Negative feedback included difficulties recruiting enough volunteers and issues around the training of mentors. A major obstacle to the success of the programme was the lack of secure funding for projects. It was also suggested by participants that the main focus of health initiatives was on younger adults rather than older people.

An unpublished draft evaluation of the Ageing Well pilot programme identified variation between stated aims of Ageing Well and outcomes in that volunteers tended to be in a lower age group than clients, the peer health mentoring approach was not consistently followed and volunteers were not trained by professionals as promised. Clients and volunteers reported positive outcomes from participation in Ageing Well, although numbers of volunteers and clients were lower than anticipated and some were already engaged in physical exercise or had already acted upon healthy eating messages. The evaluation identified the following issues

- Is the target age range too wide?
- Should exercise groups be led by volunteers and do they receive adequate and appropriate training?
- How can men be included in health promotion?
- Can people in their eighties and nineties benefit from exercise?
- Tensions arising from an initiative developed centrally that required delivery through autonomous local Age Concerns.

CHAPTER 3
RESEARCH DESIGN AND METHODS

3.1 AIM

The aim of the evaluation was to assess the impact of the Ageing Well programme on Ageing Well Coordinators, Senior Health Mentors and clients aged fifty years and over and to make recommendations for the future development of the programme. The aims and objectives and broad design were specified by the commissioners.

3.2 OBJECTIVES

3.2.1 Ageing Well Coordinators

1. To identify the skills and experiences of Coordinators, and how these impacted upon their practice in delivering the SHM training.
2. To identify Coordinators' views on any support or lack of support they received to deliver the SHM training pack.
3. To identify the views of Ageing Well Coordinators on the content of the SHM core training pack, including relevance, impact, comprehensiveness, ease of use and acceptability to SHMs .
4. To identify Coordinators' practice in delivering training using the training pack, including how sessions were delivered; whether some sessions were omitted; whether extra sessions were added; and whether external speakers were brought in to deliver some sessions.
5. To identify Coordinators' practice in supporting SHMs following the initial training.

3.2.2 Volunteer Senior Health Mentors

6. To identify the views of SHMs on the content of the SHM core training, including relevance, impact, comprehensiveness, ease of use and acceptability.
7. To identify the views of SHMs on the content and delivery of the training; whether some sessions are omitted; whether extra sessions were added; and whether external speakers are brought in to deliver some sessions.
8. To identify the skills and experiences of SHMs, and how these impacted upon their practice working as SHMs.
9. To identify SHMs' views on any follow up support from the Coordinators, following the initial training.
10. To assess whether they feel they have supported behavioural change in older people towards healthier lifestyles, giving examples where possible.

3.2.3 Clients

11. To identify the main health concerns of clients.
12. To identify which health topics offered were the most popular, and why.
13. To identify any health topics not currently offered, on which clients would like to receive information and advice.
14. To identify what links they have made with other opportunities in the community to improve their health.
15. To compare the impact of health information and advice delivered by SHMs to that delivered by external speakers.

3.2.4 All groups

16. To assess the impact of involvement in Ageing Well on the self reported health behaviours of coordinators, mentors and clients and their families.

3.3 SUMMARY OF RESEARCH

- Four focus groups with Ageing Well project coordinators (n=31). Two face to face interviews with project coordinators who were unable to attend focus groups (objectives 1-5, 16).
- Short postal questionnaire distributed to coordinators prior to the focus groups and interviews to collect baseline information (n=33) (objectives 1-5).
- Telephone interview survey of Senior Health Mentors (n=101) (objectives 6-10, 16).
- Face to face interviews with Clients (n=31) (objectives 11-16).
- Face to face interviews with Ageing Well managers (n=3).
- Review of documents including Ageing Well resources, project evaluations and reports, previous evaluation reports and relevant research articles.

The timetable was November 2006 - May 2007.

3.4 STUDY POPULATION

All project coordinators or managers identified in Ageing Well listings were sent written information about the evaluation. Criteria for inclusion in each phase of data collection included: projects using trained volunteers to undertake activities covering a range of topics such as exercise, healthy eating, falls prevention, arts and music; projects targeted on men's health; projects targeted to meet the needs of minority ethnic communities; projects working with clients in different settings including residential homes or supported housing; projects in rural and urban settings; projects in different regions of England and Wales.

Coordinators in participating projects distributed invitations and information packs on behalf of the research team to volunteers and clients. Six projects from across England and Wales were chosen for face to face interviews with clients, including projects in urban and rural areas, two projects targeted at ethnic minority groups, projects focused on different types of activities.

Coordinators, volunteers and clients from a total of 46 out of 88 projects took part (see Appendix 1). Seven coordinators declined to participate. Reasons for refusal included: retirement of coordinator or closure of the project, did not use volunteers or the project was new.

3.5 DATA COLLECTION

Data collection from the key groups of participants took place simultaneously so that preliminary analysis of each dataset could inform ongoing data collection.

3.5.1 Focus groups with coordinators

Semi-structured two hour focus groups were held in four locations in England and Wales with Ageing Well coordinators or local managers. The original plan had been to hold three focus groups following coordinators' network meetings, but a fourth focus group was arranged as six coordinators were unable to attend the Welsh network

meeting. Prior to the focus groups and interviews, a short questionnaire was distributed by email to coordinators. The purpose of the questionnaire was to identify baseline information including gender, age, skills, experience and practices to support volunteers.

The focus group interview schedule was informed by preliminary analysis of questionnaires. It was designed to explore relevance, impact, comprehensiveness acceptability and ease of use of the core SHM training pack; coordinators' experiences of administering the training programme including the support available to deliver the training and impact on their own or their families' health behaviours. The impact on health behaviours was assessed by questioning changes in personal and family behaviour in relation to levels of physical exercise, social networks and healthy eating.

3.5.2 Telephone interview survey of volunteer mentors

Semi-structured 30 minute telephone interviews were undertaken with 101 volunteers in 36 projects. The interview schedule was designed to identify baseline information including gender, age, ethnicity, household type and length of experience. Open ended questions covered volunteers' views on the delivery of training and the support provided by coordinators. Volunteers' attitudes on the relevance, impact, comprehensiveness, acceptability and ease of use of their training were collected using five-point Likert scales. A Likert scale contains a series of statements about an issue. A person's attitude is the extent to which he or she agrees with a statement.

The impact of their involvement in Ageing Well on their own and their families' health behaviours was assessed by questioning changes in personal or family behaviour in relation to, physical exercise, social networks, consumption of healthy foods and home safety. In relation to their own behaviours, volunteer mentors were invited to state whether such behaviours had improved, stayed the same or reduced using a five-point scale. The extent to which volunteers believed they had supported behavioural change in older people towards healthier lifestyles was also explored.

The initial aim had been to identify a random 10% sample of volunteers for interview from a list to be supplied by the commissioners of the study. However the list proved to be non-existent and the number of volunteers had been over-estimated. Thus an alternative strategy had to be devised. Coordinators who joined the focus groups, together with coordinators of all 'active' projects and 'regular' projects who used trained volunteers, were contacted and sent 300 information packs in two tranches for distribution to their mentors. In identifying projects with volunteers the distinction between 'active' and 'regular' projects became less clear. Coordinators were requested to distribute the packs so that the sample would be broadly representative of gender, age, ethnicity and type of activity. Consent forms were returned by 105 volunteers, representing a response rate of 29%. Four mentors withdrew for personal reasons when contacted by an interviewer.

3.5.3 Face to face interviews with clients

One hour semi-structured face-to-face interviews were held with five or six clients of six projects (n=31). The interview schedule was designed to identify clients' health topic preferences and reasons for their choices, identified gaps in the information they received and assessed the impact on their health behaviours of the information and advice from volunteers and/or external speakers. The impact of involvement in

Ageing Well on their health behaviours and those of their families and friends was assessed in the same way as for volunteers (see 3.5.2 above).

Six project coordinators distributed information packs to a sample of 8 clients each. Criteria for inclusion were that the sample would include men and women and be broadly representative of age, ethnic group and type of activity. Clients returned consent forms to the project coordinator who contacted the research team to arrange the interviews.

3.5.4 Face to face interviews with national Ageing Well managers

Two senior national Ageing Well managers and one Information and Communications Officer in England and Wales were interviewed. The interview schedule was broadly similar to the format of the project coordinator focus group interview schedule.

3.5.5 Review of documents

A review of relevant research and policy literature was undertaken. Ageing Well training materials and manuals together with evaluations submitted to the research team were reviewed to complement other data collected in the evaluation.

3.6 DATA MANAGEMENT AND ANALYSIS

Focus group interviews were tape-recorded and transcribed verbatim. Written records were made of interviews with volunteers and clients and tape-recordings made which were listened to in order to confirm the accuracy of notes. Qualitative data was coded, categorised and thematically analysed to identify themes and patterns in the data (Coffey and Atkinson 1996). Participants' responses to statements on the telephone interview schedule using Likert scales were collated and compared. Quantitative data was entered into SPSS and analysed to produce frequencies and cross-tabulations. Reports, evaluations and research papers were analysed to identify key themes.

3.7 ETHICAL CONSIDERATIONS

All participants were given written information about the research and they all gave written or oral consent. Focus group participants were reminded that they should not divulge any confidential information that was discussed. The identity of individuals has been anonymised. Ethical approval was given by the School of Health Science, Swansea University Research Ethics Committee. The commissioners' specification for the timing of the project did not allow for Local Research Ethics Committee approval to be sought and so interviews were not undertaken with people in their own homes or living in care settings.

3.8 VALIDITY

The authors collaborated during each phase of the research to share reflections during data collection and undertook the data analysis and the verification of coding and categorisation of the data in order to facilitate inter-rater reliability. Validity was also enhanced by documenting all the decisions made throughout the conduct of the study and therefore providing an audit trail. It proved impossible, given the timescales for the study, to randomise our samples of coordinators, mentors and clients and thus an element of bias may have occurred.

3.9 ADVISORY GROUP

An advisory group of 14 people including the commissioners, university academics and two Ageing Well volunteers was established. The advisory group guided the research process including approving data collection instruments and project sampling.

CHAPTER 4
RESULTS: COORDINATORS

This chapter reports the results of findings of the focus group interviews and questionnaire survey with coordinators or managers. Questionnaires were completed by 33 people, 31 of whom took part in a focus group (FG 1-4). Two coordinators who could not join a focus group because of the distances involved were interviewed on the telephone. The chapter also summarises the review of project reports and evaluations, and the interviews with national Ageing Well managers.

4.1 BACKGROUND

4.1.1. Demographic Characteristics and previous experience

The sample included thirty women and three men. The majority (84%, n=28) described their ethnic origin as British, Welsh or Irish and 15% (n=5) were from black and minority ethnic groups. The age range of coordinators was 24 – 71 years, with the majority aged between 40–59 years. Sixty three per cent were married or living with a partner (n=19), 23% were never married or widowed (n=7) and 13% were divorced (n=4). Fifty seven per cent lived two person households (n=17), 40% in households with more than two persons (n=12) and 3% in a single person household (N=1). Eleven declined to give their age and three did not give their marital status or household characteristics.

Occupations prior to becoming an Ageing Well coordinator included professional roles such as nursing, health promotion, counselling, teaching and community development (n=13); management in statutory local authority, health service and voluntary sectors (n=21); administration (n=5) and activity specialists such as fitness instructors, exercise to music instructors or walk coordinators (n=5). Some coordinators listed more than one previous role so figures add up to more than 33.

Previous experience thus varied across a wide range of work situations, including physical activity and exercise, mental health and older people, rehabilitation, nursing, teaching in universities, further education and schools, home economics, health promotion and community development, engineering and manufacturing. There was also managerial experience in accounts, human resources and training. The majority of the coordinators stressed that they were able to draw on their previous life experiences, both through paid work and particular interests and hobbies. Some spoke of having taken complete career changes. Coordinators liked the variety and flexibility that being involved in an Ageing Well project brought, the opportunity for 'hands-on' experience, as well as a sense of autonomy.

'The job of managing the [Ageing Well] service brings together all the things that I've done in my life before . . . it all came together very nicely' (FG4).

'It's being involved in physical activities, it's something that's been a big part of my life and of course its part of my job and I thought this is the perfect job basically . . .' (FG3).

A dominant theme that emerged was the opportunity it offered to work with people and make a significant difference to improving the lives of older people '*we can really*

turn people's lives around' (FG3). There was satisfaction in supporting people to make a contribution, to 'age well', and to challenge the negative impact of ageism. One co-ordinator expressed it like this

'Well, it's such a rewarding job because you are putting a smile on a lot of people's faces and you are making them feel that the feel good factor is great. You just can't express how good it makes you feel' (FG2).

4.1.2 Length of time as a coordinator and skills required for the role

More than half the sample (58%, n=19) had been in post for 2 - 4 years, with a further nine (27%) in post for more than five years, suggesting stability and continuity. A further five (15 %) had been in post for less than two years.

Some key areas were identified by coordinators as being useful in carrying out their role. Excellent written and verbal communication was essential. Effective report writing that captured the value of projects to clients and volunteers was also vital. Other skills included leadership, being able to see the bigger picture, adaptability, flexibility, creativity, training and presentational skills. The importance of knowing how to manage and support volunteers and staff was stressed, as well as being able to 'multi-task'. Good listening and motivational skills were emphasised. One coordinator mentioned the value of being able to identify skills of volunteers or clients that could be channelled into other areas that would interest them. Some coordinators spoke of the increasing need for skills in finance management, budgeting and bid writing, as these were now becoming a bigger part of the role.

For those coordinators working with ethnic minorities, an ability to speak the language and understand the culture was seen as a distinct advantage

'It's trying to get that message across to them, so I think because I've got that background, that culture, I understand the barriers that people from these groups face' (FG3).

Attributes included a sense of humour, patience and empathy, liking people and the ability to get on well with people at all levels. One co-ordinator summed this up as follows

'To have empathy, liking people is the main thing because I think that is the key characteristic. If you have that, which I think we all do, it is much easier then' (FG1).

4.1.3 Types of projects and activities

The sample of coordinators supported a broad range of projects, with 51% coordinating projects with a wide range of activities or client support and the remainder focusing on a single theme such as falls prevention and mobility or mental health. Three projects targeted ethnic minority communities. Four coordinators were based with, or worked closely with, Primary Care Trusts (PCTs). Broadly, the activities represented by the coordinators who took part in the focus groups were clustered around *exercise* (walking, exercise classes, keep fit, aerobics, chair exercise, Tai Chi, Pilates, Yoga, bowling, falls prevention, GP exercise referrals or line dancing); *educational* (computers, health talks, craft classes, reminiscence, history, healthy eating; *social activities* (holidays, day trips, lunch clubs, men's lunch club); *'other'* (counselling, health checks, crime prevention, aromatherapy, intergenerational).

Referrals came from local authority social services departments, GP practices, PCTs, Age Concerns and other voluntary sector providers, as well as people who self-referred or who were recruited by volunteers. The settings in which activities took place differed with some projects providing activities in centres to which clients came and others doing outreach work with people living in care homes or isolated individuals in their own homes. Most projects were targeted at the most disadvantaged communities in their localities.

Funding for projects was derived from a variety of sources including the Big Lottery, Age Concern England, Age Concern, the federation, NHS including PCTs in England and Local Health Boards in Wales, local authorities, Strategy for Older People (Wales) and Wanless monies. Some projects depended on funding from multiple sources. One project was a social enterprise company that worked in partnership with local voluntary organisations and statutory partners. A partnership board that managed the company included representatives of volunteers.

Some projects provided free activities, but others charged 'affordable amounts' for specific activities and several had introduced membership fees. 'Affordable' amounts ranged from £1 – to £5. The £5 charge included transport, a meal and a contribution to a 'sustainability' account. Charges were used to pay volunteers' and speakers' expenses, minibus, food, staffing and a contribution to the voluntary sector partner. Clients had been consulted over the introduction of membership fees and charges and clients preferred to pay a charge rather than see the programme close.

4.1.4 Factors that enhanced the delivery of Ageing Well

4.1.4 (i). It was suggested that policy had shifted attention to the older population and raised awareness amongst funders and partners in the statutory and voluntary sectors. Policy changes, such as the NSFs for Older People, had led to funding initiatives in some areas which enabled Ageing Well projects to develop.

4.1.4 (ii). The support from the ActivAge Unit including training materials, networking meetings and information leaflets were valued. Coordinators benefited from peer support including the exchange of ideas at meetings and in emails about activities and sources of funding. The drive and enthusiasm of volunteers were also strong themes that motivated coordinators in their roles, together with improved health and social outcomes for clients. Coordinators described projects *'where the ideas come from the people we are currently working with, as well as people you want to join' (FG2).*

4.1.4 (iii). Coordinators also derived job satisfaction from the opportunities Ageing Well offered to *'motivate, stimulate and activate'* older people and to *'make them feel they were active citizens and that they're still worthy members of their community'* (FG2). The coordinator role enabled people to find '*different ways of healthy living'.* A strong theme was being able to support people to develop their confidence to learn new skills, to undertake new activities after a bereavement, retirement or redundancy. Confidence gave people *'a new lease of life'.*

'You've seen doors opening to people. You see volunteers coming back and they come back to do something and then they slowly start to discover that they can actually, that they are good at this, or they are good at that, or they wouldn't even mind a go

at something and life simply opens up for them and it can open up for clients through the things they're doing. It's just been a delight' (FG1).

4.1.5 Challenges to the delivery of Ageing Well

4.1.5 (i). A key barrier to development and delivery of Ageing Well was also linked to funding. Funders often wanted to fund new work, rather than continuing a service. Many spoke of the problems of sustainability when they relied on year on year funding, an issue shared across much of the voluntary sector.

'You almost have to repackage yourself to make yourself new and exciting just to get the money when in fact what you are doing is worthwhile and useful and should be supported instead of keep funding new initiatives all the time, for a year here, a year there. It is frustrating that funders don't concentrate their efforts on what's there and what is working' (FG1).

However, another coordinator pointed out that devising a project that 'looked new' was an imaginative way to secure continuation funding.

'All you have to do is devise some sort of project that looks new but is actually the same, but you call it the something different so you get your funding' (FG4).

For some, there was an ethical issue about recruiting staff and volunteers when funding might end. Other coordinators spoke of the limitations imposed by funding bodies, which stifled development, and gave a temporary feel to the work.

4.1.5 (ii). Another barrier was establishing meaningful partnerships with the statutory sector, in particular some English primary care trusts (PCTs). The reconfiguration of the NHS had had an impact on relationships. It was important to understand the priorities of different organisations in order to secure funding, and to get the message of active ageing and prevention across to commissioners of services.

'It is about keeping the profile up [locally] *and getting the message across that Ageing Well is here to stay, and is very much a part of preventive work in order to keep people out of nursing homes, which is government strategy'* (FG4) .

Some coordinators expressed the view that the statutory sector did not always value the work of the voluntary sector and it was hard to prove to some PCTs, how Ageing Well supported the prevention and public health agenda. This included a lack of recognition or acceptance of volunteers working in the area of health improvement.

4.1.5 (iii). Difficulty recruiting volunteers was mentioned by some coordinators, although this appeared to depend on the role to which volunteers were being recruited. One co-ordinator described it this way

'I think one of the obstacles that we have, we have no problem at all recruiting volunteers and the activities are fun and they get lots of benefits and you know that's not a problem. The problem that we have then is really getting people to become SHMs who can actually lead activities and perhaps one of the main barriers there is that they feel that they have probably reached a time in their life when they

don't want the responsibility of that, it may be that they are lacking in confidence' (FG2).

In order to retain volunteers' initial interest some coordinators stated that they tailored training to meet volunteers' individual needs (as walk leaders or exercise leaders). Some projects provided individual or small group training so as to retain volunteers who may lose interest if there were delays in starting their training. Once volunteers were trained, one coordinator described how appraisals for volunteers were held alongside appraisals for staff as another means to retain volunteers' interest.

4.1.5 (iv). Criminal Records Bureau (CRB) checks were cited as a barrier to delivery of projects particularly with respect to retaining or recruiting volunteers. Some coordinators commented that the introduction of CRB checks had been handled insensitively by some local Age Concern groups. In other cases, long standing volunteers found it hard to understand why now, after many years of work, they were required to have their criminal record checked. Other problems included length of time to have them processed and costs. Some projects did not carry out checks, and there was a discussion about whether it was important for delivering high quality services. Others carried out checks and references before interview.

4.1.5 (v). The name 'Age Concern' was also identified by some coordinators as a barrier as it was considered that it implied late age and did not give a positive image to the young old.

'I think a lot of the younger ones view Age Concern as an organisation that works with very, very frail older people that are house bound and they don't actually see, when we actually go out and do sessions, where we're trying to recruit people into the project or as health mentors in supermarkets and places like that. We get people who come up, who are obviously in the sixties, sixty, sixty-five and they'll say "oh yes I'll take that for me mother, she's house bound", because of the name Age Concern' (FG3).

4.1.5 (vi). Coordinators spoke of the need to challenge *'ageist attitudes and stereotypes'* and to give people the confidence that they could continue to play an active role. Sometimes those attitudes were held by older people and their families. A coordinator described the outcome of a reminiscence theatre event where a family '*saw their mum in a different light'* as she took to the stage for the first time. Other volunteers were encouraged to recognise that their experiences were *'probably worth more'* to another older person that detailed knowledge of a particular illness.

4.1.6 Coordinators' views on the Senior Health Mentor model

There was much discussion about the title and role of Senior Health Mentors. The majority of projects did not use the term and 'volunteer' was most commonly used

'Our project is just volunteers. It doesn't mention senior health mentoring' (FG4).

Other terms used to describe the role were club organisers, community volunteers, health mentors, volunteer tutors, centre volunteers and escorts. In focus groups and interviews with coordinators and mentors the terms 'mentor' and 'volunteer' were used interchangeably. In some projects a distinction was made between 'volunteers' with limited training and a role that mainly involved making refreshments or putting

out the chairs for exercise groups. In one project a distinction was made between volunteers who accompanied people to activities and those who delivered them, both sets of volunteers were trained mentors and provided health information to clients. In other projects s 'volunteers' were both trained and did undertake in depth mentoring roles including leading activities. There was some concern that the full title may be off putting for volunteers, but at the same time the fuller version offered 'credibility':

'You know the role of mentor is actually for some people a role that has got a wider connotations, a deeper meaning, responsibility, and I think that can make a volunteer feel "whoa, whoa, what am I getting into" maybe, which is a shame in a way because I think the title actually gives you credibility' (FG4).

Since the original Ageing Well pilots in the early 1990s the range of projects and the role of mentors had broadened:

'We were actually in the original pilot and in the original pilot it was much more adhering to what a senior health mentor was . . . it was a much narrower focus. One thing that struck me attending all the network meetings is the diversity and interpretation of what comes under the Ageing Well umbrella' (FG4).

Coordinators discussed the concept of 'peer' mentoring with clients. Experience of being older was seen as important to the role, because of sharing similar life experiences '*they are more relaxed and identify with somebody of similar age'.* There was a sense that because people were of a similar age, this enabled a relationship to develop more easily:

'We've had requests. I think there is definitely mileage in understanding that people sometimes would like to have an initial encounter with someone of their own age' (FG3).

'I think that there's something about the mentor role though that somehow all the people want to be inspired by somebody and I think very often I think mentors can inspire people . . . "you can do it and you're a similar age to me or that bit older, then I can do it"' (FG3).

However, the coordinators acknowledged that although age was a starting point, it was not the only characteristic required of a mentor: personality traits, gender, geographical location, being part of the local community, 'someone like me' and 'using your own experience' were all important.

Speaking the same language and being from the same community facilitated recruitment of volunteers and also enabled Asian elders to take part in activities that otherwise may not have been possible:

'I think that fact that I can speak the language as well that's really sort of helped and its really helped with recruiting people from those Asian elders' groups as well' (FG3).

'I think knowing that culture and the fact that I mean senior health mentor, its about explaining that to people and I think people just see the title senior health mentor and think its you know " we've got to have, we've got to be educated and need so

much experience" and so on and its trying to get that message across to them, so I think because I've got that background that culture I understand and the barriers that people from these groups face (FG3).

Working with volunteers enabled coordinators to derive job satisfaction from seeing volunteers' confidence grow and they also valued the support they received in turn from volunteers. Activities initiated by volunteers and clients were particularly welcomed: *'you listen and you go'.* Involving volunteers in team planning meetings was also *'one of the biggest motivators'* to sustain involvement in projects. Volunteering had enabled several people who had been made redundant to develop new skills and re-enter the workforce. It offered opportunities for incomers to a community to make friends. One project offered newly trained volunteers a menu of roles to choose from in order to increase their participation. In the case of one volunteer, he had moved from driver, to walk leader, to joining a men's health club and then into paid employment.

4.2 TRAINING

4.2.1 Content and practicability the Senior Health Mentor Core Training Pack

The Senior Health Mentor Core Training Pack issued to projects by the ActivAge Unit consists of eight core sessions of 75 minutes each. It is suggested that sessions may be taught over four half days, two full days or one session per week over eight weeks. Supplementary sessions on project related or specific health topics may be added to the training programme as appropriate.

The majority of coordinators (n=29) stated they were familiar with the 'core training pack', and four said they were not. Of the group who were familiar with the pack, two new coordinators had not used it, and one did not train volunteers. The majority of coordinators who were familiar with the pack agreed or strongly agreed that the 'core training pack' was comprehensive, relevant to their needs and easy to understand (see Table 4.2.1 below). No one strongly disagreed with these statements.

Table 4.2.1 ActivAge Unit Senior Health Mentor Core Training Pack

The training pack was:	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Strongly Disagree	
	N	%	N	%	N	%	N	%	N	%
Comprehensive	11	42	13	50	1	4	1	4	0	0
Relevant to my needs	7	27	15	58	4	16	0	0	0	0
Easy to understand	11	42	13	50	4	8	0	0	0	0

Some coordinators used the pack in its entirety and some stated they did not use the pack at all. All coordinators supplemented the pack with other material to meet local project training requirements.

'*I think what is useful is that overall it gives you a solid run through of information. I would not put one piece of it, in that sense, above the other. I would say it gives you a really good base to work from'* (FG1).

'I don't use the pack at all, although it is very similar to our induction pack at Age Concern' (FG4).

The most common model was to use parts, or elements, of the pack to supplement local training to meet the needs of volunteers' roles. Two main sets of reasons were given for using the training pack selectively. Some projects supplemented Age Concern training to meet volunteers' needs in specific projects and localities. Some coordinators selected items, such as communication or working with small groups, to locally delivered training for volunteers such as IT tutors, for example.

'If your volunteer is just an IT volunteer and just goes and does IT training. They don't want to sit through a lot of that, so you can take out what's useful and use. Actually we were one of the pilot schemes with that particular training and we were told you could actually use, pick out what you needed and use it as you needed' (FG3).

One coordinator explained that she did not use the training pack because either volunteers preferred training to meet local needs or did not wish to be 'senior health mentors'.

'I don't use it [training pack] because most local volunteers either like something fresh from us and they're taking the register, collecting the money kind of thing. We did ask, when I first started new into the job, we did have a meeting to see who would be a senior health mentor and no one wanted to it. They all like doing they're own little bits for each of their classes so we do register, might get the mats out stuff like that' (FG4).

Coordinators working with minority ethnic communities questioned the suitability of the pack in terms of both language and relevance for different cultures

'I've said this over an over again probably, but I work in particular area where there's a multitude of languages and there's nothing, as far as that's concerned. What I have to do is get someone who speaks the language to actually interpret while I . . . one of the reason I don't use it because the majority of my groups are either Muslims or Jews or whatever and they wouldn't identify with some of it'(FG4).

Tailoring training to meet volunteers' individual needs (as walk leaders or exercise leaders) was also seen as a means to retain volunteers' enthusiasm and interest. It was felt important to tailor training for volunteers as it was felt unnecessary to train them as 'health mentors' when what they intended to do was lead walks. Training in other skills, such as healthy eating information, could be offered at a later stage, if requested. Some projects provided individual or small group training so as to retain volunteers who may lose interest if there were delays in starting their training. Once volunteers were trained, one coordinator described how appraisals for volunteers were held alongside appraisals for staff in order to sustain their interest.

Some projects that were placed within local Age Concerns had volunteer coordinators who recruited, trained and inducted all the volunteers. Ageing Well projects then supplemented the core Age Concern training with the specific needs of individual projects. Examples of supplementary training delivered by the 'Age Concern' projects, as well as other projects, included walk leader training, 'Heart Start' scheme from the

British Heart Foundation, health promotion specialists carrying out healthy eating and obesity sessions, Keep Well, Keep Warm, and the 'Active in Age' accredited gentle exercise programme from the Beth Johnson Foundation. First aid training and fire safety were also mentioned.

Some coordinators felt the pack was too long, and they 'pared it down'. Others thought that the tone was a little patronising at times. One coordinator reported that a project had lost volunteers with professional backgrounds in health, because the SHM training was not *'high level enough'.*

Another barrier to delivery of training was how to best use resources when there were only a couple of volunteers recruited, but they did not want to lose them whilst they waited for a training programme.

There were a few suggestions for modifications. One co-ordinator thought there was a gap about 'multi-culturalism', and how to understand other's faiths. There was a sense that some coordinators thought it was primarily aimed at white, older volunteers, and that it was less useful for training people from black and minority ethnic communities. Translation was one of the issues raised.

Another gap was training around adult protection that some felt was becoming an increasingly important area. Other suggestions for improvement included more on listening skills, protocols around lone working, an evaluation/ monitoring toolkit, marketing skills and topics on emotional well-being and dental care.

4.2.2 Delivery of training to mentors

Coordinators were asked to comment upon the training delivered to volunteer mentors in their projects. Coordinators mostly strongly agreed or agreed with the statements included in Table 4.2.2 (below) about the comprehensiveness, relevance, level of training and whether mentors were prepared for their roles. In each category between 24% and 40% were neutral. No one strongly disagreed with these statements.

Table 4.2.2 Training Delivered to Mentors

The training was:	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree	
	N	%	N	%	N	%	N	%	N	%
Comprehensive	4	16	14	56	6	24	1	4	0	0
Relevant to SHM needs	5	20	12	48	8	32	0	0	0	0
Was at the right level	4	16	12	48	9	36	0	0	0	0
SHMs learnt a lot from the training	5	20	10	40	10	40	0	0	0	0
SHMs were prepared for their role as mentor	5	20	11	44	9	36	0	0	0	0
SHMs were skilled for their roles	4	16	13	52	8	32	0	0	0	0
SHMs were confident for their roles	1	16	11	44	10	40	0	0	0	0

The majority of the Ageing Well coordinators delivered part or most of the training and brought in local people to supplement training, depending on the needs of the project. There was a view that one pack was not going to be suitable for all the projects because of the need to be aware of the local context in which projects are being delivered.

'I think they [SHMs] get a greater understanding of the local needs of the area, rather than the sort of national training' (FG4).

In one area, projects in proximity to each other shared elements of the training between them depending on expertise. For example, coordinators including a nurse, counsellor and nutritionist, trained each others' volunteers. Other projects bought in local experts. Very few coordinators had sought support to deliver the training from the Senior Health Mentor Core Training Pack. There was a difference here between long-standing projects that had been introduced to the pack when it was first developed ten years ago, to those more recent projects that were new to Ageing Well. Some felt that the more they delivered the training, the more confident they became as they learnt from their practice. A few spoke of gaining support from peers in other Ageing Well projects, and that now they were able to support and advise newer projects on the training

'*We first started the Ageing Well in [..] and got a lot of support from other Age Concerns who were already doing it. We went through the book, "Oh they do it, they do it. Can we come and see you", and I found now people are phoning me. I got a phone call last week, and I found that most Age Concern coordinators do like talking about what they do and how they've done it'* (FG3).

The length of time for delivering the training of volunteers varied depending on local requirements, number of volunteers and types of projects.

4.3 SUPPORT AND SUPERVISION

This section looks at three aspects of support and supervision: support from Ageing Well network for project coordinators, support provided by coordinators to mentors, and coordinators' views on the support mentors provided for each other.

4.3.1 Support from the Ageing Well network

Coordinators stated that they valued the Ageing Well network meetings organised by the ActivAge Unit or Ageing Well in Wales because they gave them an opportunity to meet with others and to share ideas

'I think its an opportunity to hear what others are doing because sometimes you can get stagnant in what you're doing and you think, where can I sort of develop? And you may have an idea about something, but you're not 100 per cent sure and next time somebody says "I'm doing so and so" and you think well that's the sort of pilot I'm thinking of doing' (FG4).

'It's been nice to meet other people on the same level, I don't feel on my own. I was quite confused before today but I can see that we all seem to be working towards the same goals' (FG2).

Outside the meetings, some informal networking continued, through email and phone calls. Some coordinators also belonged to other local networks where they gained support.

Practical support was also received from the ActivAge Unit when, for example, coordinators needed statistics for funding bids. '*I've used them [ActivAge Unit] as well and found them very helpful'* (FG1). Staff at the unit were seen as a useful resource, as well as being able to demonstrate at local level that they were part of a national network. It was suggested that support from the unit could be tailored to the needs of Ageing Well managers, with responsibility for several projects, whose needs may be different from coordinators of projects.

4.3.2 Support from coordinators for mentors

The coordinators carried out a range of formal and informal support, and demonstrated good practice in the management of volunteers. They clearly saw it as an important part of their role. Activities included: one to one sessions held between six weeks and three months when the volunteers had the opportunity to discuss their work, any problems they had and any changes they wished to make; group meetings of volunteers on specific projects when there was an opportunity to input into the development and planning of the project, regular newsletters and informal contact on the telephone.

'I think it's about making space, saying to people that "'if you've got any problems or want to talk about it, I'm always here". I think that helps, you know, knowing that they can come in and I'm not too busy to see you or talk to you' (FG3).

'We have an open door policy pretty well on the office and on the phone line and they all have my mobile phone number' (FG4).

The locations where contact took place varied. Some volunteers made regular calls to '*the office'*.

'Our volunteers are very much just part of our gang. They come in the office. We work as a team and they always know what's going on because we all work together and plan sessions together, and they decide who's coming to which or we phone them and say " do you want to do this in such and such a place?" and one of us go there as well so I think we are far more informal' (FG2).

Coordinators also gave examples of making regular visits to projects and activities in the community to support the volunteers, as well as ad hoc visits when requested to do so by them with varying degrees of frequency.

'I don't call my sessions supervision sessions, I just ring them and say I'm popping out to see them, they love it, they do value it so much, they get very excited' (FG4).

'I get to see her [SHM] a little bit, [when] she feels like some support and then you can leave her to it and I'll go back now and again and see if she's ok. I won't lead the volunteers, I mean they've gradually taken over leading our walking group independently. But now and again we'll go down or if its special, if its like the first time or second time of leading a walk, we'll go and support them and just show up now and again so that they know' (FG3).

On occasions, visits were made to projects where it was suspected that mentors may want a change of role.
'We do have the opportunity for supervision and identify where somebody might need to change role if they're not comfortable with what they're doing anymore, or if they want to, they change or something, so you know of any issues' (FG4).

All the projects held at least one annual event to celebrate the work of their volunteers when social events were held and recognition of their role was acknowledged. It was said that volunteers enjoyed these celebrations because it was an opportunity for them to meet other volunteers across other projects in Age Concern, as generally these events were across the whole organisation. This view was common to most of the projects

'I think as well we enjoy this part in that at least once a year we have a lunch which was good fun and also had the opportunity for some of the volunteers to share with others, with the group as a whole about the role that they had in their organisations' (FG4).

4.3.3 Support provided by mentors to their peers

There were some examples where coordinators encouraged 'buddying' opportunities where volunteers supported each other. Support from other volunteers also came at group sessions, training and the celebration events. One project always placed a new volunteer with an experienced one.

'We have the same sort of group meeting as well, but because they're working in residential homes, we have one experienced one and then the new one come along we actually always buddy so that they can do some of the coaching, and we actually then take some of the pressure off individual training and that has worked extremely successfully' (FG4).

Another coordinator described supervision sessions twice a year together with regular meetings and a telephone chain for passing messages onwards from one volunteer to the next.

'Six monthly one to one supervision and bi-monthly meeting and a phone chain which they consent to passing on to the next person on the chain and if you can't get them go onto the next one' (FG4).

Examples were also given of the social network that develops between mentors that supported them both practically with project activity arrangements and emotionally at times when they experienced personal problems.

'I think peer mentors do support one another and sometimes they do your job for you but they'll have their own little network within the organisation' (FG3).

'They build up friendships and they help to encourage people to join and do things' (FG2).

4.4 IMPACT ON HEALTH AND WELLBEING

4.4.1 Impact on coordinators

There was variation in the impact that running an Ageing Well project had on the health and wellbeing of coordinators and it would be hard to say that it had changed their health behaviours. Some had been attracted to the work in the first place because they were already interested in their health and fitness

'*I have always been a health freak. I have always been active'* (FG4).

Some coordinators suggested that dealing with information about healthy ageing motivated them to sustain exercise or diet regimes, but for others, although they were more aware of the issues of keeping healthy and active into old age, it did not necessarily change their behaviour.

'Well, I have to say no, it has made me worry about it but I actually haven't been motivated to get up and do enough exercise and I know that I'm way, way under' (FG4).

Some coordinators actually felt it had had a detrimental effect on their health because the job was busy and stressful at times.

'Its gone downhill because I have never been so busy I am working sixty to seventy hours a week and I haven't got time for me to do things, so I would say it has impacted in that I am more that aware of what we should be doing but I am my worst enemy I will go and skip lunch because I am so busy I forget to have it and I'm not having time to do regular exercise' (FG2).

However, there were a few examples of dramatic impact

'I've lost four stone since Christmas. So the actual healthy eating and the physical exercise that we've promoting with old people, really has made such an impact in my life for this last 12 months' (FG3).

Others suggested that, although perhaps attention to their physical health was not as good as this example, there was a strong sense of wellbeing, because the job was felt to be so worthwhile.

'We do so much healthy eating work, sometimes you long for a pork pie' (FG4).

4.4.2 Impact on coordinators' family and friends

In a similar way to the impact on their own health, coordinators found it difficult to know whether it was the effect of working with Ageing Well that influenced their family and friends or whether people were more generally aware of health messages.

'It is hard to say whether it is Ageing Well or other background things really' (FG4).

However, a few coordinators gave examples of where they have made an impact on their family's health

'It has made them [adult children] more aware that they do need to eat healthily. They do need to exercise regularly and think about their long term health' (FG2).

'I've been able to give my mother more advice on things that I've learnt. She's 91' (FG2).

'Definitely, I'm much more particular about what food I serve to the family' (FG4).

One coordinator described how after observing the benefits to his mother of taking part in an Extend exercise to music class at her nursing home he had introduced it into his project and now *'480 people a week'* took part in Extend groups.

4.4.3. Impact of Ageing Well

Coordinators were asked to discuss the impact of Ageing Well on older people and communities generally. Some projects had been in place for more than ten years and coordinators suggested that *t*he programme had '*really encouraged people to keep healthy longer'.* A strong theme was the diversity of types of projects.

'I think the impact and its diversity is to be celebrated and recognised. One of the beauties is actually sharing things and sparking ideas off' (FG4).

Coordinators identified the impact on clients, in particular, the social benefits of involvement in exercise and other activities.

'They're doing an exercise class, they feel it's meeting their friends. The benefits are absolutely amazing. I don't get negative comments in evaluations' (FG4).

'People are depressed. They're isolated, they're lonely. They've got no shop, no way of getting out . . . they don't want to move . . . all these things add to the feelings of depression and isolation and if you can take those people out of their homes and bring them to the centre so they can meet their friends. How can you measure that? What would these people be like if you left them in their homes day in day out? You would be adding to an already over-burdened health authority' (FG2).

In relation to a project working with Asian elders

'We make a different in their lives. That's why it's not bad that there's so much variety so many different things we can do, which is amazing we can do this job' (FG3).

Qualitative evidence about the impact of Ageing Well on physical and emotional health was generally welcomed as a means to illustrate the impact of Ageing Well projects. Health benefit over time was seen as notoriously difficult to measure and to quantify and yet it was information that funders required. Some coordinators suggested that an Ageing Well toolkit, tailored to capture quantitative and qualitative information, would be useful. Evaluation frameworks need to be designed to capture health gain as well as improvements in social wellbeing. National datasets of information could be used to support funding applications.

4.5 THE FUTURE OF AGEING WELL

Coordinators suggested in ten years time they would like to see their projects extended and '*mainstreamed'* to other localities and to be seen as *'the lead service'* for preventative health information and support for older people with more emphasis on the 'younger older person' aged 50 plus. It was felt that the programme could continue to develop its role within public health as well as the primary and secondary health care sectors. Coordinators valued the flexibility to meet local needs and to be 'creative'. Some statutory agencies needed a raised awareness of the benefits of community health developments such as Ageing Well. Core funding was preferred to the constant round of short term funding applications and arrangements.

4.6 PROJECT REPORTS AND EVALUATIONS

The breadth, depth and methodologies of the sample of project evaluations and reports examined varied considerably. Project reports submitted quarterly or annually to the ActivAge Unit in England and Ageing Well in Wales or other funders provided basic statistical information. Routine data monitoring of older people joining in project activities is undertaken through a registration form. This form records demographic data (age, gender, ethnicity and postcode), activity attended, self-reported perceptions of health status and brief medical history. More in depth evaluations supplemented these core data with client satisfaction surveys. These usually included surveys or interviews with clients and volunteers. The views of external stakeholders including partners in local authorities or NHS Trusts were included in some reports. The breadth of content varied according to the needs of project funders. Some projects had commissioned university departments to undertake evaluations and others were compiled in-house with partners such as Age Concern, NHS trusts or local health initiatives.

The reports largely depicted success stories (although not always supported by health impact data) with projects targeting specific client groups in disadvantaged areas leading to increased levels of exercise and participation in leisure activities. One report highlighted the positive impact and 'community pride' that was generated by a reminiscence project that brought together older Asian and white people from one northern town to convert their memories into an art work. Older people talking in four languages developed confidence and 'broadened their horizons' as they shared their experiences together. A project targeted at minority ethnic elders had exceeded the representation of these groups in its physical exercise activities, as a proportion of minority ethnic clients in the local population. An evaluation of a cluster of projects in the north west of England showed that the cost effectiveness of initiatives that target people aged over 50 years, was enhanced through a trained volunteer workforce; a personalized approach to health promotion; innovative, speedy responses to community needs; and collaboration between neighborhood initiatives and a trusted n organizational profile of services for older people.

One project was in the process of integrating the Ageing Well philosophy of active ageing across the whole of Age Concern in their district. Another evaluation successfully utilized a framework derived from the English NSF for Older People in order to measure the performance of its project. Most projects experienced difficulties recruiting the 'young old' i.e. people in their fifties.

Issues and problems identified in the reports included the following methodological problems: the absence of a national toolkit to appraise projects; dual registrations

where clients take part in more than one activity; incomplete data; different approaches and timescales thus making comparisons difficult; the lack of objectives and performance measures when the project was initiated; absence of data about training of Senior Health Mentors; the difficulty of measuring health gain in a short period of time with a 'floating' population of clients attending exercise classes or other activities; and lack of qualitative data that explored the experiences of older people.

4.7 INTERVIEWS WITH NATIONAL AGE CONCERN AGEING WELL MANAGERS

Interviews were held with two national Ageing Well managers and one Information and Communications Officer (AWM 1-3) in England and Wales. Although the roles of managers and the communications officer varied they are referred to as 'Ageing Well Managers' so as to protect the confidentiality of the communications officer.

4.7.1 Role of Ageing Well managers at national level

Key aspects of the role of managers at a national level was to be a resource and to disseminate information to projects about polices and strategic developments in government departments and other national agencies and to coordinate the development of projects. The role involved encouraging projects to work in partnership with other agencies and to develop their projects in line with national initiatives. Practical support also included assistance with funding applications.

4.7.2 Ageing Well peer health mentoring model

When asked to define the Ageing Well approach it was seen primarily as a health promotion programme that was about enhancing emotional, social and psychological wellbeing as well as helping people to stay healthy and fit. Lifelong learning opportunities developed in conjunction with other local agencies were also integral to the model. What was distinctive about volunteering in Ageing Well was that people could support and empower others by leading an activity that they enjoyed doing

'I think that's probably the key to retaining people, a lot of the time and keeping people motivated' (AWM 1).

'Older people being able to give something back to the community. They're not just taking but giving as well' (AWM3).

There was a tension however in achieving these objectives and recruiting people to be 'senior health mentors' as this label may imply a *'clinical sort of way'* of volunteering, whereas an Ageing Well volunteer was *'a sort of encourager or motivator' 'quite like a friend'* or a *'volunteer instructor'.*

'People would prefer to be called a volunteer and just help on a project that's fun' (AWM1).

'I don't personally like the term senior health mentor . . . I know older people can get a bit scared about the title, that they think they won't be able to do it. I would argue for projects to use their own term, something that was acceptable to the older people they're work within. I think anything to attract older volunteers really' (AWM 3).

The benefits of Ageing Well were seen to be in the peer-led approach and age was the most significant factor followed by being *'the same type of person'.*

'I think all the way through life, if you see someone you know, one of your peers or someone you can relate to either your age or same type of person as you, you would maybe aspire to what they're maybe doing. If you've got one person, saying "swimming's great" and they say "well I don't like swimming much, so I'll go with you then", that's probably breaking down half the barriers if you've got that peer support' (AWM 1).

'They've told us the peer effect is very effective because the older person sitting next to them motivates them . . . the ideal model is for people to be trained from the same background and community'' (AWM 3).

'When they come from the same background they actually communicate with people of their own age. I think they would listen to them a little bit more. It's also to do with experience and knowledge and knowing that they went through the same thing' (AWM2).

An important feature was to have *'a grass roots approach'* to bring together similar people in local communities and offer choices to meet differing expectations of older people.

4.7.3 Factors that facilitated the delivery of Ageing Well

Support from policy makers and *'top down blessing'* from the Department of Health, Welsh Assembly Government and organisations such as the National Institute for Adult Continuing Education in Wales and the Sports Council for Wales were significant. Strategic policies and funding opportunities from national statutory and voluntary bodies could be forwarded to local projects. National initiatives such as free swimming and free local public transport were valuable to support the development of local projects. The support and enthusiasm of coordinators, volunteers and clients and of each other was also significant.

4.7.4 Challenges to delivering Ageing Well

The themes identified by Ageing Well national managers were similar to those identified by coordinators and volunteers and included short term funding that resulted in projects coming to an abrupt end when funding ran out. It was necessary for projects to align themselves with other local health and social care strategies to improve sustainability. Funding pressures on the statutory sector impacted on voluntary sector initiatives.

4.7.5 Training

The national managers were aware of different approaches adopted by local projects to the 'core training pack'. Some projects used the pack comprehensively so that all volunteers gave consistent health messages. It was acceptable to use the pack flexibly to meet the needs of local projects and volunteers and to strengthen the training material to suit local needs. Time was a factor and it may not always be possible for volunteers to be trained initially using the pack in its entirety. Nevertheless it was considered important to '*get the core things across'* (AWM 1). *'Core things'* included nutrition and physical activity, basic health promotion messages, age discrimination

and confidentiality to enable volunteers to be *'confident and comfortable'* in their roles.

In addition to this it was acknowledged, by one manager, that facing someone who wanted to volunteer as an activity leader with the whole of the core training material or the label 'senior health mentor' could deter them as this extract illustrates

'If someone comes in and says "I want to help with the gardening" . . . and they [project coordinator] *say "well technically you're supposed to be a senior health mentor if you're being part of this project, so you've got to go through the whole process". I know it would worry me if that whole process put them off'* (AWM 1).

4.7.6 Support and supervision

The key support role of the national managers was defined as providing *'aspirational leadership'* at national and international levels. It was reported that national managers supported each other in developing Ageing Well. In turn national managers organised quarterly network meetings, distributed quarterly newsletters and leaflets, emailed updates regularly to project coordinators, arranged conferences and disseminated information via websites. Agendas for national network meetings were set centrally with additional contributions from coordinators. The ActivAge Unit supplied the core training material and a development pack for new projects. New projects were promoted and new coordinators supported through personal support and 'buddying' support from other coordinators. Coordinators were encouraged to support each other in developing new ideas and shared training if possible and the support that coordinators gave to volunteers was seen as crucial to the success of projects.

Evaluations and reports were a valuable resource when promoting the programme and applying for funding for new projects. The managers acknowledged that because of pressures of time and workload, project reports submitted centrally were not always complete and projects were not given feedback. But collecting evidence of the outcomes of projects was important for the programme's future success.

4.7.7 Future of Ageing Well

It was considered important to see the programme developing flexibly to meet the needs of local communities and of volunteers and clients – *'it's hard to formulate the structures and definitions of a national programme'* (AWM1). Closer links should be forged with stakeholders in local authorities and primary health to give older people more access and opportunities to reduce discrimination and social isolation and to realise the importance of healthy eating and exercise on mental health.

CHAPTER 5
RESULTS: VOLUNTEERS

5.1 BACKGROUND

Volunteers from 36 projects took part in a telephone interview. The sample included 79 (78%) women and 22 men (22%). As the total of volunteers is 101, numbers and not percentages will be used in this chapter, unless the number of responses in any section is less than 101.

5.1.1 Demographic characteristics and previous experience

Eighty five volunteers described their ethnic origin as British, English or Welsh. Fifteen were from black and minority ethnic groups, of which, 10 were Asian (Indian, Pakistani and Bangladeshi) and 5 were black (Caribbean, African and South American). Ages ranged from 25 to 85 years, with the age range of volunteers from minority ethnic groups tending to be lower than their white counterparts (25 – 73 years). Three volunteers refused to give their age. Although Ageing Well is designed to attract people over 50 years only 12 of our sample were in their fifties, compared to 73 in their sixties and seventies (see Table 5.1.1 below).

Table 5.1.1. Age and Gender of Volunteers

Age bands	Women		Men		All	
	N	%	N	%	N	%
25 - 29	1	1	0	0	1	1
30 - 39	5	7	0	0	5	5
40 - 49	2	3	0	0	2	2
50 - 59	9	12	3	14	12	12
60 - 69	27	35	10	45	37	38
70 - 79	27	35	9	41	36	37
80 - 85	5	6	0	0	5	5
Total	**76**	**100**	**22**	**100**	**98**	**100**

Sixty three volunteers were married or living with a partner; 14 were never married or widowed and 24 were separated or divorced. Fifty seven lived in two person households; 33 lived alone and 11 lived in households with more than two people.

All of the volunteers aged over sixty years were retired. Occupations were as follows: professional or managerial (n=48), secretarial / administrative / shop work (n=27), skilled manual (n=15) and housewife (n=5). When comparing men and women: 13 men gave their occupations as professional and managerial and 9 as skilled manual; women, professional and managerial (n=35), secretarial, administrative and shop work (n=27), skilled manual (n=6), housewife (n=5). Previous occupations included nursing, medicine, teaching, the civil service and engineering. Several people had previously run their own businesses. Manual occupations included mining and steel making. Volunteers below the age of sixty years included a beauty therapist, teacher and women who were outside of paid work because of motherhood. None of the volunteers reported previously having been in receipt of welfare benefits.

5.1.2 Title used to described role in Ageing Well

When asked to state what name or title was used to describe their role in Ageing Well, 69 respondents replied that they were known as volunteers, 10 stated that they were Senior Health Mentors, 11 were mentors, and a further 10 stated that they were known by the specialist activity they led, for example, walk leader, Extend teacher or ActivAge Tutor. Other titles included PAL (physical activity leader) or PAM (physical activity motivator).

Some interviewees commented that they thought the title 'Senior Health Mentor' was 'clumsy' or 'off putting', and that clients and volunteers did not know what it meant. One person commented that she did not like 'health' in the title because it may be seen by clients that she was a health worker. Another mentor commented that when she was asked by her coordinator to take part in this evaluation she inquired whether she was a 'senior health mentor'. The coordinator replied '*Well if you're doing this, then you are one*' (Mentor 64). Some volunteers pointed out that they were not aware of 'Ageing Well' before being invited to take part in the evaluation and were not clear what it meant. They knew their project by names such as 'Healthy Living Programme' or 'Health and Wellbeing' or 'Age Concern'.

5.1.3 Volunteers' time and skills

The majority of volunteers had been involved with Ageing Well for more than two years: 2-4 years (n=43); more than 5 years (n=30); 12 – 23 months (n=17; less than 11 months (n=11). Most volunteers participated regularly in Ageing Well activities: participating once a week (n=24), 2-4 times a week (n=29), and one day per month (n=5). Some volunteers stated that they provided support for clients in blocks of time, for example, ten weeks of IT classes or several months of one to one support.

Previous skills and experience that were found to be useful in the role included nursing, teaching, counselling, retail, administration and working in the voluntary, sports, exercise or complementary therapy sectors. Social skills and attributes that they found especially useful were communication, listening, sense of humour, empathy and satisfaction with the role.

'*Good communication skills are important, to speak to people on their level rather than speaking down to them and to be a good listener is important, having a good rapport'* (Mentor 25).

Sixty five per cent of the sample (n=65) were involved in other voluntary work, with 38% (n=23) spending one day a week and 34% (n=20) spending more than two days a week on other voluntary activities including committee membership, older people's forums, raising money, giving advice or information, administration and clerical work, listening to school-children reading or literacy schemes.

5.1.4 Reasons for becoming an Ageing Well mentor

Volunteers were invited to explain the key reasons that had attracted them to Ageing Well. The majority stated that they wanted to help people get more out of life (n=57), they had time to spare (n=55), they wanted to mix more with other people (n=32) and someone asked them to help (n=30).

Volunteers talked about the impact of retirement including wanting to sustain a routine after giving up paid work, not wanting to be sedentary and wanting a

challenge. *'I didn't want to stay at home worrying about my problems*' (Mentor 54). Others said they welcomed the flexibility to travel or take part in other voluntary or caring roles such as looking after grandchildren. Wanting to '*do something for others'* (Mentor 88) or to work in the community were also mentioned. One Asian volunteer described wanting to use his/her knowledge and skills to help improve the quality of life of the BME community. Others were motivated by wanting to share their enthusiasm for physical exercise or dancing with others:

'I love exercise. I used to be a rock and roll dancer and I love dancing. We have a dance in the class and then you get together and have a laugh' (Mentor 32).

*'I have had a new lease of life, the minute I get my trainers on I feel like dancing' (*Mentor 85).

'Being fit, an experienced cyclist and of the age of the clients, a bit more than most' (Mentor 21).

Several younger volunteers hoped their voluntary work would help them find paid employment. For others engaging in voluntary work was an opportunity to mix more with other people of a similar age and to learn more about healthy ageing.

When invited to explain how they heard about Ageing Well, 43 reported that contact was made through their local Age Concern. The second most common form of communication was through advertisement in their local paper or newsletter or leaflet in a community setting such as GP practice (n=22). Friends, family and other volunteers accounted for another 10 people joining Ageing Well. Six people reported having been a client of Ageing Well before becoming a mentor. Several volunteers heard about Ageing Well through local health initiatives, such as falls prevention schemes, and pre retirement events. Some volunteers had worked with their project for many years before it was 'rebadged' as Ageing Well.

5.1.5 Types of projects and activities

The volunteer sample was drawn from 36 projects. They participated in a wide range of physical, social and cultural activities from seated exercise to country walks, archery to IT, befriending and complementary therapies (see table 5.1.5 below).

Table 5.1.5 Type of Ageing Well Activities

Activity	N
Discussion with individuals	44
Running group discussions, outreach events	18
Running exercise groups /chair based exercise	32
Assisting at exercise groups	19
Giving out leaflets	22
Arts, music, sewing, crafts, dance	10
Assisting at reminiscence sessions	7
Complementary therapies (aromatherapy, hand massage, reiki, reflexology, Tai Chi, yoga)	12
IT tutor	7
Walk leader, cycling group leader	6
Providing transport	7
Providing refreshments	10
Running health shop / café / food co-operative	6
Healthy eating, cookery events, roadshows	5
Taking register	3
Organising games, quizzes, bowling, archery	5
Office work	3
Befriending / counselling / one to one support	8
Interpreting / translation	4

Most volunteers reported taking part in more than one activity with several individuals reporting up to three activities. The contribution of some volunteers was limited to taking the register, providing transport or refreshments, whilst other provided 'specialist' support as walk leaders or IT tutors. Numbers add up to more than 101 because people listed more than one activity.

Chapter 7 develops a typology of volunteer roles within Ageing Well and Appendix 3 includes 6 vignettes of volunteers to illustrate the typology.

5.1.6 Group or individual relationships with clients

A feature of the peer mentoring role is building up relationships with individuals or small groups of people. Volunteers were invited to state whether they worked with clients on an individual or group basis. The majority stated that they developed close relationships with individuals or small numbers of older people (n=76), or led activities with small groups of less than 12 clients (n=39), a further (n=21) stating they helped run events for large groups. Some volunteers worked with small groups of clients as well as organising large events.

5.1.7 Factors that facilitated the mentor role

About half of all volunteers (n=49) highlighted the significance of coordinators' enthusiasm and commitment, a further 21 valued the support of other volunteers. Twenty volunteers were motivated by the health and social benefits achieved by clients

'One client told me I "brought the outside in"' (Mentor 36).

'They come up and say "I was feeling a bit miserable when I came in, but I feel better now' (Mentor 75).

'It's a wonderful thing this Ageing Well. It helps us to continue to be active and to be young for longer' (Mentor 36).

Volunteers also welcomed opportunities to use their previous experiences and skills to benefit the community. Several also mentioned *'liking'* or *'feeling comfortable with'* older people. The benefits of volunteering were expressed like this:

'I think we are valuable assets within our community and people can tap into our knowledge and skills' (Mentor 20).

'It's a great, great thing to do, I'd advise anybody who has time to spare, it's worth doing' (Mentor 42).

The support of the local Age Concern and the social contact of '*being in a good group'* were mentioned by a further 16 volunteers.

'If it wasn't around any more I would be lost. I love meeting friends. We have a laugh. Every day I meet people' (Mentor 55).

Training was mentioned by 25 volunteers. Some volunteers valued the recognition of their role through award ceremonies and special events. Free bus travel was also valued. Several volunteers pointed out that their project had a high profile in their local community and this attracted both volunteers and clients.

5.1.8 Challenges to the mentor role

When asked whether there were any obstacles to their roles, about one third replied 'none' (n=37). The most commonly cited obstacles included volunteers' or their relatives' health problems or disabilities, lack or transport or inability to drive, late start to training, or lack of time to take part in training or to spend more time on Ageing Well activities. Project-based obstacles included lack of funding. A common theme was the need for more funding and anxiety regarding sustainability of projects where the original funding sources were withdrawing (n =13). Volunteers in four projects faced the closure of their projects within months.

'*It's a difficult time because funding is running out, the fact that we have to contribute now, instead of it being for free will cause problems for some'* (Mentor 101).

Some respondents discussed their concerns about funding and the wider implications of this on the project and the cost effectiveness of the programme seen as justification for its continuation:

'What the scheme has done has saved the NHS lot of money. People who would be going to the doctor for physical and emotional problems don't need the doctor now. Prevention is better than cure' (Mentor 100).

Other obstacles included poor transport links or unreliable transport to the project, clients having to pay for transport or food and inaccessibility of the centre where activities were held. Inadequate training and support from projects, poor communication such as not passing on messages, or lack of information about clients' health conditions, was mentioned by 9 volunteers. Some IT tutors would have liked more up to date equipment and reliable support.

Others were critical of the difficulties of finding volunteers to '*stay the course'* (Mentor 24). Other projects lacked volunteers, or lost them to paid work, and could have provided more activities with more volunteers. Conversely, in another locality one volunteer would have liked to give more time, but there were '*too many volunteers'* and so she was not required more than one day a week.

5.1.9 The volunteer mentoring role in Ageing Well

Volunteers were asked to explain the benefits of volunteers being involved in running activities and mentoring clients. The most frequently occurring theme (n=18) was around the perceived similarities and common ground between volunteers and clients. The definition of a mentor in Ageing Well is 'a partner in health- someone to trust and share with'. The commonality of shared experiences due to age seemed a significant factor in the perceived quality of the relationship between volunteer and client.

'I'm closer in age and I understand them. Younger people would just do the exercises, rather than share everything, just do one hour exercise and go' (Mentor 33).

'I understand and can relate to the age group I'm involved with. I have a greater understanding as opposed to a younger person' (Mentor 23).

'Because you're not paid and you're a volunteer, the clients know that you're just someone like them, you're just an ordinary person' (Mentor 96).

'We are of a similar age. We have more in common with each other on the walks and we make friends' (Mentor 39).

Some respondents felt that being closer in age made them more credible role models.

'For a start , you're the same age, I think older people want to see older people who are doing things as opposed to younger people, they think "that's easy" because they see you as enthusiastic about something and prepared to do something new' (Mentor 97).

'Volunteers in this aspect are the best way of running it because they take part in the activities and they are one of the group, they are among peers as it were, if you had a young person I don't think it would work as well, because you have people who think in the same way it works extremely well' (Mentor 21).

Volunteers acknowledged the achievements of 'youngsters' but stated that older people may feel more comfortable with an older person as this extract illustrates:

'For the older person they sometimes feel more comfortable with an older person. It doesn't necessarily say that it's the best because I know of some really, really good youngsters working with older people and it worked like magic. I think that

sometimes it's easier for you to bridge between the person you are working with and another organisation because they learn to trust you more perhaps' (Mentor 11).

The age of the mentor was seen as relevant when learning a new skill such as computers and IT

'I think one of the advantages I have when I work with people who are 50 or 60 is they look at me and think "if she can do it I can do it, right". Whereas if you've got a youngster . . . they might think "here's a whiz kid whose learnt it at school". Whereas it's obvious that I haven't learnt my skills at school. I've learnt my skills as I've gone along the same as they are' (Mentor 11).

Another common theme (n=11) was that people volunteered because they wanted to rather than being compelled to, the motivation to volunteer differs from the motivation towards paid employment.

'Volunteers do it with enthusiasm because they want to do it. Professionals have to do it. A volunteer can walk away if they don't like it' (Mentor 95).

Some volunteers pointed out that their contributions added value and ensured the continued running of projects because they were a cost effective, valuable resource within a community.

'Volunteers complement the paid staff and provide an additional service, in our case one to one, which would be very expensive if done by paid staff' (Mentor 94).

5.2 TRAINING

5.2.1 Number of volunteers who received training

Volunteers were asked whether they had received training when they first joined Ageing Well and 81 replied that they had. Reasons given by 19 of the volunteers who had not received any training were lack of time, already had training from Age Concern, or had professional or practice training such as nursing, teaching or complementary therapies. One other volunteer was not offered training and he said he would have felt more confident if he had been trained.

5.2.2 Length of training

The Senior Health Mentor Core Training Pack consists of eight core sessions of approximately 75 minutes duration. It is suggested by the ActivAge Unit that these sessions may be taught over four half days, two full days or one session per week over eight weeks. Supplementary sessions on project related or specific health topics may be added to the training programme as appropriate.

When questioned about both the length and content of training it became clear that most volunteers were unfamiliar with the concept of a 'core training pack'. Length of training was as follows: one day or less (n=25); 2 – 4 days (n=20); one session a week over 5 – 12 weeks (n=29); one session a week over 3 months or longer (n=4). Three volunteers stated they could not remember how long their training was.

One day training sessions were mainly delivered to 'specialist' activity leaders i.e. walk leaders, complementary therapists or IT tutors. Extend training was delivered usually in ten week blocks of three days a week.

5.2.3 Content of training

Section 4.2.1 identified that coordinators who used the 'core training pack' supplemented the content with other material, thus the content of volunteers' training varied widely depending on their project's activities. Volunteers were asked to recall the content of their initial training sessions when they first joined Ageing Well (see Table 5.2.3).

Table 5.2.3 Topics Included in Volunteers' Training

'Core training' topics
Induction to ACE / AW
What is health? Health promotion, health and ageing
Senior health mentoring – definitions and benefits of role, contributions of volunteers
Communication skills
Discrimination, ethnicity, volunteering good practice, mentor values
Healthy ageing – health topics affecting older people
Local project administration and evaluation
Eat Well Age Well: healthy eating
Additional topics
First aid
Food safety and hygiene
Protection of Vulnerable Adults (POVA)
Chair based exercise
Hand massage
Elder abuse
Winter warmth campaigns
Lifting and handling
Road safety
Falls prevention
Anti smoking
Client case studies for discussion
How to motivate people
Welfare benefits advice and pensioner rights
'What's available in the community' – services, benefits, advice, advocacy
Trading standards
Risk assessment
Home maintenance
Training topics for 'specialist' volunteer activity leaders
Induction to Ageing Well
Exercise to music / Extend / Flexercise
Walk leader (risk assessment)
Reminiscence
Hand massage
Chair based Tai Chi
Basics of IT training
Administration of activities

Just over half of the total sample of volunteers (n=56) had thus received training in the topics listed as 'core training' together with a selection of additional topics. Twenty-five volunteers had received one-day training that covered an Induction to Ageing Well to supplement professional or practice skills or training delivered by another agency, and any training that was specific to their specialism (walk leader, IT

tutor). The content of training for 'specialist' volunteers included Induction to Ageing Well including risk assessment, working with older people, working in groups, health and safety and first aid. Some 'specialist' volunteers had also undertaken more comprehensive mentor training.

Training was delivered by project coordinators, together with outside speakers. Two projects sent volunteers to local universities for training in running exercise groups or IT activities. These volunteers welcomed the opportunity to meet with other people from a wide range of voluntary organisations. Two projects used Department of Health National Primary Care Development Team.

It was not possible to make clear distinctions between the content of the initial training delivered to people who described themselves as 'volunteers' whose role involved handing out refreshments and 'volunteers' who led organised exercise sessions or engaged in one to one support with clients. Similarly some walk leaders were trained in 'healthy eating' and 'healthy lifestyles'. There were thus overlaps in the topics covered in the training of these groups. Some 'volunteers' had undergone training covering the key areas of the training pack and some 'volunteers' had not had any training

5.2.4 Volunteers' views on practicability of training

An objective of the evaluation in relation to the training of volunteers was to elicit volunteers' views on the training they had received 'using the core training pack'. Volunteers responses to questions about the content of their training sessions suggested that not all had received 'core training' as set out in the training pack. Thus this section reports the views of 81 volunteers on the training they received within the first few months of starting their volunteering to enable them to undertake their roles. Volunteers were invited to state whether they agreed or disagreed with the statements in the first column of Tables 5.2.4 (below).

Table 5.2.4 Volunteers' Views on Practicability of Training

The training was:	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree	
	N	%	N	%	N	%	N	%	N	%
Comprehensive	30	37	45	56	1	1	5	6	0	0
Relevant to my needs	31	38	45	56	4	5	1	1	0	0
Easy to understand	32	40	46	57	2	3	1	1	0	0
I learnt a lot from the training	30	37	38	47	9	11	4	5	0	0
At the right level	29	36	44	54	4	5	3	4	0	0
I felt prepared for my role as a mentor	30	37	43	53	4	5	4	5	0	0

The majority of the 81 volunteers strongly agreed or agreed that the training they received was comprehensive (93%,n=75), relevant to their needs (94%, n=76), easy to understand (97%,n=78) and at the right level (90%,n=73). They mainly agreed that they learnt a lot from the training (84%,n=68) and felt prepared for their roles as volunteers

(90%,n=73). Comments from volunteers involved with different activities included the following:

*'I felt it did build on our skills' (*Mentor 67, retired computer manager).

'It was fun, not patronising' (Mentor 2, counsellor).

'It didn't hurt reinforcing everything, even though you thought you knew it' (Mentor 80, retired nurse).

'I was taken out by [trainer] she taught me to see things from an elderly person's point of view. What you take for granted these people don't, things like arthritis. I learnt a lot and she taught me how to risk assess a walk and how a little risk taken quite often turns out to be a big risk. The only thing is the caginess. When I used to take cadets out I used to know who had diabetes etc but with the elderly they don't seem to tell me. It's as if I don't need to know' (Mentor 68, walk leader).

Some coordinators supervised their volunteers' classes when they were first trained and this was considered to be valuable aspect of ongoing training.

Amongst the volunteers who responded with 'neither agree nor disagree' or 'disagree' several themes emerged. Some volunteers including retired nurses, teachers and local authority staff, commented that their previous training in paid or voluntary work had prepared them for the role and that there was *'not enough depth*' in the training. Some volunteers who disagreed with the statement would have liked a structured programme of training. Several volunteers stated that they would have preferred more in-depth training before they began their role, rather than having on-going training later. Several volunteers would have preferred more training to enable them to feel confident in their roles. Several volunteers would have like more general training to supplement short training on, for example, being a bus escort.

5.2.5 Further training

Sixty volunteers had taken part in additional training since they joined Ageing Well. For the list of topics see Table 5.2.5 (below). The content of additional training varied widely across projects. Volunteers valued ongoing, cumulative training over time to develop their knowledge about health related issues and to keep up to date, for example, with project or other Age Concern developments. The responses to this question indicated that where there had been gaps in initial training, the refresher or on-going training supplemented gaps in most cases.

Table 5.2.5 Further Training

Topics included in further training
Health and safety
Heart Start
Blood pressure, diabetes, osteoporosis
Mental health
Health through warmth
Falls prevention
Smoking cessation
Sensory impairment
First aid
Chair based exercise
Chair based Tai Chi
Flexercise refresher
Get ready to dance
Walk leader
Fire safety
Welfare benefits
Elder abuse
Communication
Manual handling
Information Technology
Photography
Hand massage
Local grants training
Food hygiene
Healthy eating

Of the 40 volunteers who had not received any additional training, nine had received no training at all since joining Ageing Well. Reasons for not undergoing further training were mainly that volunteers had not had time to fit in extra training.

5.2.6 Volunteers' suggestions for changes to training

Volunteers were invited to suggest changes to the training and this question elicited positive responses about the training already received as 26 people said they could not think of any because the training was *'good, comprehensive'* (Mentor 7) or 'there*'s nothing more that I wanted'* (Mentor 4).

Several volunteers commented on the added value of meeting with other volunteers at training sessions. However, the size of groups for training sessions impacted on people's experiences. Volunteers in small groups of four or five people valued the opportunity this gave to get to know other volunteers. Small group sizes were mainly preferred to larger groups of 20 – 25 people. Several volunteers were critical of the high wastage rates following training sessions. This was considered to be a waste of money and there was a need for more careful selection of volunteers.

'Being a senior health mentor is a hard role. Out of 16 people trained in my project, only three remain as volunteers' (Mentor 30).

The list of suggestions for changes reflects general themes arising from the data. As stated above, the content and mode of delivery varied considerably across projects and so this list includes suggestions that may have been already adopted in other projects

- Tailor-made training adapted to the requirements of the activities that volunteers were planning to participate in.
- Training that was more flexible depending on the backgrounds and expertise of volunteers.
- Training that was informal and ongoing.
- Refresher sessions and project updates.
- The opportunity for new volunteers to meet experienced volunteers during their training.
- Training delivered in smaller groups.
- Feedback to volunteers after training.
- More time for volunteers to develop their confidence in delivering sessions and working with clients.
- Training sessions closer to home.
- Information to be given to volunteers in electronic format as well as on paper.

5.3 SUPPORT AND SUPERVISION

5.3.1 Type of contact with project coordinator

The principal method of maintaining regular and frequent contact between volunteers and project coordinators was via the telephone (n=62). The majority of coordinators were described as *'always being available on the phone'* (Mentor 85). Telephone calls could be made on an ad hoc basis and for other projects weekly or monthly phone calls were routine. Face to face contact was reported by 69 volunteers, but these were less regular than telephone calls, with 23 volunteers stating that they met their coordinators in regular individual weekly or fortnightly meetings or monthly face to face meetings (n=19). Other volunteers attended regular group meetings, some of which included training sessions. These meetings were valued as a means to sustain contact with other volunteers and to discuss any problems. Some volunteers stated that they received regular visits from coordinators to their activities and these were valued as a source of support.

Written communication was less well used and included emails, letters and newsletters. Several volunteers were critical of the lack of contact between coordinators or project staff and volunteers.

5.3.2 Satisfaction with support and supervision from coordinators

The majority of volunteers were satisfied with the amount of support they received from their project coordinator with 95 volunteers strongly agreeing or agreeing that the project valued its volunteers, 99 stating that their working relationship with their coordinators was positive and 97 felt supported by their coordinators. Every mentor agreed that support was there if it was needed and it was adequate for their needs (see Table 5.3.2 below).

Table 5.3.2 Volunteers' Views on Support and Supervision

Support and supervision	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree	
	N	%	N	%	N	%	N	%	N	%
The project values its mentors	65	65	30	30	4	4	1	1	0	0
My working relationship with the coordinator is positive	65	65	34	34	0	0	1	1	0	0
I feel supported by the project coordinator	61	61	36	36	2	2	0	0	0	0
Support is there if I need it	67	67	33	33	0	0	0	0	0	0
The support has been adequate for my needs	61	61	39	39	0	0	0	0	0	0
Other mentors are a valuable source of support (n=97)	50	52	30	31	11	11	6	5	0	0

Typical comments included the following

'She's very approachable and friendly' (Mentor 95).

'They genuinely care about us as individuals. We are not just being used as volunteers. They make sure we are okay' (Mentor 2).

'The coordinator she has an older people orientation. She finds information for us. We can help people who don't speak the language, give them information and advice' (Mentor 54).

Volunteers highlighted the importance of getting together with project staff and volunteers. Regular meetings were valued as a means to share experiences and problems. The kind of support that volunteers valued was networking, organised events and trips, advice on funding opportunities. Volunteers who led exercise classes, or reminiscence sessions, valued the back up of physiotherapists, community psychiatric nurses, coordinators or team leaders.

Volunteers who were neutral about the level of coordinator support they received included volunteers who worked with clients on a one-to-one basis. They said they would prefer more follow up discussions with the project coordinator. Two people disagreed with the statement that 'the project you are involved with values its mentors'. They commented:

'They should respect and show some appreciation. I'd put in more if I was appreciated more. I feel I have responsibility it is a great deal' (Mentor 33).

'I don't know how much they're expected to do for their volunteers really. I'll tell you quite honestly' (Mentor 75).

5.3.3 Support from other volunteers

In terms of support from other volunteers, views were mixed. The majority (n=80) stated that 'the other mentors were a valuable source of support' (see the last line of Table 5.3.2 above). Several volunteers described how support for clients was enhanced through the close working relationship between volunteers. This was especially so in projects providing a wide range of support and advice. For example, a person attending an exercise class who appeared to be depressed could be given information about the counselling service in the project.

The 17 people who were neutral or disagreed that 'other mentors were a source of support' gave the following reasons for their views: the distances involved and lack of public transport problems; lack of time and preferred to contact the coordinator.

5.4 IMPACT ON HEALTH AND WELLBEING

5.4.1 Impact on volunteers

Impact of Ageing Well on health and wellbeing was measured by asking volunteers to respond to the statements in Table 5.4.1 (below). The majority of volunteers responded positively to each statement: 64 reported that their knowledge about the importance of physical exercise had improved and 37 said it had stayed the same; the levels of physical exercise of 60 volunteers had improved or had stayed the same for 39; knowledge of health foods had improved amongst 56 volunteers in the sample, and stayed the same for 44; consumption of healthy foods had increased for half of the volunteers and stayed the same for the remainder; 75 stated their social circle had improved and it had stayed the same for 24; knowledge of home safety had improved for 70 and stayed the same for 30.

Table 5.4.1 Impact on Health and Wellbeing

Health and well being	Improved a lot	Improved a little	Stayed the same	Reduced a little	Reduced a lot
	N	N	N	N	N
My knowledge about the importance of physical exercise has	41	23	37	0	0
My level of physical exercise has	27	33	39	2	0
My knowledge about healthy foods has	31	25	44	1	0
My consumption of healthy foods has	31	20	50	0	0
My social circle has	40	35	24	2	0
My knowledge about home safety has	38	32	30	0	0

When asked to explain why their knowledge of and levels of exercise and healthy eating, or social circle had stayed the same, volunteers gave the following reasons:

they were aware of exercise and healthy eating messages prior to joining Ageing Well, and already were physically fit and ate healthy meals. Ill health and moving house were the reasons two volunteers gave for reductions in exercise and their social circle. No volunteers stated that their health and wellbeing on these measures had 'reduced a lot'.

Twenty seven respondents stated that the main benefit to their health was an improved social circle

'*Ageing Well has given me the chance to meet new people and have a new outlook on life'* (Mentor 28).

'. . . social benefits in getting out of the house, I've made new friends through Ageing Well' (Mentor 11).

The second most frequently occurring theme related to physical health: 25 respondents stated that their physical health had improved due to increased physical activity (n=21) or health-related information.

'Physically, it's improved, I now do Pilates, yoga and Tai Chi. It keeps me supple and improves flexibility and it's improved my balance' (Mentor 100).

'I'm now eating more fruit and vegetables, more greens, less meat and more fish. It motivates me. It improves my way of living' (Mentor 16).

The third most frequently occurring theme (n=21) related to improved emotional health due to increased social contact and the personal satisfaction gained through involvement in an Ageing Well project.

'Psychologically it has [improved health] *because it is so much fun, its lovely to go somewhere and people are looking forward to seeing you, it brightens your day'* (Mentor 61).

'It has made me feel happier and more relaxed' (Mentor 94).

The health benefits gained from helping people and having a sense of being useful and *'giving something back'* was also important

'*It's improved my wellbeing, something that's satisfying and helping people, good for my health I'm sure'* (Mentor 80).

'It's improved it. It's nice to be able to go out and help somebody else and see improvement in their health without any money being exchanged' (Mentor 83).

5.4.2 Impact of volunteers' involvement with Ageing Well on the health and wellbeing of family and friends

The most common response to this question, was the passing on of information, knowledge and practice for the benefit of family and friends (n=28)

'I have discussed health information gained with my husband, mother and children, five fruit and veg a day and drinking water. My mother has changed her eating habits' (Mentor 67).

'I've done gentle hand exercise with my elderly mother [in 90s] to help her dexterity' (Mentor 61).

Others stated that they had encouraged family members or friends to join Ageing Well activities

"My husband has now joined as a walk leader. He's not a chap that makes friends easy, but through walking he's made a new group of friends' (Mentor 40).

Intergenerational benefits were mentioned by several volunteers

'There's been an impact on friends and also on the grandchildren. We've taken them out and a couple of them are now keen cyclists. These things have little eddies around them, like a stone in water' (Mentor 21).

Six volunteers stated that their family had benefited indirectly due to the benefits that they had themselves gained from their role as a volunteer with Ageing Well

'…the family are pleased I'm doing something, they all appreciate how low I get because I can't work anymore' (Mentor 103).

Thirteen volunteers stated that there had been no impact on their family and friends this was mainly because they were already fully aware of issues relating to healthy living.

5.4.3 Impact of involvement in Ageing Well on the health and wellbeing of clients

Volunteers stated that participation in Ageing Well impacted in five key ways:

- Increased physical activity
- Improved social contact
- Increased confidence
- Improved mental, emotional and psychological wellbeing
- Knowledge and skills acquisition

Twenty nine volunteers stated that there was a positive impact on health mainly due to increased physical activity, but there were also examples of therapeutic benefits from therapies such as Reflexology or hand massage. The benefits were increased mobility and agility, but there were also broader benefits, such as social and psychological, which overlap with the other themes identified

'We exercise every muscle including the eyeballs and the jaws get the most' (Mentor 75).

'I know it's made a huge difference to a lot of them it's improved their mobility, the older and stiffer they are the more they get out of it' (Mentor 85).

The physical, social and psychological benefits of physical exercise for clients were recognised:

'It is excellent because they are fit because of the classes and activities and secondly they meet the people and talk, that helps with depression' (Mentor 101).

Some projects offered complementary therapies which again had multiple benefits:

' . . . a hand massage is not intrusive, its physical and it may be the first time in weeks that a person has been physically touched, but you're not intrusive, it's not threatening, so it relaxes them from the start because they can withdraw their hand quite easily' (Mentor 96).

Twenty six volunteers said that improved social contact was the main impact on clients' health, having the opportunity to talk and share with others.

'*It relieves their anxieties. Some are very old. We have a chat. They enjoy the company'* (Mentor 15).

'People are lonely. It improves the quality of life. Once they've made the first step they get involved in other things' (Mentor 99).

In many projects improved social contact and reductions in social isolation were accompanied by access to health information. One mentor recounted taking small groups of Asian women to a rehabilitation day centre where she interpreted health information for them

'Attendance was high, the women really enjoyed it. It got them out of the house mixing with women of the same age group and learning about health information' (Mentor 70).

Twenty two respondents stated that increased confidence was of greatest benefit to clients' overall health. Improved levels of confidence were gained by joining in group activities and also through one to one health mentoring

'Most of them we take on have lost confidence due to illness or bereavement. The health mentoring gives them confidence and security and empowers them to be more independent' (Mentor 94).

Closely related to this is mental emotional and psychological wellbeing. Volunteers described how involvement in activities *'brought clients out of themselves'*.

'*Even if they're shy, they may not talk to you the first time, you talk to them and then they're waiting for you next week. It brings them out of themselves'* (Mentor 47).

'The project creates friendships with people who are isolated. We are building a bond with people. It gives them something to rely on, a sense of security. If you trust someone, that they will help you, it takes some of the stress off' (Mentor 37).

Other volunteers talked about how clients had been enabled 'to help themselves' through the acquisition of new skills and knowledge

'It helps a lot of people; it gives information for people to help themselves. They can have a chat and stop brooding about things' (Mentor 27).

'One of the women I tutor had previously been in a class of twenty younger people at the local college. It was "I'll be with you in a minute". It was very frustrating. After she had done our one to one course, she then went back to college and got five certificates. We gave her confidence' (Mentor 38).

As well as making general statements about the health gains of clients, volunteers were asked to give examples to illustrate how they had influenced a client's health and behaviour. Thirty five respondents gave examples of individual clients, the impact on health and behaviour ranged from improved physical mobility, improvement in chronic conditions, increased confidence and independence, bereavement support, mental health benefits, social benefits and monetary benefits through access to appropriate benefits and the impact of gaining new knowledge and skills.

'*One lady who comes to Tai Chi had Asthma used to take an inhaler, hasn't used it for a while now'* (Mentor 24).

'They can walk further and faster. One chap had a walking stick- doesn't need it anymore. They can move easier, you can see it' (Mentor 69).

'An 80-year- old client is now eating more fresh fruit and veg, she is ordering her food online from Tesco's. The local shop is closed. She now has a much greater choice of fresh foods' (Mentor11).

Some volunteers gave more general examples such as the benefit of the 'Sloppy Slippers' home safety campaign aimed at falls prevention. One mentor's role involved mentoring and working with individual clients to empower them to regain their independence

'The *client is now very confident and is able to venture out to local services, can cross roads* [using motorized wheelchair] *and has increased independence' (*Mentor 94).

5.5 CHANGES SUGGESTED TO AGEING WELL

When asked to suggest changes to the way their projects were delivered, 24 volunteers replied that *'no changes'* were required

'No, I think we've got it down to a fine art. It's a flagship project. I think it important we don't lose its friendly atmosphere. It ticks away quietly' (Mentor 85).

Other volunteers identified concerns about funding, improved transport and facilities, the need for expansion and development of projects, raising awareness of projects, more client involvement, better use of volunteers' skills and improved communication.

Another common finding was the need for more volunteers, including more male volunteers. This was identified in relation to providing a more diverse service and addressing what was seen as a gap in provision. Some volunteers commented that volunteers have a wealth of skills that could be better utilised

'Volunteers could be used to give more. We are not encouraged to do much more than chat with others as they have paid people to do the talks. Volunteers have a wealth of skills over the years that could be used more effectively and differently' (Mentor 1).

'I did the training on health mentoring and I'm not actually doing a lot of health talks which I'd quite like to do' (Mentor 25).

Ten volunteers stated that they would like to see their project expand, ranging from recruitment of more members, offer more classes and more activities, go to more venues, access more people and offer services for longer. The need for transport and improved premises was identified by seven respondents. Some volunteers felt that clients should be given more choice and should be more involved in decision-making. Other volunteers thought that there should be more opportunity for Ageing Well volunteers from different projects to meet and get together to discuss and share ideas at either local or regional level.

CHAPTER 6
RESULTS: CLIENTS

6.1. BACKGROUND

Thirty one interviews were conducted with clients from six projects. The clients who took part attended sessions organised in community centres and thus the evaluation did not include any clients from other settings, for example, those living in care homes or those who received support from volunteers on a one to one basis in their own homes.

6.1.1 Demographic Characteristics and Health Status

The sample included 25 women and 6 men. The majority (n=15) were married, 12 were widowed or divorced, 2 separated and two had never married. Just over a third (n=11) lived in single households with the remainder living in households with two or more occupants. Clients' ages ranged from 56-86 years with an average age of 71 years. The majority (71%, n=22) described their ethnicity as Welsh or British and 29% (n=9) of clients were from black and minority ethnic groups. Of these 9 clients, 5 were Asian (Indian, Pakistani and Bangladeshi) and 4 were black (Caribbean and South American). Clients from minority ethnic groups tended to be five years younger than their white counterparts with an average age of 66 years (range 56-74 years). A breakdown of clients' age by age bands and gender is presented in Table 6.1.1.

Table 6.1.1 Age Bands and Gender of Clients' Age

Age bands	Women		Men		All	
	N	%	N	%	N	%
50 - 59	3	12	0	0	3	10
60 - 69	9	36	1	17	10	32
70 - 79	7	28	4	66	11	35
80 - 85	6	24	1	17	7	23
Total	**25**	**100**	**6**	**100**	**31**	**100**

As an indictor of clients' socio-economic status clients were asked their previous occupation prior to retirement. All were retired with the exception of one client. Eight clients were housewives. Previous occupations included: professional/ management (n=6); administrative / shop work (n=7); skilled manual (n=5); unskilled manual (n=4); economically inactive (n=9). Of the six male clients one had previously worked in a profession, three in skilled manual work and two in unskilled work. Professions included teaching, environmental health officer and nursing. Administrative and clerical work included secretaries and shop workers. Skilled manual work included a blacksmith and pottery worker and unskilled manual work included a cleaner, storeman and factory worker. One client was in receipt of welfare benefits.

Whilst clients were not specifically asked about their current health status, 28 provided this information during the interview. Eight clients reported being generally fit and well. The remaining 20 clients reported having health problems, often more than one, but the main health problems are presented. Nine reported having arthritis or painful joints which impeded their mobility. For two of these clients this had resulted in taking early retirement and one needed to use a walking frame. Two

clients suffered with depression, two had diabetes, two had back problems which one sustained following a fall, and the remaining five clients had a respiratory problem, hypertension, high cholesterol, a stroke and one had recently been hospitalised in an intensive care unit.

6.1.2 Frequency of Attendance at Activities

Seventeen clients (55%) attended Ageing Well activities on at least a weekly basis. A further 42% (n=13) attended between 2 or 3 times a week (n= 9) or 3 to 4 times a week (n=4). One client attended two or three times a month. It can be seen therefore that the majority of clients attended activities on a regular basis.

6.1.3 Types of Activities

As can be seen from Table 6.1.3, clients attended a range of activities and often clients attended more than one activity.

Table 6.1.3 Types of Activities

Activity	Number
Physical exercise	16
Seating exercise	13
Diet and healthy eating	8
Arts or crafts	6
Walking group	5
Accident prevention and falls	4
Music and dance	3
Cookery	1
Other	17

The most commonly attended activities were physical and seated exercise (n=29). Eight clients attended activities related to diet and healthy eating and six attended arts or crafts. Clients were less involved in activities related to music or dance, cookery and accident prevention and falls. 17 clients reported being involved in other activities. Within this category clients reported being involved in more than one activity. The most frequently reported `Other' activities were involvement in sports and games (n=6) (e.g. snooker, bowling, Bingo), just having a chat and refreshments (n=5), listening to talks by invited speakers (n=3), Tai Chi (n=3), IT courses (n=3) and going on day trips (n=2).

The men (n=6) were more likely to attend activities related to physical exercise such as walking or seated exercise, talks provided by external speakers (e.g. on tax and health issues), games such as bowling and to attend just have a coffee/tea and a chat with friends. Due to the small numbers involved these findings should be viewed tentatively.

6.1.4 Activities Enjoyed

Physical exercise whether seated, keep fit or walking was the activity which was most frequently mentioned as being enjoyed (n=18). Just under half the clients interviewed (n=15) reported that meeting people and the companionship offered by participating in the activities was what they enjoyed. Eight clients reported that they enjoyed the talks provided by external speakers which covered a range of topics including health

advice, welfare benefits, and tax advice as well as talks on local history. Whilst a further four clients commented that they enjoyed the health screening (blood pressure checks, blood glucose screening) which was provided. The social benefits of participating in the activities were emphasised when a further three clients reported that it was good fun, three clients stated they enjoyed the food and having a chat and one enjoyed the parties celebrating the religious festivals. Other activities mentioned included sports and games (e.g. bowling, swimming, and archery), Tai Chi, Line dancing, crafts and IT.

6.1.5 Activities Not Enjoyed

Twenty six clients (84%) reported that there were no activities which they had not enjoyed. This was because the coordinators consulted with the clients regarding which activities they would like and some clients reported that the programme was jointly planned:

'*Volunteers and managers ask us what we want. They consult us. Most of the activities are ones we have requested*' (74 year old female).

Of the five clients who had not enjoyed activities, in two cases this related to the physical abilities of the clients as they had found it difficult to participate in the exercise class. One client felt that Tai Chi was too slow, one client could not see the need for sewing classes and one reported that a talk on depression had been in itself depressing. Overall there was a high level of satisfaction with the activities provided by the Ageing Well projects.

6.1.6 Suggestions for Additional Health-related Activities

Clients were asked whether there were any additional health related topics they would like to see provided. 39% (n=12) stated that there were no further topics which needed to be provided. Clients suggested more than one topic. The five most frequently reported additional topics were for health advice (n=4) specifically in relation to information for carers and regarding diabetes, health screening checks (n=3), outings and day trips (n=3), information on inheritance tax and welfare benefits (n=2) and crafts specifically painting and drawing (n=2). The full list of additional health topics requested is presented in Appendix 1. It is acknowledged that most of these activities are already being provided by projects within Ageing Well but were not all currently being provided by the projects which were surveyed. Two clients requested that health information should be communicated in ways which meet the clients' needs. It was suggested that health information is provided in languages other than English and Welsh to meet the needs of ethnic elders, many of whom could not speak or read English. Providing information in a range of formats besides written leaflets was also suggested. Additionally, a need was identified for health information to be presented in a way which was easily understandable by older people. A specific example related to the need to convert weights and measures into imperial measurements for the information to be meaningful for some older people:

'But what I couldn't get, they were saying in grams you know, butter and salt, things you know. I think in inches, stuff like that. I'm not into that. It does muddle me if they say things like that' (73 year old female).

Activities suggested specifically by the men included organised walks, swimming, health screening, more information on tax issues and for some men, but not all, day trips out. As one man commented:

'When you walk you talk, I like to talk (72 year old male).

These findings should be viewed tentatively because of the small numbers involved.

6.1.7 Involvement in Other Health-related Activities

Clients reported being involved in a number of other health related activities. Nearly a third of clients (n=10) reported walking regularly and a further third were involved with other groups such as the Women's Institute, Good Neighbour Schemes, Home Start, Communities First, Patient Forum and local Charities. Six clients were also involved with Church activities, either attending activities provided by the Church or acting in a voluntary capacity assisting with organising and delivering Church activities. A number of clients therefore were acting as volunteers for other charitable schemes in their local areas. Swimming (n=4), attending exercise classes (n=3) dancing (n=2), card/board games and attending computer courses (n=2) were other health related activities which were mentioned.

6.1.8 Age Range of Clients Attending Ageing Well

Clients were asked to estimate the age range of other clients. This question yielded a very mixed response. It is acknowledged that clients had to judge the age of the other members as this information was not commonly shared. The age range reported was from 45-90 years, a span of 45 years. As the eligibility criteria for attending Ageing Well projects is 50 years and over it is surprising that some clients were reported as being in their mid forties. The majority of responses could be captured within the age range of 60-85 years. As previously stated the age of clients interviewed ranged from 56-86 years. The findings suggested that the age range varied with the type of activity as those attending a Café or health shop were deemed to be from an older age group than those attending an exercise/keep fit class. Clients preferred being with people of a similar age group as they could share experiences, empathise with one another and felt under no pressure to compete:

'In a group the same age and generation – all of us together, with out own little stories to tell' (69 year old female)

6.1.9 Factors which Enhance Involvement in Ageing Well Activities

The main factor which enhanced involvement also related to transport (n=10). Two clients reported they had their own car or were transported by a relative. Two stated that public transport was good or that they had a free bus pass and six clients commented that transport was provided either by Ageing Well or by services such as 'Dial a Ride'.

The location of venues was the second most frequently reported factor (n=7) which enhanced involvement. Clients commented on the groups being local and easily accessible. The third most frequently reported factor which enhanced involvement was attending with family or friends (n=6). Other factors included the friendliness, personality and support of the staff, with the volunteers being specifically mentioned (n=4), trips being free (n=1) and that activities were in the day (n=1). Nine clients

(29%) of clients reported that there were no factors which enhanced their involvement in Ageing Well activities.

6.1.10 Factors which Impeded Involvement in Ageing Well Activities

Thirteen clients (42%) reported that there were no factors which impeded their involvement in Ageing Well activities.

The main factor which did impede involvement related to transport (n=13). There were several issues related to transport including poor public transport, the need for transport to be provided for evening events and communication difficulties with the `Ring a Ride' service resulting in some clients not being picked up to attend the activities. This latter situation specifically related to clients whose first language was not English. Eight clients commented that transport would be a problem if they could not drive or they did not have friends or relatives who could transport them to the venues.

Six clients commented on the location of the venues commenting on the travelling distance to get to the activities, dangerous roads which had to be crossed and road works which impeded access. Other factors included classes/activities being over subscribed and insufficient notice of forthcoming events and activities. One client commented that lack of provision of a prayer room for Muslim men impeded involvement, but it was stated that too few men attended the activities to warrant such provision. Finally two clients reported that their own disability impeded involvement in physical activities and one reported that steps into some venues impeded access.

6.1.11 Charging for Ageing Well Activities

The majority of clients (71%, n=22) reported that they were not charged for attending Ageing Well activities. Two clients were unsure and seven clients (23%) stated that they were charged. Charges were nominal ranging from 50p for an exercise class to £5.00 for two people to play bowls for two hours. Some clients reported being charged for lunch which was approximately £2.00.

Whilst the majority of clients (n=20) reported that they would be willing to pay fees to take part in Ageing Well activities, nine clients were unsure and two clients were unwilling to pay fees. Of those who were willing to pay this was with the provisos that the fee charged would be reasonable and nominal. Seven clients expressed concern that charging would deter some people from attending, especially those on limited incomes. One client specifically stated that she would not support an annual membership fee being introduced.

6.1.12 Sources of Information

Clients reported hearing about the Ageing Well projects from more than one source. The most commonly reported source of information was by word of mouth from a friend (n=11), advertisement (n=4) or local Age Concern (n=3). Within the `Other' category five clients reported that either a relative (n=5) or a health and social care provider (e.g. doctor, physiotherapist, housing caretaker) (n=4) had recommended the project to them. It can be seen therefore that personal recommendation is the main source of information about the Ageing Well projects. Only four clients reported that advertisements had been a source of information. Other sources of information included the Church and a Luncheon club. Three clients took the initiative and joined

the projects after seeing the premises open or from seeing the project's minibus in their area.

6.2 SUPPORT AND ADVICE

6.2.1 Group or individual relationship with volunteers

Nearly a third of clients (n=10) were involved with one volunteer, whilst a further third (n=10) were involved with between 4-6 volunteers. Five clients did not know how many volunteers were involved and three reported that they had no involvement with volunteers. Two clients were involved with 1-2 volunteers and one client reported involvement with 30-40 volunteers. It is suggested that this latter finding reflects the number of volunteers in the local Ageing Well project as a whole.

Eight clients did not know whether the volunteers were paid or volunteers. Fourteen clients reported that the mentors were volunteers, three stated that they were paid staff and six reported that there were paid and volunteer mentors.

6.2.2 Support offered by Volunteers

Findings indicated that volunteers supported clients in a number of ways. Clients provided information on more than one way in which volunteers supported them.

Volunteers were reported as mainly either leading sessions or groups (n=8) or offering support (n=8). Volunteers were also involved in providing practical help (n=6) such as preparing and serving food, taking registers, helping with organising activities and providing materials for crafts. Clients reported that the volunteers motivated, encouraged and sometimes cajoled them (n=6) and commented on the approachable and friendly manner of the volunteers (n=5). Two clients reported that the volunteers provided information and in relation to an IT course showed the client what to do.

In subsequent questions (2.2.a and 2.2.b) twenty clients reported that volunteers provided personal advice and assistance and 17 reported that they lead activities/sessions for large groups. The following extracts provide a flavour of clients' views regarding the relationships and kind of support provided by the volunteers:

'There is encouragement, they give encouragement and information. It's also somewhere to come to' (71 year old female).

'She motivates the group, uses humour and encouragement' (82 year old female).

'We can talk things though with her [mentor/volunteer]*. When we arrive if your back is playing up, she will say go at your own pace. She knows us well, she notices if we aren't well. She says "Have you been to the doctor?"'(*75 year old female).

One client specifically commented that it would be helpful to have more volunteers who were middle aged as they could help the clients more as:

'*They are healthier than older people*' (56 year old female).

It is interesting to note that this client was in her mid fifties.

6.2.3 Adequacy of Support from Volunteers

Twenty six clients (84%) reported that they had sufficient support from volunteers and no one indicated that they would have liked more support. Comments indicated that some of the volunteers were viewed more like friends and made clients very welcome:

*'Yes I see her [*mentor/volunteer] *more as a friend'* (82 year old female).

'*Made very welcome when you come to the [*name of project]' (81 year old female).

'Yes and if for any reason she couldn't help then I know she would be able to find someone who could' (86 year old female).

6.2.4 Differences in Approaches between Volunteers and External Speakers/ Activity Leaders

Fifteen clients (48%) stated that they did not attend activities led by volunteers and external speakers/activity leaders, 42% (n=13) reported that they did and 10% (n=3) were unsure. The main differences reported related to volunteers having a more in depth knowledge of the clients and their needs, acquired through sustained relationships and the ability of some volunteers to communicate in the clients' preferred language. This latter ability was particularly important for clients whose first language was not English:

'Volunteers speak client's language, understands the lifestyle and very friendly' (56 year old female).

Some clients made reference to the volunteers as being more like friends, who put them at ease and enabled them to ask questions which they may not have asked of external speakers. The volunteers were aware of the strengths and limitations of clients which were seen as being particularly important when involved in exercise classes. Clients commented that volunteers motivated and supported them. A specific example was that a volunteer leading an exercise class linked a new client with an existing member to provide new clients with additional support. Clients also reported that volunteers used simple language, offered advice and that they did not feel under any pressure to participate.

Four clients specifically expressed a preference for a person of their own age group to lead the activities:

'What do younger people know about life? It's better to have a more mature person, to be our age group, so that exercise is appropriate for your needs' (82 year old male).

'I do another exercise group in the village. It is exercise for more mobile people to music and is run by a paid professional. The pace is too fast, it's hard to keep up and it's difficult to ask for advice. With [name of trained volunteer], you can say to [name], she understands and keeps an eye on you. This is what you need' (75 year old female).

'More appropriate to have someone own age leading the exercise classes' (73 year old female).

Whilst one client preferred to be with her own age group because:

'Nobody laughs at you if you make a mistake' (74 year old female).

However, other clients commented on how well young paid professionals adapted their activities to suit the needs of older clients as illustrated in this extract:

'The Tai Chi instructor is very young, has adapted to our age group, understands the age group' (74 year old female).

It seems therefore that whilst age was a factor the differences reported were more to do with the style, understanding and approach of the individual volunteer or paid worker to the needs of older people.

6.3 IMPACT ON HEALTH AND WELLBEING

6.3.1 Impact on clients

Clients were invited to report the impact of involvement with Ageing Well on the same range of measures as the volunteers. As can be seen from Table 6.3.1 clients' involvement with the Ageing Well projects had most impact on improving their knowledge about the importance of physical exercise and on widening their social networks (97%, n=30).

Table 6.3.1 Impact of Ageing Well Involvement on Clients' Health and Wellbeing

	Improved a lot	Improved a little	Stayed the same	Reduced a little	Reduced a lot
My knowledge about the importance of physical exercise has	17	13	1	0	0
My level of exercise has	14	14	3	0	0
My knowledge of healthy eating has	11	8	12	0	0
My consumption of healthy foods has	11	8	12	0	0
My social circle has	21	9	1	0	0
My knowledge about home safety has	13	8	10	0	0

Ninety per cent (n=28) also reported that their level of physical exercise had improved. For three clients their level of physical exercise had stayed the same but this was because they already were quite active and had always exercised regularly. Knowledge of home safety was also reported as having improved by 68% of clients (n=21). However 10 clients reported their knowledge of home safety had stayed the same.

Whilst 61% (n=19) of clients reported that their knowledge and consumption of healthy foods had improved, 39% (n=12) reported no change. The reasons given for reporting no change included that some clients already had a good knowledge of health eating and ate healthy foods and therefore no change was deemed necessary. However for a small minority of those reporting no change this was because they enjoyed their food

and were not prepared to change their eating habits as reflected in the following extract:

'No I eat anything I fancy, if I fancies it I eat it and if I don't I don't and if I goes I goes' (75 year old male).

Clients provided numerous specific examples of how their involvement in the Ageing Well projects had impacted on their health and wellbeing. One client had been diagnosed with hypertension through the health screening provided, two reported losing weight, one stated that she had been helped to cope with the menopause, a further client reported that her breathing had improved since taking up the swimming classes, whilst another reported that her diabetes was better controlled. There were many examples of clients reporting the easing of aches and pains, improved suppleness and mobility and in one case a reduced need for chiropractic treatment as a result of involvement in the exercise projects:

*'Aches and pains in the morning. Once I get here and do the exercise, I feel wonderful' (*74 year old female).

'Much more able to get about than 3-4 years ago. Miss it [exercise class] *when I don't go – it affects the arthritis'* (69 year old female).

'It's [the exercise] *one way to keep fit. It's not just the exercise, different people come, so we meet different people'* (82 year old male).

However, as the extracts indicate attending the exercise classes not only improved physical health but also impacted on clients' emotional and social wellbeing:

'My mental health and social circle has improved through mixing with others in the class [seated exercise class]' (86 year old female).

'I have made a lot of friends through coming here and feel more active and happy' (72 year old male).

Many clients referred to the importance of *'getting out of the house'* and that involvement with the projects prevented them from being at home and for some being on their own. Attendance at the projects therefore contributed to combating social isolation and reducing associated detrimental effects on emotional and mental wellbeing. Two clients reported that through attending the projects it enabled them to put their own problems into perspective as indicated in the following extract:

'. . . I don't think I worry as much as I did. When you broaden your circle you can see that people are worse off than you. They have problems and you are better off' (S1, 75 year old female).

Four clients reported receiving practical benefits in the form of aids and adaptations to the home, such as a bath seat and hand rail and information regarding welfare benefits to which they were entitled after having attending talks from external speakers provided through the Ageing Well projects.

6.3.2 Impact on Health and Wellbeing of Family and Friends

Nine clients (29%) reported that their involvement in the Ageing Well projects had not had an impact on the health and wellbeing of their family or friends. A few clients reported that this was because families were living away.

Of the 22 clients (61%) who reported that there was an impact, this was mainly in relation to sharing information which had been gained from attending the projects. Much of this health information related to healthy eating as indicated in the following extracts:

'Like say for instance my grandson it always used to be Cola, it's water now. He's 11 years old….he used to have lemonade and juice together, now he doesn't' (73 year old female).

'My wife has stopped using fattening stuff, less butter, oil and cut down on rice to twice a week….no sugar and things like that and plenty of vegetables and brown chapatti' (72 year old male).

'My 85 year old mother now eats more healthily. She enjoys hearing what I do and I can show her some exercises' (59 year old female).

The latter extract also indicates that some clients shared and demonstrated the exercises they had learnt from the exercise projects, and encouraged their friends and family to take up exercise.

Four clients had encouraged their family, friends and neighbours to join the projects, whilst five clients reported that their involvement at the projects meant that their families worried less about them. The families knew where they were, that they were safe and getting involved in activities as illustrated in the following extracts:

'It is reassuring for my family that I am keeping active and taking part in activities – they don't tend to worry as much' (82 year old widow).

They're not so worried about me now' (69 year old divorced female).

6.3.3 Main Benefits of Ageing Well

Clients reported more than one benefit. Social benefits were reported by the majority of clients, as can be seen from Table 6.3.3 below. This was a recurrent theme reported throughout the client interviews.

Table 6.3.3 Main Benefits of Ageing Well

Benefits	Frequency
Social benefits/meeting people/getting out of the house	28
Keeping physically active	9
Getting out of the house	8
Improves mental well being	5
Provides information	3
Broadens your life	3
Not to be a burden on others	2
Provides reassurance	1
Simple way to improve health	1

Clients enjoyed meeting other people from a range of different backgrounds and getting out of the house:

'The main thing is companionship and friendship' (80 year old female).

'I get a good feeling coming here, enjoy coming. If you stay at home you feel low and depressed' (68 year old female).

'You have a laugh here. At home you are speaking to the wall' (56 year old female).

'Meeting people, company. Just getting out and about' (82 year old female).

'Meeting people from all walks of life' (75 year old male).

A couple of clients specifically mentioned enjoying being involved in an activity with people of a similar age:

'In a group the same age and generation – all of us together, own little stories to tell' (69 year old female).

The age range of clients attending the groups ranged from 56-86 years, although many were in their seventies. However, it cannot be assumed that the interests and needs of clients aged in their fifties are necessarily similar to those aged in their eighties.

It is apparent from the extracts that whilst attending the activities provided social benefits, clients' emotional and mental and wellbeing were also enhanced.

Nine clients specifically mentioned keeping physically active although this was usually reported in conjunction with the social benefits as illustrated in the following extracts:

'The social aspects are very important as well as the physical benefits for your health' (82 year old female).

'Activity and then the social connection' (74 year old female).

The overwhelming majority of clients (97%, n=30) reported that they would recommend the Ageing Well projects to their friends and family. The one client who would not, stated that she does not provide recommendations. The main reason for clients' responses related to the social benefits which the projects provided. Twelve clients reported that they enjoyed the company and that involvement in the projects improved social contacts:

'*Yes particularly if you live alone. Company very enjoyable. Have a laugh and get to know each other*' (68 year old female).

'Yes – gets us out of the house, motivates us. We have met a lot of nice people also' (67 year old female).

'Yes it keeps you going and you can enjoy the company' (82 year old female).

Two clients reported that it provided something to look forward to, whilst a further client highlighted that the environment was safe. One client commented on the physical benefits whilst a further client stated that awareness of other services was raised through attending the projects. Finally one client commented that it put your own problems into perspective.

6.4 CHANGES SUGGESTED TO AGEING WELL

Nineteen clients (55%) reported than no changes were required whereas 45% (n=14) felt that some changes could be made.

6.4.1 Extending existing provision

The main change suggested related to extending the existing provision, either through providing more sessions (n=3), longer opening times (n=2), providing evening activities (n=1) or just keeping the project open (n=1). Two clients requested that the health screening should be restarted, with a further client emphasising the need for continuity of activities especially with respect to the health screening. One client requested more information on home safety.

6.4.2 Provision of additional activities

Eight clients requested that the following activities/services be provided: a walking group in the Summer, complementary therapies (e.g. relaxation and massage), ballroom dancing, hairdressing, establishing a bowling league, day trips (n=2) and a Christmas party. It is acknowledged that most of these activities are provided within the Ageing Well programme, but it would seem are not being provided at the projects surveyed.

6.4.3 Location and environment for activities

The third most frequent reported change related to the location or environment where the activities were held (n=6). Two clients wanted activities to be more centrally located, whilst the remaining four made comments related to the environment in which activities were held. One stated more space was required and three clients commented on the need for better seating, improved access (i.e. provision of a ramp) to the toilet and a raised toilet seat and better lock on the toilet door.

6.4.4 Organisation and delivery of activities

Five clients made suggestions which related to the organisation and delivery of activities. Suggestions included better advertising and promotion of activities, commencing walking activities on time, having more volunteers to run groups, having more people in some of the groups and providing a men only group.

6.5 OTHER COMMENTS

Twenty clients made additional comments. Over half of these comments related to maintaining, extending and generally praising the service. Comments reflected the need to maintain the service and that all the staff were friendly and helpful. Additionally to provide longer opening times, extend the service to other areas and to those who were less fit, encourage more men to attend and that the service should be government or lottery funded. The following extracts provide a flavour of these comments:

'I would like to see it expand. It gives you choice – whether to attend. See it elsewhere, develop it. We need to keep using it to keep it going. I hope this spreads and doesn't fall flat' (61 year old female).

'How to involve more men? Men have more ill health, because they overdid things in their working lives' (67 year old male).

'Would like to thank Age Concern for running the service. Would be greatly missed if it stopped. Feels it should be government funded. Feels lottery money should be given to this project' (75 year old male).

Other comments made reference to gaining a lot of information and that holding the activities in a local housing complex had raised awareness of the need for the housing managers to do more to promote health with their residents:

'Just very nice that the groups were set up in the first place. Lots of knowledge given to us and very interesting speakers' (68 year old female).

'Age Concern events in the Housing Complex made the managers there aware that they should do more about `keeping healthy'. They now do a lot of activities' (81 year old female).

Finally one client asked what would be outcome following this evaluation as she had previously been interviewed for another evaluation

'Who is going to take this forward? We have been interviewed before' (74 year old female).

CHAPTER 7
DISCUSSION

The Ageing Well programme received an extremely enthusiastic response from everyone who took part in the evaluation. Involvement in Ageing Well was seen to have had a positive impact on the mental and physical health of the majority of participants in particular social wellbeing. The evaluation identified the valuable contribution that older volunteers make in promoting the health and wellbeing of people aged over 50 years and sustaining broader strategic public health objectives for active ageing.

This chapter addresses three key objectives of the evaluation which were to examine:

- The Ageing Well programme in practice.
- Practicability of the Ageing Well core training material and support and supervision for paid and voluntary staff.
- Impact on health and wellbeing of coordinators, volunteers and clients.

It then summarises the lay health mentoring model within Ageing Well. This chapter draws together the findings from the three groups of informants: coordinators, volunteers and clients.

7.1 PROFILE OF COORDINATORS, VOLUNTEERS AND CLIENTS

Volunteers and coordinators brought together a breadth of skills and experience to the role, with two-thirds of coordinators having been in post for more than two years. Nine coordinators out of the sample of 33 had been in post for more than five years. Two- thirds of volunteers had been with Ageing Well for 2 – 5 years, with a further third having taken part for more than five years. The length of time coordinators and volunteers had been engaged with Ageing Well suggests continuity over time. In terms of backgrounds, experience and skills there were similarities in the profiles of coordinators and volunteers, with significant proportions of coordinators and volunteers having professional or management backgrounds. On the other hand a quarter of clients came from professional backgrounds, with the remainder being housewives, having had skilled or unskilled manual occupations or had been in receipt of welfare benefits prior to reaching retirement age.

The gender profile of coordinators, volunteers and clients revealed that the vast majority of each group recruited to the study were women. The majority of volunteers (63%) were married compared to just over half of clients. One third of volunteers and clients lived alone. It is noteworthy that Ageing Well is appealing to an older group of volunteers and clients, with a minority of both being in mid-life or the 'young old' group. The age span of volunteers ranged from 25 – 85 and 56 - 86 for clients. The age range of volunteers and clients is broadly similar, with little difference in the profile of men and women, except that there were slightly more women in the age bands under 50 and over 80 years. This contrasted with the National Survey of Volunteering in the UK (1997) where it was found that men and women were equally as likely to volunteer. The same survey also found that volunteering peaked in middle age with a decline in numbers following retirement, although an increasing trend of volunteering in this age group was found when compared with an earlier survey. BME volunteers

and clients tended to be slightly younger than their white counterparts, with the oldest volunteer being 74 and the oldest client, 73 years.

In relation to the BME and male volunteers, closer scrutiny of the data did not reveal significant differences in skills and socio-economic background, reasons for volunteering and types of activity involved in between their white counterparts in the case of BME volunteers, or women in the case of men. All volunteers under the age of 50 were from BME backgrounds. All BME volunteers were involved in projects focused upon meeting the needs of minority ethnic communities. The numbers of both male and BME volunteers in the sample were small.

7.2 AGEING WELL PROJECTS AND ACTIVITIES

The evaluation revealed a diversity of project types and differences in experiences for coordinators, volunteers and clients involved in Ageing Well in England and Wales. Since it was created some 14 years ago the programme has developed in breadth and depth. It has developed from a base of nine projects in the early 1990s to 88 in 2007, with more projects in development in Wales. The programme however will see some projects close this year due to lack of continuation funding. The diversity of projects is due to efforts made to match project goals and activities against the needs and wishes of volunteers and clients in local communities.

The projects that participated in the study were developed to provide health promotion activities for people aged over fifty years living in deprived urban communities or others who lived in isolated rural communities. Some projects targeted hard-to-reach social groups such as people from minority ethnic communities, people living in socially disadvantaged localities, or men. About half of the projects enabled older people to participate in a broad range of physical activities such as walking or exercise classes, complementary therapies, arts and history, reminiscence, healthy eating and other health-related talks. Other projects were focused on single activities, such as exercise, or delivering support to isolated individuals in their own homes, people living in residential care or people with mental health problems.

The settings in which activities were delivered varied with some older people attending activities in their local day centre or community hall, and others being visited in their own homes or residential care setting. A feature of Ageing Well is capacity-building and outreach work. The majority of volunteers heard about Ageing Well through their local Age Concern and the second most typical source of information was through an advertisement or feature in a local newspaper, newsletter or leaflet. However clients were more likely to join Ageing Well because of personal recommendation from friends or family, or health or social care providers including physiotherapists or GPs. It was clear that not all volunteers and clients were aware of the national Ageing Well brand and knew their project by its local name (e.g. Age Concern, Healthy Living Programme).

7.3 ATTENDANCE AT ACTIVITIES

Most of the clients who took part in the evaluation joined in Ageing Well activities at least once a week, with about a half of the sample taking part more than twice a week. Clients of projects reported that they enjoyed physical exercise whether seated, keep fit or walking and they also valued the companionship of other people. Talks on health advice, welfare benefits or local history, as well as dancing, IT and

crafts were also popular. Men were more likely to join walking groups or exercise sessions or talks provided by external speakers. The number of male participants was small so these findings should be treated with caution. The most requested additional topics included health advice, information for carers, health screening checks, outings and day trips. These items were listed by the clients who were interviewed and some of these activities were already provided by other projects. However, clients also suggested that health information should be provided in formats more readily accessible to older people including languages other than English or Welsh. A need was also established for health information to be provided in a way readily understandable to older people. A third of all clients were involved in other health-related activities in their communities and a further third took part in other community activities such as Good Neighbour Schemes, Home Start or the Women's Institute. A number of clients were volunteers in charitable schemes.

7.4 FACTORS THAT FACILITATED THE DELIVERY OF AGEING WELL

The enthusiasm and motivation of national and local Ageing Well managers, coordinators and volunteers were key to the success of Ageing Well. Coordinators and volunteers were motivated by the opportunities that Ageing Well offered to make a difference to the quality of life of older people. When asked to explain why they had volunteered for Ageing Well, the most common response of mentors was that they *'wanted to get more out of life'* or they had *'time to spare'*. Asian volunteers (and coordinators) described wanting to use their knowledge and skills to help improve the quality of life for people in their BME communities. Sharing their interests in exercise, dance or IT were also motivating factors.

Coordinators, volunteers and clients gained mutual advantage from a supportive project environment. Observing health gains made by clients were also important for coordinators and volunteers and in turn clients were motivated by the friendliness of coordinators and volunteers. Coordinators and volunteers described being able to use skills acquired in the workplace, such as nursing, complementary therapies or administration, or in other voluntary work. Both groups stated that the following personal attributes and skills were helpful in the role: liking older people, good communication and listening skills, a sense of humour and empathy. BME coordinators and volunteers emphasised the importance of understanding the culture and barriers that people face.

Some issues such as access to public or private transport were mentioned as factors that enhanced delivery of Ageing Well, but these same issues could create obstacles too. Good transport links, provision of transport such as 'Dial a Ride', being able to drive or walk to accessible venues enhanced participation. Other clients and volunteers, however, reported difficulties getting to projects where private transport was unreliable or projects were based on busy main roads. Free bus passes which enhanced participation in some projects were useless for clients of schemes away from bus routes or where public transport was infrequent.

Funding was also mentioned as both a facilitating factor and a barrier to development of Ageing Well. Coordinators required information about the strategic priorities of different health organisations in order to secure funding. The recent policy climate that promotes the development of preventative health initiatives for the over 50s had fostered partnerships with health partners, such as PCTs or LHBs, and new funding opportunities (such as Wanless monies, Big Lottery, Older People's Strategy grants in

Wales). However the short-term nature of some funding streams created uncertainty and instability that preoccupied many coordinators with an inevitable impact on stress levels. Volunteers and clients were not immune from anxiety about the future of their projects. Charging for activities was one solution introduced by some projects and being considered by others. Some projects introduced charges, for example, 50p for an exercise class to £5 for two hours of bowls, and another was in the process of negotiating membership fees. The majority of the clients who were interviewed reported that they would be willing to pay charges where it was necessary to sustain projects. However both volunteers and clients felt charges could deter low income older people from joining in and so their introduction should be approached with caution.

7.5 FACTORS THAT CHALLENGED THE DELIVERY OF AGEING WELL

Coordinators also identified problems in developing partnerships with the statutory sector, as the role of voluntary initiatives such as Ageing Well in the preventative, active ageing public health agenda was not always fully recognised. This attitude together with a dearth of evidence in the UK to support the lay health mentoring model may undermine development.

The second challenge, linked to the lack of robust evidence, is the doubts and anxieties of health professionals. These include clinicians concerned that lay people may give the 'wrong' health information and that they are not able to respect confidentiality in the same way that professionals are bound. However, an understanding of the lay model shows that the key role is in *interpreting* professional information and advice in a way that understands the values and beliefs of the person. The level of health information would cover mainstream health messages, for example, five portions of fruit and vegetables a day, promoting exercise, smoking cessation sessions. The issue of confidentiality relates to good volunteer practice in training and support, of which Ageing Well and Age Concern have vast experience. It requires making that case to professional doubters.

It was evident that not all coordinators gave their volunteers information about Ageing Well and the training received by some volunteers did not include information about Ageing Well. Thus some volunteers and clients were unfamiliar with the concept. However, this evaluation did not encounter any of the resistance to a nationally-led Age Concern initiative in an essentially locally run network of Age Concern branches that was observed during the pilot phase (unpublished evaluation of the pilot programme for Age Concern England, 1997). Some coordinators suggested that the name Age Concern denoted late age and was not a positive image for the 'young old' whom the programme also hoped to attract. Consideration needs to be given to the age span and differing levels of fitness that Ageing Well currently seeks to bring together as 'peers'.

A fourth challenge in developing a lay health approach to healthy ageing involves the difficulty of recruiting the 'right' volunteers or paid workers from deprived communities. The essence of the model lies in involving people who relate to each other's circumstances, and to reach deep into communities to address inequalities. This issue is also relevant for recruiting volunteers into Ageing Well from groups who are under represented in the programme. These include in particular people in midlife and men. Recruitment through a community development process and accessing local

networks would reach a wider group, as well as working through community 'champions'.

The recruitment and retention of volunteers was also seen as a difficulty by some coordinators and volunteers. As well as the funding issues discussed above, volunteers also mentioned personal issues such as lack of time, other volunteering or caring roles as impeding their involvement with Ageing Well. Clarity of what Ageing Well is and the possibility of a range of ways to get involved as volunteers (see typology of volunteering below) has the potential to address some of these issues. Also the opportunity for people to learn new skills and extend their volunteering role as they develop in confidence can be offered. For example, the health trainer model offers people a qualification through national competencies, of which the delivery of the training can be tailored to the needs of local people. Another incentive may be payment for leading activities.

7.6 TRAINING OF VOLUNTEERS

Capitalising upon the skills of a lay workforce requires the provision of adequate support and supervision. A key objective of the evaluation was thus to identify the views of coordinators and volunteers on the content and delivery of the SHM core training material supplied by the ActivAge Unit. The evaluation found examples of good practice and in relation to initial, as well as ongoing, training. The most common model was for coordinators to use elements of the 'core training pack' to supplement local training to meet volunteers' needs. It became apparent, particularly in relation to the training that was provided to volunteers that coordinators interpreted the over-arching national guidelines for the Ageing Well programme in relation to training with some flexibility in order to meet local requirements. Some coordinators used the whole of the pack and some did not use it at all. The majority of coordinators stated that it was comprehensive, relevant and easy to understand and stated that after training volunteers were prepared for their roles.

Eighty per cent of volunteers had received training when they joined Ageing Well and the majority of these stated that the training they received was also comprehensive, relevant and easy to understand. However, it was clear that most were unfamiliar with the idea of a 'core training pack'. Thus the research team questioned volunteers about their training in terms of whether it gave them sufficient knowledge to undertake their roles. About half of the sample of volunteers who had been trained had received training in the 'core training' topics, together with supplementary sessions. Sixty volunteers participated in additional training that filled gaps in their initial training, leaving nine volunteers who had not had any training. Most volunteers who had been trained also stated they had learnt a lot from the training, it was at the right level and they felt prepared for their roles. Practice in delivering training varied across projects, with some coordinators undertaking most of the training, and others bringing in outside speakers where appropriate or sending volunteers to local colleges for training. Two-thirds of volunteers were trained over two or more days, with a quarter being trained in one day mainly in 'specialist' areas. Projects that were located within local Age Concerns supplemented Age Concern training with additional topics to meet local needs. Of the group of 19 volunteers who had not been trained when the joined Ageing Well, the most common reason given was they had already been trained by Age Concern. Of the 40 who had not had additional training, the most common reason was lack of time due to other commitments.

Both coordinators and volunteers pointed out shortcomings in relation to training. Coordinators working with minority ethnic communities questioned the core training pack's appropriateness in terms of both language and relevance for different cultures. Delivering the entire content was also considered by some coordinators to be unnecessary for volunteers who led specific activities such as walking groups or IT classes, or for volunteers who undertook support roles such as record-keeping. The main concerns of volunteers varied according to their backgrounds and skills. Some volunteers with professional backgrounds argued that the training lacked depth and others including people with one day 'specialist' training would have preferred earlier and more in depth sessions to enable them to feel more confident in their roles. Inevitably suggestions for changes to training varied according to the project in which volunteers were placed. Volunteers' main suggestions for changes to training included adapting training to the requirements of the activities that volunteers intended to take part in and local circumstances (other local initiatives etc); offering more flexible training depending on the expertise of volunteers and ongoing refresher training that also enabled volunteers to meet together.

7.7 SUPPORT AND SUPERVISION

Support and supervision from coordinators are also key features of the lay health mentoring model. Ageing Well demonstrated excellent support models for volunteers, and particular strategies for supporting the different roles could usefully be developed. Volunteers require ongoing training, support and supervision and the resources required to provide this should not be underestimated (Visram and Drinkwater 2005).

The evaluation looked at support and supervision in a number of different dimensions. Vertical support included advice to coordinators from the ActivAge Unit, from coordinators to volunteers and from volunteers to clients. Horizontally support included peer support between coordinators, volunteers and clients. On the whole there were positive relationships at all levels. The exchange of views at Ageing Well network meetings was highly valued and informal communication was sustained between coordinators. Support from the ActivAge Unit was valued. Coordinators said they supported volunteers in a number of different ways including one to one meetings with volunteers individually or in groups to discuss their work, visits to projects to support volunteers and annual events to celebrate the work of volunteers. Volunteers stated that their main means of communicating with coordinators was via the telephone and face to face meetings. Coordinators and volunteers valued face to face meetings. Written communication was less well used and included newsletters, emails and letters. Some coordinators encouraged 'buddying' opportunities between volunteers. Coordinators were aware of social networks that developed between volunteers that gave practical project-related and personal support.

The majority of volunteers were satisfied with the amount of support they received, with the majority agreeing that they felt valued, had positive working relationships with coordinators and that support had been adequate. Some volunteers described the coordinator as a 'friend' and it was clear that friendships were common between volunteers. However when it came to assessing support from their peers, volunteers views were more mixed. The majority agreed that they were a source of support, but there were rather more negative reactions because volunteers could not meet with their peers for a variety of reasons including lack of time or poor public transport.

The mentoring relationship between volunteers and clients differed both in terms of the events and activities provided by projects for clients and the depth of the interaction that emerged between mentor and client. Volunteers were more likely to report developing relationships with small groups of clients, than the other way around. Clients reported being involved with one mentor in a third of cases, with the remainder of clients reported involvement with more than four volunteers, indicating that volunteers tended to focus on one activity with small groups of people and clients may take part at different times and in different activities led by a variety of volunteers. The majority of clients indicated that they received sufficient support from volunteers and commented that they felt motivated, encouraged and sometimes cajoled by volunteers. Some of the volunteers were viewed as friends and it was evident that a warm social environment was fostered in the six projects.

7.8 IMPACT ON HEALTH AND WELLBEING

Findings clearly indicated that clients, and to a lesser extent volunteers and coordinators gained health benefits from participating in Ageing Well projects. These findings support those identified by MacGregor and Sheehy (2004) in their evaluation of the Lothian Ageing Well projects. There was a clear consensus from coordinators, volunteers and the clients themselves that clients had benefited physically, socially and emotionally from participating in Ageing Well activities.

As might be expected clients reported a more positive impact on their health status than did volunteers. Whilst clients were not specifically asked about their health status or pre-existing health problems, clients voluntarily reported having arthritis which for some significantly impeded their mobility, suffered a stroke, been recently hospitalised and having chronic mental health problems such as depression. As the average age of clients was 71 years of age and nearly a quarter were aged 80 or over it is likely that many would have one or more chronic conditions. In Wales it is known that two thirds of over 65 year olds report having at least one chronic condition with one third having multiple chronic conditions. Two thirds of 85 year olds report having a limiting long term illness (Welsh Assembly Government 2007). Additionally some of the Ageing Well activities were provided in housing complexes or residential care homes which cater for older people who have additional health and social care needs. A third of clients interviewed lived alone and several commented that without Ageing Well they would be at home *'speaking to the wall'* which indicates the potential for social isolation. It would seem therefore that Ageing Well in England and Wales were attracting clients who were not all `relatively fit and had adequate social networks' which contrasts with the findings of the Lothian evaluation (MacGregor and Sheehy 2004, p47).

The majority of volunteers reported a positive health impact, although between a third to a half reported that their knowledge of and levels of exercise and healthy eating had stayed the same. This was because they were well informed about healthy eating and the importance of exercise prior to their involvement in Ageing Well and were generally fit and active.

There was also less impact on the health status and health behaviours of coordinators. For some this was because they already adopted healthy lifestyles. A minority had made significant changes to their health behaviours, whilst a few reported detrimental health consequences from their role which at times was stressful. The literature reports the pivotal role of the volunteer co-ordinator (Jones 2004, Merrell 2000) and

the need to ensure that they have sufficient support (Jones 2004, MacGregor and Sheehy 2004) so as not to become overburdened and experience burnout.

There were marked similarities in the most frequently reported health benefits for clients and volunteers, which were widening social networks and improvements in knowledge and levels of physical activity. Research has highlighted the importance of social support for promoting the health and wellbeing of older people, as there is reduced mortality and less mental health problems amongst older people who have access to adequate levels of social support (Kocken & Voorham, 1998, Oxman et al 1992). For older people lacking social support networks, the provision of support groups involving peers can act as `surrogate support systems' (Kocken & Voorham 1998, p16) which can help mitigate against the negative health consequences associated with social isolation.

Social benefits are also particularly important for volunteers. As the UK Survey of Volunteering 1997 identified volunteering is primarily a social activity (Davis Smith 1998). Research has also indicated that the development of positive relationships can sustain volunteer involvement (Pearce 1993). Our findings indicated that volunteers valued the relationships and friendships they had made through participating in Ageing Well. It has been shown that volunteering provides the opportunity to make friends, widen social networks, become more involved in the community and importantly have fun (Thomas and Finch 1990).

Over 90% of clients and over 60% of volunteers reported improvements in their knowledge and levels of physical exercise. Many Ageing Well activities are aimed at improving mobility and physical exercise and cater for the varying needs of older people by providing gentle seated exercise to guided walks, swimming and cycling. It is well established that obesity and physical inactivity are risk factors for the development of a number of diseases and conditions including diabetes, coronary heart disease and cardio-vascular disease (House of Lords 2005; Welsh Assembly Government 2003b). The risk of developing these conditions also rises with age. For example, 1 in 20 people aged 65 will develop Type 2 diabetes which rises to 1 in 5 people aged 85 (Welsh Assembly Government 2003b). Importantly our findings indicated that clients valued the social aspects of participating in a group activity as well as the exercise. Promoting physical exercise in older people therefore has many beneficial health consequences.

Participation in Ageing Well had the least impact on knowledge and consumption of healthy foods, although 61% of clients and over half of the volunteers reported a positive impact. It would seem that health messages about healthy eating had already been assimilated and adopted particularly by the volunteers. However, the importance of reinforcing health messages should not be under estimated. The findings also indicated that health information gained from participating in Ageing Well was shared with family and friends of clients, volunteers and to a lesser extent of coordinators. Additionally clients and volunteers encouraged and recruited family and friends to participate in the Ageing Well activities. Health information and knowledge about Ageing Well activities is therefore being disseminated throughout the community, which is a key component of the peer educator model (Bishop et al 2002).

The literature suggests that volunteering should be viewed as a health enhancing activity (VDS 2003) or as health insurance (Narushima 2005). It has long been

established that there are many benefits to be derived from volunteering, which include emotional, social and intellectual benefits (Inman 1995). Our findings indicated that the volunteers reported improved emotional wellbeing and high levels of personal satisfaction from helping others, which supports the literature on volunteering (Davis Smith 1998, Inman 1995) and on peer education (Barlow and Hainsworth 2001). Emotional benefits gained from volunteering include providing a sense of pride, achievement and self satisfaction, feeling useful and gaining confidence (Inman 1995). Our findings also indicated that some volunteers participated in Ageing Well as it provided them with the opportunity to maintain skills or acquire new ones and widen interests, which are reported as some of the intellectual benefits of volunteering (Mostyn 1983) and of peer education (Barlow and Hainsworth 2001, Kocken and Voorham 1998).

7.9 THE CONCEPT OF 'PEER' HEALTH MENTORING WITHIN AGEING WELL

Coordinators mostly discussed the concept of 'peer' mentoring of clients in relation to age. Being of a similar age facilitated the development of a relationship. However other characteristics of mentors, such as, personality traits, gender, geographical location, being part of the community, speaking the same language and being 'someone like me' were also important. The commonality of shared experiences owing to age was a significant factor for volunteers. It was suggested that being closer in age made for more credible role models. Being older and teaching new technologies such as IT was also seen as important to enhance the educational environment for older learners. Clients were invited to compare the approaches of volunteers and external speakers when leading activities. Once again age was a factor, with older volunteers being seen to have more in depth knowledge of clients' needs. Older volunteers were seen to have more insight into the strengths and limitations of older participants in exercise classes. Volunteers and clients described the friendships that developed within projects, between coordinators and volunteers, volunteers and clients, and clients with each other. However some clients singled out younger paid professionals for praise when they adapted their activities to suit the needs of older clients. Thus style, understanding and approach were just as important as age as far as some clients were concerned.

Our findings clearly identified the importance of the positive relationships which had developed between clients and volunteers and volunteers and the co-ordinator and their beneficial impact on health and wellbeing and for sustaining participation in Ageing Well. In general, clients had less direct contact with coordinators. The majority of volunteers reported developing close relationships with individuals or small groups of clients, whilst a third of clients reported mainly working with one volunteer. This contrasts with the findings from the Lothian evaluation into Ageing Well which identified that mentors preferred to work with large groups of mentees, rather than develop the close one to one relationship implied in the peer mentoring model (MacGregor and Sheehy 2004). However, despite mainly working with individuals or small groups of clients our findings indicated a lack of clarity with regard to the concept of peer mentoring. There was evidence of ambiguity in respect of the title Senior Health Mentor which was rarely used in practice by clients or volunteers. Not all of the coordinators were clear about the concept of peer mentoring or that training was a necessary pre-requisite for this role. This is not unexpected as there is a lack of clarity within the literature with numerous titles, models and definitions being proposed (Bishop et al 2002, Barlow and Hainsworth 2001, Earp and Flax 1999). Whilst there was evidence that some volunteers were

working as peer educators/mentors and clients were able to identify and name particular volunteers, other clients were unclear as to who were paid and who were volunteers.

Within Ageing Well a range of volunteer roles has evolved to meet the diverse needs of the service and those of the volunteers. Some volunteers fulfil the important tasks of welcoming clients, providing refreshments, taking registers and preparing venues for activities, some have extended their role to lead activities and groups, whilst others are working with clients on a one to one basis as peer mentors. Peer mentoring has been defined as 'the development of a close relationship between two people in which the mentor will actively guide and assist the mentee in making necessary changes in his or her own life' (Clutterbuck and Megginson 1999 as cited by MacGregor and Sheehy 2004). Bishop et al (2002) in their study of the implementation of the natural helper lay health advisor program in North Carolina identified that there was ambiguity regarding the lay health advisor role and proposed that it may be useful and an asset to the program to develop other tasks in addition to the lay health advisor role to avoid alienating people who wish to contribute to the program. In this way a broader range of people may be attracted and recruited to the programme.

It is interesting to note that there is evidence to suggest that some people aged 55-65 are attracted to more structured volunteering which affords a status such as that of lay leader or peer educator, which helps to fill the vocational void left by retirement. Other key motivational factors include feeling useful through directly helping others and therefore making a valuable contribution to society and finding a peer group (Barlow and Hainsworth 2001). A Canadian study of community volunteering among older people identified that volunteering was used by volunteers who were recent retirees as a self-help strategy to sustain their sense of self and to cope with their feelings of exclusion from society (Narushima 2005). It would seem therefore that the factors which motivate people aged 55-65 years to volunteer may differ from those aged 65 years and over but with an ageing population there is an increasing pool of retired people who have a valuable and important contribution to make to maintaining and improving the health of their peer group. Ageing Well offers an opportunity for older people to be engaged in a community-based style of care which may be more appealing than volunteering in mainstream health and care services where the role of volunteers is being marginalised because of growing emphasis on budgets and achieving targets (HM Treasury 2002).

7.10 DEVELOPING THE LAY HEALTH PROMOTION MODEL IN AGEING WELL: A TYPOLOGY OF VOLUNTEER ROLES

Challenges to the implementation of healthy active ageing initiatives have been highlighted in the discussion above. These include the lack of a robust evidence base that demonstrates how using lay health workers can improve health and reduce inequalities. This is primarily because of a lack of large-scale studies, particularly in the UK, and even fewer that specifically involve older people. However, experience in practice, including within Ageing Well, shows that involving lay people from communities to reach their peers with health messages can be successful (Coull *et al* 2004; MacGregor and Sheehy 2004).

Despite the programme being promoted as one that utilised the skills of 'senior health mentors', few volunteers in our total sample of 46 projects were actually known by this title. Coordinators, volunteers and clients mainly referred to 'volunteers', with a

minority reported to be 'senior health mentors'. However interviews with all groups of participants revealed that despite not being called 'senior health mentors' many volunteers were actually engaging with clients in a continuum of mentoring roles. The literature reviewed in Chapter Two identified three different categories of lay health worker. These were lay health advisers or natural helpers, peer educators and advocates. These categories do not translate across to Ageing Well, but do offer an insight into the value of defining different roles within one approach. Scrutiny of the roles undertaken by volunteers found a spectrum of roles undertaken by volunteers which enabled the development of a typology of volunteer mentoring within Ageing Well to be constructed including 'volunteers', 'activity leaders' and 'community health volunteers / senior health mentors' (see Table 7.10 and Vignettes A – F in Appendix 3 to illustrate different roles).

Table 7.10 Typology of Ageing Well 'Volunteers' (Community Workforce)

Definition	Role	Training
Volunteer Vignettes A & B Appendix 3	Assists at Ageing Well activities, e.g. welcomes people, takes records, serves refreshments, sets up venues, assists people with mobility problems. Hands out leaflets, encouraged to take an interest in others' concerns. Unpaid	Core Age Concern Volunteer training. May or may not include 'Ageing Well Core Training'.
B. Activity leader (volunteer) Vignettes C & D Appendix 3	Leads specific group activities, e.g. Extend, IT, walking groups, Nordic walking May or may not receive payment /expenses People encouraged to share their interests with others	Core Age Concern Induction Training, plus specific training for activities, or previous experience/ qualifications, e.g. Extend training, Walk leaders, IT experience Subsequent training may reflect items in the 'Ageing Well Core Training' such as diet, alcohol, exercise etc
C. Community (health) volunteer (*SHM model*) Vignettes E & F Appendix 3	Work in local communities ('natural helpers',) to encourage their peers (older people) to take up healthy activities; support peers to attend sessions; offer information on healthy lifestyles such as diet, falls prevention, social networking	Core Age Concern Induction Training, plus 'Ageing Well Core Training' on health improvement and older people; specific health information on diet, alcohol, exercise, etc

Some project coordinators reported that they were developing 'health trainers' in their projects. One of our mentor interviewees had been trained as a 'health trainer' but one was no longer working in this paid role and another (aged 25 years) was taking

part in a pilot scheme and so we have not included vignettes of the health trainer role – nevertheless we suggest that Ageing Well continues to develop this model in the future.

Greater clarity about the volunteer-led activities in Ageing Well has the potential to increase the client base, as well as make Ageing Well more attractive to volunteers. As volunteers grow in confidence they may wish to change and extend their volunteering contributions. The new directions for community services, *Our health, our care, our say* (Department of Health 2006) refers to the importance of the lay health promotion model in supporting 'life checks' at critical points in the life course, and in particular, for people around the age of 50 years. The Department of Health is currently planning the roll out of these life checks to people aged 45-60 and trained volunteer health mentors could play a vital role in its success through the network of Ageing Well projects. Some Ageing Well projects may wish to be 'early adopters' of this initiative.

7.11 ADOPTING A GENDER SENSITIVE APPROACH IN AGEING WELL

The evaluation has shown that Ageing Well is predominantly a service populated by women. The findings reflect those of a recent Age Concern review, 'Working with Older Men' (Ruxton 2006), which found that the majority of Age Concern services are 'female dominated'. The review was prompted by a desire to understand some of the barriers that prevent older men using services and concluded that the most important issue was for organisations to have a strategic approach to working with older men that is appropriate to their individual circumstances and the needs of their communities. Examples include taking initiatives to where men are (quizzes in pubs, health checks in barber's shops, football matches), offering health checks in the workplace for men aged 50 – 65 years; following guidelines reproduced on the Men's Health Forum website to produce health information designed to reach men of all ages.

7.12 INVOLVEMENT OF BLACK MINORITY AND ETHNIC GROUPS

There is also an under representation of BME groups among Ageing Well volunteers. It is acknowledged that opportunities to contribute and participate in volunteering are not evenly spread across all groups of society and that people of Asian background are less likely than their white or black counterparts to become involved in volunteer work, suggested reasons for this are factors related to culture and tradition (Department for Work and Pensions 2005). Language difficulties may be another possible barrier with lower numbers of English speakers among older Bangladeshi and Pakistani women. These factors may contribute to why the younger volunteers in this evaluation were from minority ethnic groups.

Coordinators working with ethnic minorities acknowledged that speaking the same language and being from the same community facilitated recruitment of volunteers and enabled Asian Elders to participate in activities that otherwise may not have been possible. Therefore the coordinators and volunteers were able to link into informal and formal networks within the community. Gaskin (2003) found that the practice of giving voluntary help runs deep in many BME communities but diversity produces a range of cultural understandings of volunteerism and organisations hoping to attract BME volunteers need to be aware of this diversity.

CHAPTER 8
CONCLUSIONS AND RECOMMENDATIONS

The Ageing Well programme is part of an innovative European health promotion programme for older people. It adopts a preventative approach to reducing illness and disability and promoting good health. It is based on the core concepts of peer mentoring, volunteering and health improvement through capacity-building amongst older people. This is the first national evaluation report of Ageing Well in England and Wales. It included two types of evaluation:

- Process evaluation – exploring the training, support and supervision of volunteers.
- Outcome evaluation – explore the outcomes in terms of the mental and physical health of coordinators, volunteers and clients.

The programme continues to be in tune with the current policy environment that promotes preventative health and seeks to optimise opportunities for healthy ageing. However in drawing upon the contributions of clients, volunteers and coordinators and the lay health mentoring literature, this chapter concludes that there is scope for improvement and redevelopment to build on achievements to date and to reshape Ageing Well for the future.

8.1 MAIN FINDINGS:

- The 'senior health mentor' model adopted in Ageing Well is not fully recognised across all projects and the majority of volunteers were not known by this title even where they were undertaking a mentoring role with clients.

- The Ageing Well programme successfully delivers a diverse range of projects and activities that offer health-related information and advice, exercise sessions, healthy eating and arts and other social events. Projects may be generic and deliver a broad range of activities, or they may focus on specific health conditions, such as falls prevention.

- Older people may join in activities in local community centres, or activities or treatments may be taken to them individually in their own homes or in a care home setting.

- The programme is delivered by paid coordinators, together with the support of volunteers and some paid activity leaders and outside speakers. The role of coordinators is pivotal in supporting the needs of volunteers and clients.

- The programme appealed mainly to volunteers and clients over 60 years of age and more needs to be done to attract people in mid life.

- Other key challenges include: sustainability and funding issues; developing partnerships with statutory and other voluntary providers; recruiting and retaining a volunteer workforce.

- There were shortcomings in record-keeping, for example, of clients' health status on joining a project and characteristics of the volunteer workforce.

- The majority of volunteers had received training to undertake their volunteering role within Ageing Well, but their training did not always fully comply with the 'core training pack' provided to coordinators. Nevertheless, volunteers' training was considered to be comprehensive and relevant by most coordinators and volunteers.

- Most coordinators and volunteers were positive about the support and supervision they received to undertake their roles and the vast majority of volunteers felt valued. Being part of a national network gives local projects a valuable identity.

- Coordinators, volunteers and clients reported health and social benefits from taking part in Ageing Well, with the most gains been reported by clients. Some coordinators and volunteers reported long-standing interest in fitness or diet and thus their exercise levels and knowledge of healthy eating were more likely to have stayed the same as they maintained their health status.

8.2 RECOMMENDATIONS

The Ageing Well model

- The concept of Ageing Well should be more clearly defined in order to strengthen the model and build on good practice within the programme.

- Age Concern England's ActivAge Unit and Ageing Well in Wales should work with coordinators, volunteers and clients to agree and promote shared definitions of the range of volunteering and mentoring roles within Ageing Well.

- Consideration should be given to revising the 'senior health mentor' title. A title with 'volunteer' included in it may be most appropriate.

- Consideration should be given to revising the Ageing Well membership categories 'active' and 'regular' projects.

- A typology of volunteering roles is suggested that has the potential to increase the client base and make volunteering more attractive to a wider range of people including those approaching retirement, in mid life or seeking to increase their job prospects.

- Consideration needs to be given to the age span and differing levels of fitness that Ageing Well currently seeks to bring together as 'peers'.

Recruitment of volunteers

- Recruit more men and people from minority ethnic groups by developing strategies to address their particular needs.

- Work with local employers to increase the pool of volunteers at part of pre-retirement planning.

Training

- A national resource pack should be developed in consultation with coordinators, volunteers and clients, which covers the key principles of Ageing Well as a

health mentoring model. The resource pack could be adaptable to meet the requirements of volunteers taking up different mentoring roles. The pack would supplement the training already offered by local Age Concern volunteering programmes.

- The ActivAge Unit should consider developing training packages for supporting local trainers to deliver the training to their volunteers.

- Consideration should be given to supporting volunteers who wish to extend their role and train as nationally accredited NHS health trainers. The ActivAge Unit may wish to contribute a module to this national model on specific competences for health trainers working with older people.

Support and supervision

- Build on good practice and establish and promote a range of opportunities for coordinators to network and support each other. This may include buddying relationships between coordinators, clustering projects in areas of specific interest such as BME communities, mental health or men specific work, and more opportunities at network meetings to share ideas and examples of practice.

- Ensure that all volunteers have appropriate supervision that meets individual requirements.

- Establish a central database to provide accurate information on volunteers participating in Ageing Well.

- Refine project evaluation forms in partnership with local projects to establish benefit to local projects and ensure better return on information about client outcomes, for example, using questionnaires such as Short Form (SF) 12.

- Collate evaluation forms and provide feedback to the coordinators

Partnership/ funding base

- There is scope for Ageing Well to work more closely with statutory sector providers and community groups to increase the number of projects and to increase numbers of volunteers and clients. Links to the health improvement agenda and active ageing strategies would be particularly beneficial.

- Ageing Well offers distinctive advantages – the contributions of older volunteers to support their peers – and these core features should be retained.

- Longer term funding streams would improve sustainability, with less reliance on grants. For example policy changes to joint commissioning for health and wellbeing may offer a strong lever for statutory funding.

Clientele

- Seek to attract more men into Ageing Well as clients and as volunteers through adopting gender sensitive strategies.

- Ensure transport is available as this is one of the key factors which impedes participation.
- If considering charging for services, these fees would need to be nominal so as not to deter those from lower incomes.

- Consider extending the health screening provision, in particular through the midlife life checks currently being developed nationally.

8.3 SUGGESTIONS FOR FURTHER RESEARCH

- Focus groups with coordinators, volunteers and clients to agree definitions of volunteering and mentoring roles.

- Cost effectiveness analysis of Ageing Well.

- Building on improved record-keeping and data collection of clients' health status, undertake quantitative analysis of client's health gains alongside qualitative data collection.

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International Longevity Centre- UK: www.ilcuk.org.uk
Men's Health Forum: http://www.menshealthforum.org.uk/

APPENDIX 1
RESEARCH PARTICIPANTS

Participants from the following Ageing Well projects took part:

Healthy Living for Older People, Abertillery
Senior Health Shop Barry
Ageing Well Blackburn
Ageing Well Bolton
Venture Out, Bridgend, South Wales
Ageing Well Burnley
Camden Networkers Programme
Ageing Well Cardiff and the Vale of Glamorgan
Age Concern Cardiff and the Vale, Healthy Wealthy and Wise
Ceredigion Day Centre Project
Colchester Ageing Well Falls Prevention Service
Devon Lifestyle 50+
Dudley Leap over 60
Ageing Well Durham County
East Cheshire Healthy Lifestyles
Eastbourne Active Age
Enfield Fit for Life
Gateshead ActivAge
Ageing Well in Halton Reach for the Stars
Activage in Haringey
Healthy Living for Older People in Harrow
Kensington and Chelsea Healthwise
Ageing Well Knowsley
Health and Wellbeing Project, Llanelli
Ageing Well Merton
Ageing Well Montgomeryshire
Ageing Well Neath Port Talbot
Ageing Well Newham
50+ CHD Project, Newport, South Wales
Northampton and County Lifetime Project
North Tyneside Active Age
Ageing Well Northumberland
North West Cumbria Active Living
Active Ageing Pembrokeshire
Peer Health Mentoring, Sefton
Ageing Well Somerset
Ageing Well South Staffordshire
Ageing Well Counselling Stockport
South Tyneside Active Age
Ageing Well Stoke on Trent
Surrey Go 50
Lifelong Healthy Living Project, Usk
Ageing Well Positive Living and Mental Health Warrington
Ageing Well in Warwickshire
Wirral Active Ageing
Ageing Well York

APPENDIX 2
ADDITIONAL HEALTH-RELATED TOPICS/ACTIVITIES SUGGESTED BY CLIENTS FOR INCLUSION IN AGEING WELL

More health advice, specifically including diabetes, and information for carers	4
Health screening	3
Days/trips out	3
Crafts (painting and drawing)	2
Information on inheritance tax and welfare benefits	2
IT skills training	1
Music	1
Ballroom dancing	1
Photography	1
Outdoor activities	1
Walking group	1
Relaxation techniques	1
Keep fit	1
Lifting weights	1
More health information in other languages	1
Ensuring health information is meaningful for client group	1
Incorporating information identified by clients	1

APPENDIX 3 VOLUNTEER TYPOLOGY
VIGNETTE A Volunteer
Mentor : Mr C, aged 70, retired carpenter

Background and context
Mr C is a volunteer at a project that provides a range of activities including exercise and healthy eating in community centres and residential homes. He is called a volunteer.

Reasons for volunteering
Mr C has always been active in the community, in local politics, the residents' association and Communities First. He spends two or three days a week with the project and *'enjoys every minute of it'*.

Training and support
He was trained by a county-wide voluntary organisation umbrella group and his training covered healthy eating, food safety and hygiene, health and safety, how to complete grant application forms. He meets the coordinator 3 or 4 times a week when he *'pops in the office'. 'She's a very good friend'.*

Mentor role
Mr C assists with setting up venues, by doing the *'heavy work'* such as moving furniture. He hands out information leaflets and also assists clients with mobility problems, pushes the wheelchairs of clients when *'out on walks'.*

Impact on Mr C's health and wellbeing
Mr C said his emotional and physical health had improved *'I feel a lot healthier'*. He was motivated by the response from clients *'they're so glad to see me'. 'I love to talk to older people, you learn the value of life'.*

Mr C's view of impact on health and wellbeing of clients
He joined clients in healthy eating sessions with a nutritionist and knew they were now eating more fruit, pasta and rice based on recipes given to them. *'Some said they didn't like pasta, but when we made them sauces they liked it'.* Some clients had lost weight and this had eased their arthritis and joint pain.

APPENDIX 3 VOLUNTEER TYPOLOGY
VIGNETTE B Volunteer
Mentor15: Mrs A, aged 73, retired secretary

Background and context
Mrs A describes herself as a volunteer and is involved in a range of activities within the Ageing well project such as administration work, helping with form filling, welcoming people and handing out leaflets. She also attends the project's exercise class as a participant. She works as a volunteer at least once a week and has been involved with the project for several years.

Reasons for volunteering
Mrs A actively looked for 'anything to do with volunteers', she wanted to help people to get more out of life and to mix more with people. *'I want to help people'* and have a *'laugh and a giggle'.*

Training and support
Mrs A received initial Ageing Well mentor training a few years ago. The training was over two days and covered a variety of topics; Healthy eating, race equality, 'Heart Start', food safety and hygiene among other topics, *'these have stuck in my mind.'* She found the training very enjoyable, relevant and prepared her for her role and since then she has received refresher training. Mrs A describes the project coordinator as *'wonderful, she is kind and caring, she listens.'* She has regular face to face contact and if she doesn't see her for a fortnight, the coordinator will contact her.

Mentor role
Mrs A describes her way of working with older people as developing a close relationship with small numbers of older people, talking to them and giving them time when they are upset, asking them how they are and having a laugh. She is sometimes asked for advice she said that it was not her role to give advice, but she could give a leaflet or find out *'who could help here'.* Also, she talks to family members and friends about stopping smoking and eating a healthy diet.

Impact on Mrs A's health and wellbeing
Involvement in the Ageing Well project has had a positive impact on Mrs A's health; she looks after herself, eats healthily and attends the exercise classes. '*It's brilliant . . . it helps me.'*

Mrs A's view of impact on health and wellbeing of clients
Mrs A said that the opportunity for social contact is of great benefit *'It relieves they're anxieties'.* She says that some clients attend every day *'they enjoy the company, some are very old, we have a chat.'* It is a place where they clients come and share their concerns and also have a laugh, therefore having psychological and social benefits.

APPENDIX 3 VOLUNTEER TYPOLOGY
VIGNETTE C Activity Leader (IT)
Mentor 11: Mrs J, aged 62, retired administrator

Background and context
Mrs J is a volunteer IT tutor with older people in a project that also promotes exercise and health lifestyles. She is called a 'volunteer' and she is wary of the term 'senior health mentor' as she does not give health advice. She thinks the term 'senior health mentor' may put off volunteers as well as clients. Neither did she relate to the word peer – it was '*something at the end of the beach'.*

Reasons for volunteering
Mrs J enjoys sharing her computer skills and helping people reach their potential. She wants to enjoy her retirement and volunteering for short blocks of time, rather than every week, fitting around her personal commitments. She can plan her work with clients for a set time period and then have a break for several months.

Training and support
She uses her previous skills and her training involved an induction to Age Concern, volunteering and information on interpersonal skills. She felt the training was comprehensive and she was well-equipped for the role. The coordinator undertook a risk assessment before she meets clients. When she asks for support she gets it, but prefers to work on her own. She likes the informality and flexibility and her volunteering is an extension of how she used to work.

Mentor role
She teaches computer skills to clients on an individual basis in the local library or in their own homes for a maximum of ten weeks. She felt that as an older woman with IT skills she was a role model for others. Women would perceive her as someone who would understand their needs and men would not feel threatened by her.

Impact on Mrs J's health and wellbeing
She gains a very high personal satisfaction from the role. She has made friends in her village through visiting clients and meeting other volunteers.

'I do love people to achieve, I always have. I want them to achieve what they want . . . I knew I was going to retire and I knew if I didn't discipline myself to do something that took me out I would lose a lot of my social skills'.

Mrs J's view of impact on health and wellbeing of clients
One of Mrs J's 80 year old clients was now eating more fruit and vegetable as she could order on line from a supermarket. She had enabled her clients to retrieve health and work-related information from the internet and stay in contact with friends and relatives.

APPENDIX 3 VOLUNTEER TYPOLOGY
VIGNETTE D Activity Leader (Exercise)
Mentor 49: Mrs R, aged 74, retired teacher

Background and context
Mrs R runs Ageing Well chair based exercises classes twice a week in her local area. She is also very actively involved in other voluntary activities within her community, she is involved in voluntary activity '*sometimes everyday, but not at weekends'.*

Reasons for volunteering
Mrs R met the local Ageing Well Coordinator at another activity with which they were both involved and *'she asked me to become a volunteer'.* Mrs R likes to keep fit and she finds her previous occupation helpful to her role. She also said that she can help make a difference to clients' lives.

Training and support
Mrs R had received previous training with Age Concern; she has been offered training but is so busy she cannot fit it in. she has recently attended a one day refresher training for exercise leaders. Mrs R has frequent face to face meetings with the project coordinator whom she describes as '*excellent'* and '*has become a friend'*.

Mentor role
Mrs R runs two Chair based exercise classes a week, she also describes her way of working with older people as developing a close relationship with small numbers of older people. She illustrated this by giving an example of how she and class members supported a bereaved client.

Impact on Mrs R's health and wellbeing
Mrs R does not feel that involvement with the Ageing Well project has had an *'awful lot'* of impact on her health, she has always liked to keep herself fit. She says that *'it is nice to be appreciated'* and that she thoroughly enjoys being involved with Ageing Well, otherwise she would not do it.

Mrs R's view of impact on health and wellbeing of clients
The impact is not only on physical health but also on mental health, friendships develop among clients and this helps their general wellbeing.

APPENDIX 3 VOLUNTEER TYPOLOGY
VIGNETTE E: Community (health) volunteer (SHM model).
Mentor 94: Mr M, aged 68, retired manager

Background and context
Mr M volunteers for an Ageing Well project that works with Age Concern and local health providers to provide support for isolated older people minority ethnic elders to join Ageing Well activities of their choice. He has been trained as a Senior Health Mentor.

Reasons for volunteering
Mr M believed he had the skills to help people to give them confidence to '*make them active and independent*' and the knowledge to impart information about local facilities. He wanted to help people get more out of life and to mix with people more. *'I felt I'd be better working one to one. It is better in situations where people don't want to go out or to mix. It gives them a start and confidence to get on'.*

Training and support
Mr M was trained over 10 days by the project coordinator and outside speakers. The training covered topics in the Senior Health Mentor training pack together with road safety and safety at home, first aid and client case studies *'that psyched us up for the real thing'.* He felt he was '*quite well trained. We were prepared for different situations'.* Training is followed up by monthly meetings with other mentors and the project coordinator. He feels the coordinator is *'very supportive'* and strongly agreed that the project valued its mentors.

Mentor role
Mr M visits people in their own homes, asks them what they want to do and takes them out. His '*ability to understand people and their needs and to make them more relaxed and be easy with them, to be able to work with them without placing them under pressure'* were factors that were helpful to him in his role.

Impact on Mr M's health and wellbeing

'*It's made me use my skills to help people and contribute positively to the needs of older people so that has made me feel happier, more relaxed, so I am feeling useful. The coordinator has made me feel I've done well. I've become mentally better, emotionally and physically too.'*

Mr M's view of impact on health and wellbeing of clients
Mr M's client experienced problems leaving her home because of mobility problems and sight loss and was at risk of social isolation.

'She is now very confident and able to venture out to local services, can cross roads. She has become independent. Once she wanted me to take her to the park on her motorised scooter. She later took other people, also on scooters, along on her own. She is very active now.'

APPENDIX 3 VOLUNTEER TYPOLOGY
VIGNETTE F: Community (health) volunteer (SHM model).
Mentor 85: Mrs L, aged 65, part-time development worker

Background and context
Mrs L was involved with the development of a facility for her local community which has become the centre for a variety of community activities. It is a sustainable community enterprise run by non-salaried staff. Mrs L is a volunteer mentor who runs exercise classes and also has an organisational role. She volunteers for Ageing Well up to three times a week.

Reasons for volunteering
Mrs L said that she finds volunteering very rewarding and wished she had done it years earlier, she said '*Being a volunteer has a lot going for it.'*

Training and support
Mrs L did not receive Ageing Well mentor training when she first joined but she undertook a ten-week course to prepare her for the role of exercise leader. Since then she has had further training in first Aid, nutrition and falls prevention. Mrs L speaks regularly with the project coordinator on the phone and meets with her at least once a month. She feels very well supported and valued in her role.

Mentor role
Mrs L is involved with running a range of exercise classes that range from seated to moderate levels. She describes her way of working with older people as taking small groups, running events for larger groups and developing close relationships with small numbers of older people. Mrs L said *'I like getting to know them; I like to work with them, not for them.'*

Impact on Mrs L's health and wellbeing
Since involvement in the project Mrs L's knowledge and level of physical exercise, knowledge and consumption of healthy foods, social circle and knowledge of home safety has improved a lot. She said *'I think it has changed me beyond recognition, I have a new lease of life.*'

Mrs L's view of impact on health and wellbeing of clients
The benefits to clients physical health and wellbeing due to exercise is marked with improved mobility. Clients integrate the physical exercise into their daily activities. *'One client said that he was aching after gardening and he said I remember what you told me about stretching that eased it completely.'*

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