Evidence-based Guidelines on Health Promotion for Older People:

Social determinants, Inequality and Sustainability

United Kingdom National Evaluation Report – Final Draft

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1 The Evaluated Health Promotion Cases for Older People

This report features in-depth analyses of three health promotion interventions amongst older adults that have taken place in the UK during the last ten years (and much longer in one case). All three projects have been assessed as demonstrating high levels of effectiveness in achieving specific results with regard to the public health of their targeted local older people. The three interventions vary quite dramatically in both the nature and goals of the intervention as well as the means of evaluation, yet all possess a number of discernable characteristics which are crucial to their success in promoting the health of older people. Such facets may be taken to represent key components of what comprises 'best practice' in health promotion amongst older people. These features will be elucidated implicitly throughout this report before being clarified more explicitly in its concluding discussions.

1.1 National Selection Procedure

The selection and analysis of the three projects forms the third part of an ongoing study into effective health promotion amongst older people in the UK and indeed across Europe. Over 150 studies/reports relating to interventions taking place within the UK during the years 1996 – 2006 formed the basis of an initial literature review. Based on the findings of this review, and similar analyses carried out in 11 other EU countries, a number of characteristics pertinent to effective health promotion amongst older adults were set out. These criteria for effective health promotion were combined with wider issues linked to social determinants, inequality and sustainability to create a tool to ascertain the likely effectiveness of projects. Based on this assessment instrument, a short-list of the 20 most effective UK projects were drawn up and analysed in depth. Using this more detailed information, the 20 projects were then reassessed based on similar criteria and the two most effective projects clearly stood out as being 'Silver Song Clubs' and 'The Warrington Falls Management and Prevention Service'. Another high scoring project was added to this list which also demonstrated particular aptitude in tackling socio-economic and ethnic inequalities – 'The Bromley-by-Bow Centre'.

In-depth evaluation literature already existed on each of the three projects. These studies were then subjected to detailed document analysis and scrutiny in order to ascertain precise information on the structure, process and outcomes of each intervention. Semi-structured qualitative interviews were then carried out with a range of stake-holders (external academic evaluators, project managers, facilitators) in order to obtain a more comprehensive knowledge base of each project as well as

offering a means of triangulating the data. In all, 6 documents were analysed and 8 interviews were carried out.

1.2 Short Presentation of the Three Health Promotion Cases for Older People

Silver Song Clubs

This highly innovative intervention programme consists of a network of clubs which facilitate social music making and singing for groups of older people. The programme is particular aimed at those at risk of the negative effects of social isolation and/or age related decline in cognitive functioning.

From a small initial number of clubs based in and around Dover in 2004, there are now well over 30 clubs spread across the South East of England and beyond. Each club meets regularly and is assisted by local volunteers invited through other musical organisations.

Clubs take place in a range of venues in order to maximise accessibility for the local older community. Transportation is also arranged to facilitate the participation of isolated individuals. Referral pathways have been set up to assist those at risk of isolation or experiencing cognitive decline, though a number of participants self-refer after seeing local adverts or hearing about clubs through word of mouth. Specific music making activities are especially tailored for ethnic minorities as well as distinct interventions to assist older people and their carers coping with late stage Alzheimer's disease. Further clubs take place within secure mental health units.

The Warrington Falls Management and Prevention Service

The project set out to reduce the incidence of falls amongst the local older population which suffered from one of the highest rates of fall related injuries in the country. The project is multi-factorial in the way it seeks to educate older people regarding risk factors associated with falls as well as offering exercise classes (including physical training for muscle strength and flexibility, combined with balance and co-ordination exercises) and home assessments. The project represents a prime example of an evidence-based, established model of health promotion for older people. Falls prevention has been a central concern of policy makers in the UK and therefore this project represents a highly comprehensive intervention targeting this risk factor. It is also of proven sustainability as it was initiated in 2004 and continues to run in 2008. It functions in and around Warrington across 8 districts of the city.

The Bromley-by-Bow Centre

The centre is a community project set amidst one of the most deprived local communities in the UK. It seeks to harness the collective resources of the local

community to run a variety of projects for all ages. One of the key foci is health promotion amongst older people and the centre uses a range of innovative user-led interventions to achieve this. As well as a highly original approach, which is focused on process rather than outcomes, the centre has been running since 1984 and continues to function on the basis of relationships as a means to health promotion.

2 Results of the National Case Studies

2.1 In-depth Analysis of Case 1: Silver Song Clubs (Sing for Your Life)

2.1.1 Structure Evaluation Results

The project is open to all older people though particularly seeks to target and encourage the participation of the socially isolated and provides transport for these people and others to and from the clubs. There are also specific groups run for those experiencing Alzheimer's and other forms of cognitive impairment. Culturally relevant sessions are targeted at specific ethnic groups - for example a Punjabi group is run in a local town with a significant number of older people from this ethnic-background. The group takes place in the Punjabi community centre and is facilitated by local Punjabi musicians. Other groups are run in secure units for older adults within mental hospitals.

The project is based on the theoretical premise (supported by a growing body of empirical research) that communal singing and music making has a number of important health benefits for everyone, not least older people. These include lowered blood pressure, improved immune system function, improved brain/cognitive function, social interaction, and mental, social and emotional engagement. "*There is ample evidence to show that participatory social music making has a positive impact on both physical and mental health. Quality of life can be both maintained and improved. Our aim is to sustain independent living for older people*" (Sing For Your Life [**SFYL**], 2007a, p. 1).

By encouraging social, mental, cognitive, immune and physical functioning of participants and extending the availability of such music making and singing to as many older people as possible, the project aims to prolong the independence and general health of older people. Music making sessions are particularly aimed at improving (or at least minimising the decline of) cognitive function. This includes specific sessions tailored for those experiencing Alzheimer's disease.

The song clubs take place in a range of settings including day centres run by Age Concern, other community centres and similar locations. There are a small number of

groups which take place within secure units of mental hospitals. Efforts are made to attract those who may be isolated geographically and/or socially and transportation is provided in order to facilitate these people taking part.

A number of local agencies are involved in the project, from a specially funded research centre linked to a local university to other health and social care organisations, older peoples groups, arts organisations and patient groups: "*We work with a number of partners including Making Music South East, Age Concern, Alzheimer Society, Music Mind and Spirit, Primary Care Trusts, and the Sidney De Haan Research Centre for Arts and Health*" (SFYL, 2007b, p. 2). Referral pathways have been set up in order to encourage older people who are likely to benefit from the groups (such as those experiencing isolation or cognitive decline) to be linked up with a group, though a large number of attendees are due to word of mouth and corresponding 'self-referral'.

Each group is run with 11 key goals in mind. These goals encompass social values, concern with aiding cognitive function, empowering older people, reminiscence, incorporating different cultural styles of music and respecting cultural norms: "*1. Initiate one-to-one welcoming; 2. Invoke memories; 3. Stimulate fine motor skills; 4. Stimulate grand motor skills; 5. Encourage social interaction; 6. Encourage client leadership; 7. Provide progressive learning outcomes; 8. Provide platforms for reminiscence dialogue; 9. Give free choice; 10. Cover multicultural material; 11. Encourage shared performance*" (SYFL, 2007b, p. 4).

Along with these guiding principles, there is a clearly organised management structure to ensure the effective running and quality of music making sessions throughout the growing network of song clubs. There is regular supervision of new clubs and facilitators to ensure the quality and goals of each group are in keeping with the vision and aims of the project. The projects are mainly run by a network of dedicated volunteers, therefore the costs are low. Funding comes from a number of sources including large benefactors and local health care organisations.

The long-term structural aim for the project is "*to be commissioned by Public Service Providers and mechanisms to be created to signpost the socially isolated and older people suffering from the effects of age related mental health conditions to our services*" (SFYL, 2007b, p. 3). This would enable song clubs to be run and benefiting older people across the entire country. Hence a crucial concern for the management of the programme is building relationships with healthcare funding agencies. Whilst this is important for the long-term implementation of the project (see comments on sustainability in section 2.1.3) due to the way current dependency on short-term funding resources "*are very difficult to manage*" (Interviewee 3 - manager), managers also acknowledged that negotiating with health and social care organisations continues to be a "*massive and complex*" (Interviewee 3 - manager) job.

In the United Kingdom, healthcare funding flows through local Primary Care Trusts who buy healthcare services on behalf of the local population. For the county of Kent with a population of 1.65 million, there are three Primary Care Trusts (there were

formerly 9) which allocate funding and make decisions on appropriate referrals. The situation becomes more complex when considering 'social care' which is funded by the two municipalities (Kent and Medway). Social care includes long-term care of frail or disabled older people, for example those experiencing Alzheimer's disease. Hence for one small geographical area there are a number of different agencies to liaise with, each with their own funding policies and financial constraints, thus making structural planning for the organisation and infrastructure of the scheme very complicated. "*The biggest problem of all is this cross-over between health services and counties* [the municipalities which fund social care]" (Interviewee 3 - manager). That the clientele and purpose of the song clubs sit close to the border between 'healthcare' and 'social care' means that one organisation is likely to suggest funding such a project is the responsibility of the other.

2.1.2 Process Evaluation Results

The target group is effectively *all* older people, as all can benefit from communal singing and music making. Though emphasis is placed on those which the groups may particularly help. These include isolated older people, who are identified and targeted through co-operation with other health and social care agencies working with older people. Other older people which the clubs seek to engage are those experiencing cognitive decline such as Alzheimer's. A key hallmark of the Alzheimer's groups is that they are run as much for carers as the people experiencing the condition. As one of the co-ordinators pointed out in the interview, "*it's something they can actually do together*" (Interviewee 4 – co-ordinator). Hence the groups act as an encouragement to carers as well as specifically seeking to provide a 'brain gym' for the cared-for. As well as the typical activities which encourage interaction, the Alzheimer's groups target stimulating short-term memory through the use of the physical actions and the like. Alternatively the groups held in secure units harness the 'normal and familiar' to benefit older adults in this environment. In this way the project shows a capacity for "*accessing different types of memory*" (Interviewee 1 - facilitator) across different groups as well as within each.

The potential for group music making and singing to benefit older people - particularly in social and cognitive terms - are key foci of the running of each session and the structure and content of the sessions are designed to harness this potential. "*The Silver Song Club model is an integrated programme designed to promote mental and physical wellbeing and build community capacity. It uses music, the most evocative of the arts, to bring together people from different social, cultural and socio-economic backgrounds. It harnesses and disseminates skills already present in the community*" (SFYL, 2007b, p. 4).

By encouraging social, mental, cognitive, immune and physical functioning of participants and extending the availability of such music making and singing to as

many older people as possible, the aim is to prolong the independence and general health of older people. "*Taking part in regular community singing: Raises oxytocin, associated with social bonding and the formulation of new memory; reduces cortisol, the 'stress hormone'; increases levels of melatonin, a deficiency of which is associated with Seasonal Affected Disorder; raises levels of immunoglobulin A (IgA), which helps to protect against infection*" (SFYL, 2007a p. 2).

Many groups take place in settings where older people regularly congregate, such as in day centres and church halls. There is provision of transport in order that the geographically/socially isolated may be brought in to benefit from the groups too. The clubs "*work with local stakeholders to identify and target older people living in the community and those at risk of social isolation and provide transport to participants if needed*" (SFYL, 2007b, p. 9).

Arts organisations provide expertise and talented people to facilitate and offer musical accompaniment. The local university is the base of much of the research into the running and benefits of the groups. Other older peoples' groups also provide venues or assistance.

The model seeks to use the power of music and reminiscence (through singing old songs) to form the basis of group music making from which older people derive a whole host of social, physical, emotional, mental and cognitive benefits. Whilst there is an overall structure, which seeks to ensure the quality and overall aims of the project, each group has very much its own dynamic. As one co-ordinator points out: "*There is no way of fixing what happens…every group is different, what works in one place does not work in another*" (Interviewee 4 – co-ordinator). Another underlines that "*pitching the choice of songs at the right level is really important*" (Interviewee 5 – facilitator) in order to usefully engage with the group. Hence the structural guidelines set out in the previous section which each club must adhere to form the basic framework within which a more flexible, responsive format may develop which is more specifically tailored to the social, musical and needs environment.

The number of song clubs has expanded rapidly with the success of the project. "*Initial pilot clubs were established in East Kent during 2005/6. Substantial awards from Arts Council England, South East, and The Headley Trust allowed the network to be expanded into East Sussex, West Sussex, Surrey and Hampshire during 2006/7. There are now over 30 Silver Song Clubs in operation across the South East region*" (SFYL 2007b, p. 3). This growth of the project is perhaps its most important change since it began, bringing with it various organisational and financial ramifications. Whilst the basic aim of the clubs has not changed, experience and research has allowed the groups to generate specific benefits for those taking part: "*the activities go beyond 'having a sing-a-long' and have been designed, trialled and modified to generate particular responses*" (SFYL, 2007b, p. 13).

The research centre is focused in carrying out and bringing together new research into the potential benefits of song clubs for participants and the structure and content of music making sessions are adjusted in order to make the most of this expanding

knowledge base. Hence the aims of the programme "*are derived from an on-going research and evaluation process focused on identifying and codifying best practice and the most up to date research themes from around the world*" (SFYL, 2007b, p. 4). Such research is crucial for maximising the effective running of the groups but also for the long-term growth and viability of the programme. Local health and social care funders have to be convinced that investing in such a project will save them money in the longer term, hence specific figures in terms of cost-effectiveness and outcomes are necessary and there is an emphasis within current research linked to the project to be able to arrive at such accurate indicators. This of course is a difficult task in itself due to the immeasurable nature of much of the processes and outcomes surrounding the project's work. But where this can be done, and government Public Service Agreement targets exist such as reducing demand for residential care by 5%, the project has an opportunity to convince local commissioners of services that they can 'invest to save'.

2.1.3 Outcome Evaluation Results

Qualitative and quantitative methods are being used to gauge the effectiveness of the groups in benefiting participants in terms of mental, physical and social health. An initial exploratory study evaluated the clubs using individual interviews, focus groups and observations. Further research linked to the project includes a systematic literature review, international collaboration with research involving choirs in Germany and Australia, cost-benefit analysis and research into the effects of communal singing on carers, as well as the cared-for.

Care is taken to try to weigh up more intangible benefits as well as the more typically measurable. The research undertaken by the research centre which is linked to the project organisation includes specific research which seeks develop an evidence-base for the benefits of communal singing amongst older people and enhance expertise. This is combined with an ongoing process of evaluation - "*a constant process of internal and external monitoring and evaluation is used to guarantee quality of service provision*" (SFYL, 2007b, p. 5).

Initial cost/benefit analysis suggests the likelihood of positive findings in terms of overall outcomes. A major cost/benefit analysis is underway which seeks to use recent developments in this area in order to weigh up more 'intangible' benefits alongside the 'quantifiable' in order to gain an understanding of the full benefits/limitations of the Silver Song Clubs in proportion to direct financial outlay:

"Recent developments in cost/benefit analysis have allowed it to be applied to complex social interventions with multiple benefits/outcomes. This method of analysis involves accurate modelling of costs and benefits including elements such as social benefit and short/long term cost reductions. We are working with Total Value Consultancy who have significant experience in improving value for money, including assessment of tangible and intangible costs and benefits" (SFYL 2007b, p. 15).

Associated with these more or less measurable outcomes are the effects, both long- and short-term, on participants' health: "*The key benefits of participation in a Silver Song Club are as follows: improves overall rating of physical health; alleviates loneliness; better morale; fewer doctor visits; less medication use; fewer instance of falls; improved respiratory function*" (SFYL, 2007b, p. 5).

The silver song club network has proved itself of capable of rapidly expanding its level of service provision whilst incurring minimal costs due to the highly voluntary nature of much of the way it is organised, located and facilitated. However increasing links are being forged with local healthcare authorities and other third sector organisations - the long term goal being that the project is able to be run on a national level, funded by the National Health Service. This would of course guarantee the projects long-term sustainability though, even in the short-term, the evidence-base of the project, combined with its innovative format which seems to capture the enthusiasm of funding agencies, has allowed the project to secure a number of grants, of both larger and smaller scale. Yet in spite of these apparent successes the managers note that "funding is a perpetual problem" (Interviewee 4 co-ordinator); "a continual battle" (Interviewee 3 - manager) said another. Even though many of the venues are negotiated to be used for minimal expense and the groups are facilitated by volunteers, the overall running of the project, the ensuring of the quality of the clubs and the carrying out of high quality research costs money. These costs of course increase as the number of clubs expands due to the success of the project.

The expansion of clubs, from an initial handful to a great number, spread across southern England, in many different settings and amongst a wide range of ethnic and socio-economic settings, makes clear the transferability of the project. Simple adjustments to the meeting arrangements, facilitators and musical content allow the basic premises of the clubs to remain the same. For example, one of the clubs "*meets fortnightly and is divided into two sections for male and female participants. This is done to respect cultural heritage and traditions*" (SFYL 2007b, p. 9).

There has been a gradual increase in recognition of the project. The project received an 'Award For Volunteering Excellence' in 2007. There has also been both local and national media exposure - the project was featured on a BBC Radio 4 programme.

Initial qualitative evaluations found the clubs were extremely popular with those attending and that these people derived high levels of satisfaction as well as physical, mental and social health benefits. "*Activities which generate feelings of self satisfaction and self achievement engender self worth and self fulfilment*" (SFYL, 2007b, p. 12).

The project encourages those taking part to develop news skills through music and singing as well as giving those taking part a high degree of choice as to group activities. Musical performance offers those taking part a sense of self-esteem and confidence due to what could be referred to as "*the challenge of mastery. Activities*

which generate feelings of self satisfaction and self achievement engender self worth and self fulfilment" (SFYL, 2007b, p. 12). 'Giving free choice', as seen in section 2.1.1 is one of the basic maxims on which every group operates.

By way of summing up, as is clear from the content analysis and interviews, in spite of the efficacy of the project, its biggest (and perhaps only serious) problem is that of ongoing funding. Whilst so far sufficient finances have been successfully secured by hard-working staff, these funding issues become a greater concern as the project expands and therefore requires greater resources. The long-term aim of the project, which would solve this funding concern, would be for the National Health Service to commit to funding Silver Song Clubs. The difficulty with this, and indeed with more localised funding, is being able to provide clear figures to justify the investment and prove to PCTs that funding the clubs will save them money through reductions in hospital admissions and long-stay residential care. The current cost/benefit research seeks to overcome this problem of quantifying the less tangible and thus it can be said that the project is aware of the major issues it faces and is positively seeking to deal with them.

2.2 In-depth Analysis of Case 2: Warrington Falls Management and Prevention Service (WFMPS)

2.2.1 Structure Evaluation Results

Older people seen to be at a particular risk of falling are referred to the service, as assessed by professionals through a risk assessment tool. This is then subsequently followed up by a more in-depth assessment. Older people were reached either through referrals or by advertisements of the service which encouraged some to self-refer. The local area has one of the highest rates of hospital admissions from falls in the country hence the locality is worth noting too: the "*second highest in England, well above the national average of 23 hospital admissions per 1000 population of persons aged 75 or over as a result of a fall*" (Caiels and Thurston, 2005, p.2).

The basis of the project is well informed by the wealth of literature available based on a large number of studies in the UK and abroad. Stemming from this, the intervention draws on research which strongly suggests that falls prevention is most effectively achieved when multi-factorial interventions are put in place which include education/advice and, where necessary, physical/strength and balance training. Exercise initiatives are most effective when targeted at 'at-risk' groups. Yet whilst there was a substantial body of research on which the project based itself, there remained a number of uncertainties also which had to be negotiated as the project progressed:

"although a multi-faceted approach in preventing falls in older people is considered to be the most effective, the optimal type, duration and intensity of intervention remains unclear. We found that there is not one model service, approach or structure for effective work to implement the NSF [National Service Framework] Standard for Falls, but core principles (that can frame local variation in design and implementation) and essential structures to support services – such as effective IT networks and administrative back up – are ingredients and determinants of success" (Caiels and Thurston, 2005, p.3).

The utility of such 'core principles' ought to be borne in mind as the likely recommendations stemming out of the present report will possibly be used in a similar manner.

The key population that the project was seeking to target were older adults held to be at risk of falling – this was generally understood as having fallen recently. The locality where the project took place has one of the highest fall-related morbidity rates in the country, therefore highlighting the need for intervention. This high level of morbidity may well be linked to the fact that "*people aged over 65 years living in Warrington have been found to lead relatively sedentary lives, with 75% of this group taking little or no regular exercise*" (Directorate of Health Improvement, Warrington PCT, 2002 – cited in Caiels and Thurston 2005, p.2). Yet, whilst there seems to be a more endemic problem with regard to this lack of exercise, in a health service environment where the limited nature of resources are clearly apparent, previous research suggests that the most cost effective outcomes are reached when resources are specifically targeted at these 'at-risk' individuals as opposed to a broader intervention aimed at the entire older population.

The setting of the classes varied across the locality of the project but most typically included residential care homes and day centres frequented by older people. Co-operation with residential homes meant that classes taking place within them were able to be attended by residents as well as other older people living in the vicinity. As far as possible, group activities were run in local venues easily accessed by the community. It was also seen as crucial to provide transport to ensure easy access. Falls project staff also visited people in their own homes in order to conduct safety assessments and recommend ways in which the lay out of homes could be improved so as to minimise the risk of falls.

The project was run and staffed by the local Primary Care Trust. Older people were able to self-refer as encouraged by advertisements placed in local General Practice surgeries and hospitals, though this method provided only a very small percentage of total referrals. Further to referrals stemming from health professionals in contact with older people, a number of other agencies were engaged by the programme and were eligible to refer older clients to the interventions: "*The WFMPS [Warrington Falls Management Prevention Service] has links with, and works in conjunction with the following local agencies: Warrington Borough Council; Age Concern; Citizens Advice Bureau (CAB); North Cheshire Hospital NHS trust; Carecall)*" (Caiels and Thurston, 2005, p.41).

As previous reference to the multi-factorial nature of the intervention would suggest, there were a number of aims which the interventions sought to achieve: "*The WFMPS objectives, as stated in the original proposal are: to reduce the incidence of injurious falls; to increase functional performance and mobility levels; to heighten awareness of the multi-factorial risks associated; to influence the compliance of wearing hip protectors; to plan and teach personal survival strategies for surviving; to relieve social isolation and promote social inclusion*" (Caiels and Thurston, 2005, p.4).

Whilst the evaluation report had little information on the management structure, information gleamed from interview material noted that the project was set up by the local Primary Care Trust (PCT). Two co-ordinators were appointed who oversaw the running of the scheme, facilitated by two administration staff. The various interventions, overseen by the co-ordinators, were staffed by a range of health professionals employed by the PCT including physiotherapists and occupational therapists. Another key role played by the co-ordinators was in fostering support and developing awareness of the scheme across the local area. This was chiefly achieved by a number of presentations given to a number of different health and social care agencies working with older people – particularly General Practices and residential care homes.

2.2.2 Process Evaluation Results

A number of agencies working with older people were able and encouraged to refer clients to the service who were seen as at risk from falls. Advertisements were also used as a way of encouraging other older people to self-refer if they felt at-risk though, as noted already, this means of engaging with the target group was not particularly fruitful. Equally it would seem that harnessing the support of General Practitioners along with other experienced healthcare professionals was problematic in that many of them were cynical to the long-term viability of the project. It would seem that a number of the more experienced doctors had seen many health promotion projects 'come and go' and therefore were rather reticent to refer patients. This was undoubtedly a factor which reduced the number of referrals. As much as this perception of the project was unfortunate, it was nonetheless not as problematic as it may appear due to the fact that staffing issues were a concern. There was no mention in the evaluation report of public recognition and rather, as the main evaluator clarified, staff were in fact "*worried about an explosion of referrals that they couldn't cope with*" (Interviewee 6 - evaluator).

Awareness from research that multi-factorial interventions have been proven to be the most effective have formed the basis of the design of this project which uses health education, risk assessment and awareness and physical exercise in combination to tackle the prevalence of falls formed the basis of the intervention

though some of the interventions proved more successful and achieved greater levels of compliance than others when implemented in a non-scientific setting. For example ‘hip protectors’ may well lessen the risk of injurious falls, however they were seen as bulky by many and therefore compliance with wearing these was ‘very low’. There would seem to be a trade-off between what is ‘safe’ and other issues such as dignity, as one client pointed out “*they make my hips look enormous*!” (as reported by interviewee 6 - evaluator).

The project sought to target those most at risk of falls in a number of ways. Firstly the project was based in an area with a very high level of falls related morbidity. Secondly it asked local agencies to refer at-risk clients based on an assessment tool. Once referred, a more detailed assessment was carried out to further assess suitability (risk). The evaluation found that those taking part in the project were indeed high risk older people and hence the referral pathway and assessment tools would seem to be appropriate: "*Over two thirds of these (68%) were classified as either ‘very high risk’ or ‘almost inevitable’, while the mean falls risk score for individuals was 23 (very high risk). This shows that the WFMPS is capturing those with a high risk of falls and thus receiving appropriate referrals*" (Caiels and Thurston, 2005, p. 28).

Choosing locally based community settings as well as providing transportation to the venue to ensure as far as possible that no one in need of the service missed out due to accessibility concerns was of central importance to the project:

"A key factor in the success of the programme is its capacity to engage members of the target group. A critical factor in successfully engaging this client group is the ease of access to appropriate community facilities. Thus, transport is a crucial factor in facilitating attendance. Other practical issues include finding and retaining appropriate accommodation in which to run sessions, this is also important to recruiting and retaining service users" (Caiels and Thurston, 2005, p. ix).

The significance of transport, yet that financial provision for this was limited, was one of the early hurdles for the project. Initial reaction to this was described as ‘damage limitation’ in that staff in certain instances had to resort to using their own cars in order to ensure clients could attend meetings. “*This problem was exacerbated by a shortage of vehicles with suitable disabled and mobility friendly equipment*" (Caiels and Thurston 2005, p.41).

Although the project was run by the Primary Care Trust, other organisations were involved in as far as they referred clients into the scheme. One general referral assessment form was developed to be used by a whole host of agencies who interact with older people in the locality:

"A wide range of health professionals from health and community services can refer clients to the WFMPS using this assessment form. These include GPs, practice nurses, community nurses, physiotherapists, podiatrists, occupational therapists, hospital nurses, hospital therapists, hospital consultants, social workers, support workers, and the community alarm project worker. Two voluntary

agencies (Age Concern Warrington and the Citizens Advice Bureau [CAB]) can also refer clients to the service, as well as older people themselves being able to self-refer" (Caiels and Thurston, 2005, p. 4).

More specifically about the process of the intervention itself, as has been referred to earlier, the projects range of intervention approaches is as varied as its client base:

"*The WFMPS appears to be capturing a diverse client group (aged between 65 years to over 100 years of age) and as such have clients of differing falls risk and physical mobility. It also focuses on changeable attributes of those service users such as increasing strength and providing education about how to reduce the dangers associated with falling*" (Caiels and Thurston, 2005, p. 40).

Health education in order to increase awareness of the risks associated with falls and how best to minimise these is combined with physical classes which also seek to encourage confidence in physical capacity and balance through exercise and strength training. Tackling social isolation was another key element of the project and the fostering of a friendly and encouraging atmosphere was one of the key goals of the classes. The level of social interaction was mentioned by a number of the participants and in this way these classes can be viewed as benefiting mental health as well as physical capacity. This in turn aided the motivational commitment of the participants towards effective completion of the various exercises during the classes. Concerns were raised by a number of participants as to how likely they were to continue with the physical training once the 16 week course had finished. This of course raises questions as to the long-term effectiveness of such an intervention.

2.2.3 Outcome Evaluation Results

A mixed method evaluative framework was carried out looking quantitatively at physical capacity and self-reported falls information as well as qualitatively in terms of responses through focus groups. Hence the evaluation was as comprehensive and multi-dimensional as the intervention itself. The evaluation was commissioned by the PCT and carried out by independent academics at a local university, therefore heightening the likely rigour of the research.

Whilst little information is provided on the cost-effectiveness of the scheme, the evaluation nonetheless underlines the massive cost to the NHS caused by falls amongst older people and that this expense is predicted to rise considerably in the near future: "*Aside from the human cost of hip fracture, the economic implications of this outcome are significant. One single hip fracture costs £13,000 in the first year and £7,000 [€9,300 for follow-up care and nursing in the second year (Health Promotion England, 2001). In 2001, the NHS spent approximately £1.7 billion [€2.25 billion] per annum on hip fractures (DoH, 2001)*" (Caiels and Thurston, 2005, p. 6).

Modest improvements were made as measured by the physical capacity tests, though qualitative responses suggest very positive improvements in physical ability,

confidence, ability to carry out tasks, reduced falls and reduced social isolation. This emphasises the importance of triangulation in evaluations in order to acquire a more complete picture of client experiences and outcomes. Of course whether the qualitative responses were accurate and the capacity tests flawed or *vice versa* is difficult to ascertain. What is noteworthy though is the level of psycho-social effects and the way these seem to have acted to enhance the physical effectiveness of the interventions. These would not have been elucidated by a purely quantitative evaluation approach.

The service continues to exist and there is no evidence to suggest these effects will not have been repeated, moreover "*as the WFMPS became more established, referrals increased which led to one part-time member of the team taking a full-time role to prevent the service becoming overwhelmed*" (Caiels and Thurston, 2005, p.41). There is no evidence of successful transferability in the report, however all the aspects of the project (mentioned above) could very easily be replicated elsewhere. That falls is, as stated above, so costly to the National Health Service means that falls prevention has become a central concern of the UK Government's national health policy framework for older people (National Service Framework) and therefore local healthcare funding agencies (PCTs) are willing to allocate funds to similar programmes where there is evidence that such investment will save money overall through reduced admissions due to fall related morbidity. Though as the evaluator noted, there is the difficulty in proving the cost-effectiveness of the project. Whilst it is relatively straightforward to calculate the costs of fall-related admission or broken-hip, precisely how many falls have been avoided as a result of the project and exactly how many of these would have resulted in serious injury is inevitably speculative. In spite of the effectiveness of the project, a relatively small percentage of the local older population actually took part in the programme and therefore even where a down-turn in falls admissions occurs, it may seem tenuous to link this solely to the existence of the project. Hence in a similar sense to the Silver Song Clubs in the previous example, the difficulty in quantifying the immeasurable is significantly effectual on the project's long-term success and resources.

Public recognition was one of this study's criteria for determining the 'success' of projects though as stated above, the experience of the Warrington falls project casts doubt over the appropriateness of using this variable. Obviously a project's publicity or lack of it may well be disproportionately effective compared with the actual intervention itself. Moreover the apparent way in which this project disregarded publicity due to fears of over-stretching limited resources makes starkly apparent the financial constraints within which health promotion projects typically work. As a consequence of this outcomes which might, *prima facie*, appear as highly successful for the project may actually be rather problematic for those providing the service. Hence the rationing of health promotion services becomes a crucial component for understanding effective outcomes and this is why the project seems to try to focus on

those at highest risk of falling. For it is with these older people that limited resources can achieve the most pronounced results.

A wide range of consumer satisfaction was evident in the report as became evident through the findings of the qualitative research. Especially in terms of people being physically empowered, having their confidence increased and above all through the benefits of social interaction and encouragement through the group setting:

"Participants stated that the social aspect of attending the programme had been instrumental in improving people's physical functioning, and that this was just as important as the physical training itself. Participants said that they enjoyed the opportunity to meet others and make new friends with those who had had similar experiences with regards to falling" (Caiels and Thurston, 2005, p. 34).

There is evidence that the project leads to the empowering of people physically through increased mobility, educationally through better awareness of risk factors associated with falls, and via improved social networks and confidence: "*The WFMPS exercise programme helps elderly persons retain their independence in doing everyday tasks by improving and sustaining strength, balance, functional ability and confidence about falling*" (Caiels and Thurston, 2005, p. 42). The project was also found to have reduced the social isolation of a number of its clients and this in many senses could be seen as empowering. Whilst empowerment in itself could be viewed as a dubious quality within health promotion, as the next project discussion will emphasise, when it is understood in the sense of being linked to improved social networks and increased physical activity its import within health promotion becomes more apparent.

2.3 In-depth Analysis of Case 3: Bromley-by-Bow Centre

2.3.1 Structure Evaluation Results

The target group are residents who, by the nature of the locality, face a range of challenges to healthy living. The local population is highly ethnically diverse, with the largest portion being of Bengali ethnicity. They are reached by a range of arts and community work which are at the heart of the centres work. The centre also hosts a range of different or mixed faith religious services as a means of bringing together and reaching a range of local citizens: "*There has been a long tradition at the Centre of providing common services for different ethnic groups, reflected in the interfaith ceremonies within the United Reformed Church (URC) on site. Although many health and welfare services are targeted at specific needs and different social groups, it is of over-riding importance at the Centre that such services be integrated within the umbrella of one organisation*" p. 3 (Froggett *et al*, 2005, p.3).

The local community is probably the poorest in the country and has a specific and significant health and social needs as a result:

"Tower Hamlets is the most deprived local authority area in the country. In 2000, the Bromley ward ranked 237 according to the Index of Multiple Deprivation. Deprivation includes high unemployment. At 8.3%, the unemployment rate in Bromley by Bow in 2001 was even higher than the – already high – 6.6% in Tower Hamlets. Of those unemployed in Bromley by Bow, 16% have never worked, and over a third are long-term unemployed (LBTH 2001, ONS 2004b)" (Froggett *et al*, 2005, p. 16).

This issue of long-term lack of work has an impact on the psycho-social and physical health of many individuals in the community. Such deprivation is in no way a new phenomenon and thus, whilst there is a degree of movement into, and out from, the locality, many of these long-term unemployed have moved into the 50 and over age group. The tendency towards a more sedentary lifestyle amongst these individuals raises both physical and mental health issues which often compound one another.

The centre's model is very much a holistic approach, in terms of blending arts and health promotional experiences as well as trying to be as multi-generational as possible, albeit with certain features deliberately targeted towards older people. Allowing those involved in the centre to try new projects and ideas is another hallmark of the centre. Within these new ventures there is an emphasis placed on participation, creativity and process for its own sake and a deliberate move away from the target culture and outcomes focused nature of many health policy initiatives.

The centre is in the heart of Tower Hamlets, a crucible of health determinants as a result of its socio-economic status and ethnic diversity. The former is often influenced by the latter in that limited language skills and alternative cultural norms may impede educational attainment and/or access to the job market. This in turn of course influences the deprivation of the community as well as its relationship with healthcare institutions. These complex needs however also present a clear route of accessing this population, therefore in addition to more ‘typical’ health promotion work:

"the Centre has also had success in providing advisory and leisure activities for older Bangladeshi men as well as attracting high participation among younger Bangladeshi women particularly via its educational provision. Older Bangladeshi women especially benefit from it’s out reach work and many are registered with the GP practice. Vulnerable elders from a variety backgrounds needing intensive support are catered for in the Community Care project and share in common facilities and activities" (Froggett *et al*, 2005, p. VI).

The centre is in the midst of the local community it looks to serve and has grown over a period of 20 years from a run-down church hall into an architecturally adventurous and creative building, with other annexes across the local area. The centre is of course aware that it cannot reach the whole community purely through its location, and therefore undertakes various outreach/visiting programmes as part of its work (as described elsewhere in this report). The centre also houses a General Practice as well as a host of other social services and community related agencies. Thus a very wide range of activities are run out of the centre. "*This later incorporation of the*

Health Centre into a community arts project is an inverse of the usual relationship between health and community services and has been a unique opportunity to bring community influences to bear on local NHS health care" (Froggett *et al*, 2005, p. IX).

The centre sees its work as much related to relationship building and meeting the multi-dimensional needs of local people as direct health promotion work. Whilst of course the health needs of the local community are acute, the health promotion work tends to flow out of wider community based arts work and uses these creative activities as a means of educating local people about health living. "*Health promotion at the Centre uses spectacular events, visuals and narrative as memorable ways of providing information, thus increasing health awareness and ownership. Frequently these opportunities arise in relation to food and this naturally leads on to health promotion events on nutrition. Such work goes beyond providing information and is grounded in inclusion and relationships*" (Froggett *et al*, 2005, p. 9)

The centre has for a long time sought to avoid usual stringent management structures, though seemingly due to its growing size these have become inevitable to a certain extent. However, much effort is made to allow a free flow of ideas and to try out new ideas as much as possible. The centre uses a range of funding sources from more typical Department of Health funding to entrepreneurial local projects and sees this flexibility, whilst staying true to its core values, as a key factor in its success:

"The Centre model, therefore, combines a potentially abrasive entrepreneurship ready to use non-local contacts and vertical partners needed to establish the Centre as a weighty local player on its own terms with significant partnerships with local and regional partners. It involves insisting on terms that do not compromise the type of new culture that the Centre struggles to embody. The Centre's success so far as a community enterprise is, we think, at least partly due to its capacity to keep the different components of what we have also called a social co-entrepreneurship model in a workable state of creative tension" (Froggett *et al*, 2005, p. 97).

2.3.2 Process Evaluation Results

The centre works to mobilise the local community in a variety of ways as a means of engaging people in creative and health promotion activities which are integrated as far as possible within the umbrella of the whole centre. Whilst many ventures seek to bring together the local community in all its diversity, other projects are deliberately targeted at making links with certain ethnic sections of the local population. In this sense, the means of engaging with the target population is through a 'whole-systems' approach – a way of harnessing the strengths and capabilities latent within the local community:

"Yvonne… organises a Diabetes Fair (see Diabetes, in Chapter VI - Integrated Models of Practice in Community Health and Well-Being) - a turning point that taps into resources in the community and elsewhere in the Centre to produce an exuberant health promotion event. She realises that living well with diabetes requires the mobilisation of community networks as well as health education. She forms strong links with health networkers and holds a second fair for the Bangladeshi community. Yvonne

learns to combine painstaking scientific focus on the detail of disease management with a broader social view of the way in which illness impacts on people's lives. She increasingly sees the value of art, translating this insight into action" (Froggett *et al*, 2005, p. 58).

The above extract was worth quoting at length due to the way it shows how bio-medical scientific knowledge is combined with an ethnically sensitive, socially aware approach that engages with local citizens through art and other such creative media.

The whole-systems perspective of identifying and harnessing the energy and resources of the local community and individuals for everyone's benefit is borne out in the day-to-day life of the centre which sees art and other creative activity as an essential way of mobilising local skills and energies for the betterment of the entire community in health related terms and on a far wider level.

As a result of this whole system perspective, and inline with the Wanless report (Wanless, 2002), the centre seeks to engage the local community in order to allow its own resources to be harnessed in terms of healthy living and developing a supportive community. Whilst almost by its very existence within the poorest local area in the country means determinants are being addressed, the subtle and complex way in which socio-economic poverty and related cosmopolitan issues exist and impact on health mean that a much more holistic approach is necessary in order to benefit the health of individuals and that of the community at large. The centre thus has a much broader, integrated understanding of what engagement with local communities entails compared with the rather simplistic, narrow understanding seen in the Wanless report (Froggett *et al*, 2005, p. 22).

With regard to accessibility, the centre is in the midst of the local community it seeks to serve and uses various artistic, religious and community events to engage the population as well as using outreach workers to target areas of the population who would otherwise not have any contact with the centre. This aspect of the centre's work "*is not free from tensions with the community. There have been debates about the balance between on-site and outreach work and about political 'ownership'. Relying on local outreach and Centre staff with detailed community knowledge and cultural sensitivity raises difficult work-life-balance issues. These include 24-hour accessibility and problems of entering professional relationships with friends*" (Froggett *et al*, 2005, p. V).

The centre is also the base of a range of health and community services which are offered to the local community at the same venue, thus further blending the relationship cross-over between a community centre and a site of health promotion:

"The Health Centre benefits from a range of ancillary services that include community nurses, health visitors, midwifery, baby clinic and complementary therapists. It has been profoundly influenced by its location within a wider community centre, with which it shares a reception area. Its specific approach to health provision rests on this sometimes uneasy relationship and staff are used to negotiating the tensions that arise from it. Its health promotion activities are provided through imaginative co-working

between health professionals, resident artists, educators, outreach workers and volunteers" (Froggett *et al*, 2005, pp. IX – X).

The centre seeks to harness the creative imagination and energy of the local community through a range of events and longer running projects which use narrative, visuals and other related media to engage the local community and breakdown divisions and stigma related to chronic health conditions for example. By encouraging the professionals to step back and allow the 'clients' to create and own the events they take part in, there is an empowering and facilitation of the development of personal networks and support systems by which the community itself can foster its own wellbeing. Though at the same time there is an acute awareness that another role of the centre is to act as a refuge or safe-haven for damaged and vulnerable local people and thus there is no onus on people to be 'empowered' and passivity is welcomed as much as active involvement.

The centre actively encourages the trialling and pursuit of new ventures and therefore is subject to continual change, seeing its current existence as the organic evolution of a long-term process as opposed to any scientifically designed blueprint. As with many of the health promotion projects examined as part of this study, the ongoing need for funding is a constant pressure on those running the scheme. Though the centre has continued to run successfully for over 20 years, it is clear that the path has not always been straightforward:

"The Centre has prospered during a period that has seen constant fluctuations in health, welfare, education and local regeneration policy. These changes have not always favoured its survival and growth. Like many other voluntary organisations it has relied on multiple sources of finance and has been obliged to accommodate uncertainty and devote precious resources to maintaining its funding stream" (Froggett *et al*, 2005, p. IX).

2.3.3 Outcome Evaluation Results

In line with the anti 'target-culture' ethos of the centre, the evaluation was unsurprisingly highly qualitative and more process focused rather than seeking to measure outcomes or quantify benefits. Though the outcomes of the some of the ventures are referred to, this is typically in a more in-depth, narrative manner as opposed to seeking to generalise overall benefits.

No information was available in terms of cost-effectiveness. It is important to stress that the centre does not see or strive to define its work in such outcomes related terms as it sees this as against the holistic, experimental and relational essence of its work. The focus is very much on the process, which encourages experimentation and avoidance of instrumental targets which inevitably would compromise its fundamental ethos.

From the discussion of the various work done by the centre it is clear that the projects run do have clear social effects by bringing people together as well as empowering

effects on the way chronic conditions are now 'owned' by the older people and therefore managed more effectively due to the way stigmas have been broken down and education increased as to how one can usefully manage one's health. The way the centre can act as a refuge for some and a galvanising point of engagement for others also suggests significant effects on mental health amidst the wider social context.

The centre has been running for 20 years and has gradually built up the range of health and other services it offers through partnership with mainstream services as well as through a more creative model of social entrepreneurship. Its gradual emergence within the community, rather than being implanted artificially would seem to be one of its strengths in terms of the trust-based relationships it shares amongst local citizens. In terms of its physical presence and setting, this too has gradually developed from a dilapidated church hall into a architecturally adventurous, green place of refuge amongst an otherwise grey and austere urban setting: "*It's just so very green, bright, spacious, and so nice. It feels like you're coming into a separate little world. It's so serene and beautiful, such a contrast to the outside world (Employment service outreach worker)*" (Froggett *et al*, 2005, p. 2).

The organic, gradual development of the centre means that any direct replication or transferability of the service would be impossible or at least highly artificial were it to be attempted. However there is evidence of comparable projects functioning in the North East of England which are based amongst similarly disadvantaged communities and who work with similar, broad conceptions of community engagement towards health promotion (McNulty and Parsons, 1999).

The centre has been the focus of much national attention due to its successful work amongst the most impoverished area in the country and its radical, holistic and multi-agency umbrella approach. The reinvigorating of local communities for the social, mental and physical wellbeing of its constituents is a key concept in current government policy, hence why the work of the centre is so renowned: "*The Centre has for some time been regarded by central Government and a number of partner agencies as a flagship of social enterprise and integrated working*" (Froggett *et al*, 2005, p.3).

There is a wide degree of consumer satisfaction implied within the evaluation report as well as several narratives given of individual stories of how the centre has had a significant, positive impact on the lives and wellbeing of local people.

The whole system approach which forms the backbone of the centre's ethos is very much about harnessing the energy and capacities of those it seeks to serve, rather than trying to 'fix' them. However the centre also recognises that where empowerment is encouraged in a way in which people are not completely comfortable, this results in a decidedly disempowering result. Consequently the centre also recognises and sees itself as being a refuge for the passive and vulnerable, seeking to avoid any stigmatisation of such behaviour.

"The belief that everybody has something to contribute promotes collaborative engagement in practical action. People with different needs gain from mutual interdependence and the feeling of being needed. Such participation builds community and generates transferable citizenship skills that people put to wider use. At the same time, the Centre recognises the value of passivity and the importance of reflection before action. The appreciation of passivity is of particular relevance for more vulnerable individuals, some of them older people, whose needs can clash with those of more active and assertive groups. Integrated provision necessitates an ongoing careful negotiation of boundaries" (Froggett *et al*, 2005, pp. IV – V).

This model incorporating an appreciation of passivity is of course a stark contrast to common perceptions of health promotion with its emphasis on empowerment and mobilisation. The way "*older people are allowed to 'be', and to develop a personal balance between the active and passive sides of the self*" (Froggett *et al*, 2005, p. 126) may, at least in the short-term, impede the potential for health promotion and lifestyle changes. However, amidst such chronic deprivation and the heightened needs and vulnerability which correspond with such an environment, this passivity is essential if the centre is to be inclusive and avoid alienating the most vulnerable. As befits the centre's whole-systems perspective, which flows out of an "*originally religiously inspired whole-person model*" (Froggett *et al*, 2005, p. 96), empowerment is allowed to develop from within the individual and therefore might be viewed as a more 'real' notion of empowerment; as opposed to that which is enforced from without and which therefore ceases to be empowerment at all.

3 Conclusions

3.1 Recommendations for Successful Health Promotion for Older People

Structure

By far the most apparent and recurring structural factor amidst the analysis above is **finance**, and more particularly of projects ability to access funding streams. It would seem clear that within the current United Kingdom environment, there is indeed money available to be used for health promotion amongst older people. The crucial issue for each of these three projects is having the evidence of successful outcomes and expertise to access this.

Multi-agency co-operation is therefore important in this light as a means of accessing a range of different funding sources and therefore spreading the short- and longer-term financial risk of the project, rather than just being dependent on one financial source.

Effective management is also crucial in many senses, not least in raising finance. Thus it is important, in spite of trying to draw general structural recommendations, to refer to the projects in a disembodied manner. Individual personas and skills are clearly visible amongst all three projects and have been essential in their ability to effectively implement interventions but above all in successfully recognising and accessing potential funding streams.

The one project of the three without a clear persona apparent from the research material was the Bromley-by-Bow Centre. This is possibly due to its long-run existence where the project has now developed a body and sense of purpose of its own. In all three projects though there appears to be certain concrete, clearly focused **maxims which are uncompromisable, balanced with a flexibility** that allows the interventions to adapt to specific cultural contexts or determinants and tailor their work to corresponding individual needs.

The Bromley-by-Bow Centre and Silver Song Clubs are most able to do this due to their **organic growth**. The former especially, in dealing with such a deprived and vulnerable community, is hugely reliant on the trust which has been gradually been won through its long-term existence. Similarly the Silver Song Clubs have gradually increased in number as interest has flourished and volunteers made themselves available. Trying to artificially manufacture or impose such an intervention would no doubt face significant hurdles with regard to a lack of social capital and high level of transaction costs, as can be seen to an extent from the Warrington Falls example.

Process

Multi-agency working is furthermore greatly helpful in the process of health promotion. When dealing with a population group who are highly difficult to reach, including isolated individuals who are often at greatest risk, the more agencies who are able to refer to, or work in association with, an intervention, the greater its potential for reaching those most at risk.

In considering the various risk factors pertinent to the three examples, a **holistic model** of intervention would seem to be crucial in dealing with the multi-dimensional and inter-related co-morbidities facing many older people. **Multi-factorial interventions** are therefore effective in recognising and working with the interdependency of mental, physical and social health of clients. This allows such interventions an increased capacity to successful aid older people as well as providing a means of usefully **engaging with the target population**. When such engagement happens organically and through the active, willing involvement of the older person, **real empowerment** occurs. Because such a harnessing of the persons own skills and energies occurs as a result of their own volition and through their own doing, the changes brought about are accordingly more sustainable.

Outcomes

The preceding discussion of empowerment has important implications for the way outcomes ought to be viewed within health promotion amongst older people. The

greater extent to which outcomes are focused upon as a means of judging the 'success' of a project, the greater the potential for the process to be neglected as having an intrinsic worth in itself. Where outcomes are 'measured' in a relatively narrow, instrumental way, notions of empowerment and engagement come to be imposed and acted out in an a superficial way as a means of achieving quantifiable ends. Engagement and empowerment, lived out as natural ends in themselves, therefore contribute to more effective long-term outcomes. The effectiveness therefore of these projects is to **value process over outcomes** in a way which facilitates their work. Or rather, part of their success is in their ability to conceive of outcomes in a more holistic way which does not lead to notions of process being compromised.

Of course, such a successful approach is highly at odds with the first maxim in this section, that of securing long-term finance. Valuing the intangible, psycho-social aspects of health promotion is not easily compatible with the language of health service providers and other such funding agencies. Hence another key basis of the success of these three projects, especially the Bromley-by-Bow Centre and Silver Song Clubs, is their **ability to be process-orientated, articulating their work in a language of outcomes**.

Central to this question is the task of quantifying the 'soft' variables which are typically beyond measurement and therefore beyond the instrumental rationality of policy-makers and funders. Whilst the Bromley-by-Bow Centre, can seemingly afford to flout such conventions through its innovative entrepreneurship, status and its location within a high-priority area, the long-term viability and success of the other two projects, especially the song clubs, is dependent to a degree on their ability to prove their **cost-effectiveness**. Innovative techniques are required to establish in the format required to convince funding agencies.

3.2 Specific Recommendations for Project Aims (1 page)

Inequality

Of the three projects, the Bromley-by-Bow Centre was clearly the most directly concerned with tackling inequalities. Having a central building in the midst of the community were a wide-range of services, health and otherwise, are located would seem to an effective way of engaging people within the community and building relationships. There remain however a large portion of the community who will still need to be reached proactively. Hence the role of outreach workers or a range of professionals from various agencies who are able to refer at-risk older people is essential. In this sense specific targeting is important to reach the most vulnerable and maximise efficiency of limited resources.

When older people are referred or reached, there is a need for holistic referral which considers a wide-range of physical, mental and social issues – such are the complex and interdependent factors which affect the health status of those most vulnerable

from inequalities. Multi-disciplinary teams are therefore crucial to the ability of interventions to adequately deal with the co-morbidities impacting on such older people.

Social Determinants

Social determinants are closely related to inequalities, though one cardinal determinant which is influential across all older people, regardless of socio-economic status or other factors of inequality, is social isolation. This is a huge factor recurring through much of the UK literature and indeed these three projects. Combating isolation and integrating older people into communities can have a large positive impact on mental and social health.

Sustainability

Many of the conclusions regarding outcomes in section 3.1 are pertinent to considerations of sustainability. The abilities of projects to articulate the value of their work to funding agencies is crucial to their long-term viability. Associated with this is of course the need to financially quantify the value-added effect of their work on older people's lives and, especially, the potential savings such health promotion would bring to health services in terms of hospital admissions or chronic care.

Multi-agency involvement spreads the risk of financial support so that projects are not totally dependent on one source of income. It also increases the capabilities of interventions to engage a wider number of older people. Though there are risks involved with multi-agency work in terms of transaction costs.

Cost/benefit ratios can be improved through the use of volunteers and harnessing the latent capacities within the community being reached. Such voluntarism is more likely to be harnessed by organic projects developing from within the community rather than those created by health providers. Hence policy-makers, as is increasingly the case in the UK, may maximise the return of financial investment by funding charities and third-sector projects already in existence rather than creating new schemes themselves, though this assumes the existence of an active, creative and efficiently organised voluntary sector.

Finally, it is essential in elucidating principles around efficiency that the discussion does not become disembodied. The individual champions driving these projects and the enthusiasm shown by many of those involved are crucial to their long-term success. Awareness of local funding streams, and how best to access these, is fundamental to sustainability and such knowledge is often held by one or two vital individuals.

4 References

Caiels, J. & Thurston, M. (2005). EVALUATION OF THE WARRINGTON FALLS MANAGEMENT AND PREVENTION SERVICES. Chester: Centre for Public Health Research, University of Chester

Froggett, L., Chamberlayne, P., Wengraf, T. and Buckner, S. (2005) BROMLEY-BY-BOW CENTRE RESEARCH AND EVALUATION PROJECT: INTEGRATED PRACTICE – FOCUS ON OLDER PEOPLE. London: Bromley-by-Bow Centre

Health Promotion England (2001a). FACT SHEET 2: OLDER PEOPLE AND ACCIDENTS. London: Health Promotion England.

McNulty and Parsons, (1999) COMMUNITY ACTION ON HEALTH ANNUAL REPORT 1998-1999. Newcastle upon Tyne: West End Health Resource Centre.

SFYL = Sing for your life (2007a) BE PART OF IT: SING FOR YOUR LIFE! [Information leaflet]. Folkestone: Silver Song Clubs

Sing for your life (2007b) SILVER SONG CLUBS: SUPPORTING OLDER PEOPLE THROUGH PARTICIPATION IN RESEARCH DRIVEN AND PROFESSIOANLLY DELIVERED PROGRAMMES OF PARTICIPATORY MUSIC – OVERVIEW, RATIONALE AND RESEARCH. Folkestone: Silver Song Clubs.

Wanless, D. (2002) SECURING OUR FUTURE HEALTH: TAKING THE LONG-TERM VIEW. London: HM Treasury.