

Health Development Agency

The Gap Years: Rediscovering Midlife as the Route to Healthy Active Ageing

A report of a national evaluation of eight pilots focusing on improving health for people in midlife (50 to 65 years)

Helen Bowers, Jenny Secker, Marlen Llanes, Dale Webb (2003)

This comprehensive report presents the findings of a national evaluation of an England-wide initiative, resourced from the Department of Health's Public Health Development Fund, and managed by the Health Development Agency. The initiative aimed to explore and develop effective interventions for supporting and promoting health amongst people aged 50 to 65 years. The evaluation was carried out by the Older People's Programme, Kings College London.

The report, which spans the period September 2001 to September 2003, is divided into four parts: 'Setting the Scene', 'The Journey of Discovery', 'What Works, for Whom, in Which Circumstances, and Why', and 'Modelling the Future'. The evaluation adopted a hybrid approach based on two key methodologies: Realistic Evaluation, focusing on establishing key contexts, mechanisms and outcomes, and Theories of Change, identifying and making explicit the underpinning assumptions and local 'theories of *why* certain interventions will lead to desired outcomes for specific target groups. The authors concluded that this style of evaluation is important for evaluating policies that seek to enlighten practitioners and policy makers about the ways in which they could use the lessons from successful pilot initiatives.

The report sets out a strategic framework that needs to be adopted at a regional and local level, supported by a clear and cross government policy on active ageing that takes a life course approach. It focuses on targeting the needs and circumstances of people in midlife that will contribute to improving health and well being – whilst reducing inequalities in health and opportunities for an active older age.

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Headline Messages

- ❖ The cohort of men and women currently aged around 50 to 65 years consider themselves a distinct generation with particular preferences and needs, which have not been recognised in the delivery of public services. They do not identify themselves with 'older people' services, and feel ignored by generic adult services.
- ❖ People in their fifties are experiencing multiple transitions, which enable them to 'take stock' of where they are and where they are going. The awareness of growing older means that this cohort are receptive to health improvement messages that can lead to a more independent, healthier old age.
- ❖ A strategic whole system approach to local service delivery is required in order to effectively capture multiple methods and partnerships. Service settings also need to be varied to capture the diversity of this cohort; the workplace, community venues and primary care settings were identified as key places.
- ❖ People wanted opportunities to reflect and consider their futures and plan what they needed to have a healthy and active older age. They wished to be enabled to take forward their actions themselves, and services to be available to meet their choices. They did not want welfare services or to be 'done to': empowerment rather than dependence.
- ❖ In policy terms, this cohort is key to reducing health inequalities and improving the gap in life expectancy (as well as quality of life in old age), within the next ten years.

Forward Programme of Work

The Health Development Agency has developed a three year programme of work (2003-2006) to ensure the learning from this initiative goes forward to influence practice development and policy formation at national, regional and local levels. A range of activities, resources and tools will be produced to support change.

Full report available on the Health Development Agency website: www.hda.nhs.uk from the beginning of November 2003. For further information please contact:

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improving health for people in mid-life (50 to 65 years)

Helen Bowers, Jenny Secker, Marlen Llanes, Dale Webb

Produced for the Health Development Agency by the National Evaluation Team, Older People's Programme,
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About the Health Development Agency

The Health Development Agency (www.hda.nhs.uk) is the national authority and information resource on what works to improve people's health and reduce health inequalities in England. It gathers evidence and produces advice for policy makers, professionals and practitioners, working alongside them to get evidence into practice.

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Summary

This report presents the findings of a national evaluation of an England-wide initiative, resourced from the Department of Health's Public Health Development Fund. The initiative aimed to explore and develop effective interventions for supporting and promoting health among people aged 50–65 years.

The Pre-retirement Health Initiative spanned a two-year period, from March 2001 to March 2003, and featured a range of activities, services and interventions supported through the work of projects in eight pilot sites around England. The main aim was to reach people at the time of retirement transition, supporting them in considering their health and wellbeing to increase the likelihood that they will experience a healthier and more active older age. A secondary aim was that this would, in turn, reduce the burden on the NHS of an ageing population (that is not healthy and active). In addition, the initiative was to focus on people in lower socio-economic groups, or those otherwise socially excluded, to address inequalities in health (and health-related opportunities).

The initiative included a comprehensive programme of evaluation. Each pilot project was accompanied by a local evaluation, funded and commissioned by a local project team. In addition to this local work, this national evaluation was commissioned by the Health Development Agency (HDA), focusing on the cross-cutting messages, lessons and evidence emerging not only in, but also across, the eight pilot sites. Each local evaluation produced an individual report concerned with the activities and outcomes achieved by the individual pilots. The national evaluation spanned the period September 2001 to September 2003.

This report is the last of a series of five produced for the HDA over the two-year period. Each of the previous four interim reports focused on the emerging findings, and on building evidence as observed and analysed at six-monthly intervals.

These interim reports captured the unfolding story, at specific points in time, of:

- What works when promoting and improving health for 50–65 year olds
- For whom – specific target groups and populations
- In which circumstances – local geographic, political, socio-economic and demographic contexts
- Why – specific aspects of design, delivery and experience that determine why some people engaged in and benefited from these experiences.

Our final report synthesises that story to give the complete picture at the end of this two-year initiative. It does not attempt to replicate the content of the previously published interim reports.

This summary provides a guide to the full report. The aim is to highlight the salient points presented in each chapter so that readers are able to locate material most relevant to themselves. The structure of the summary therefore reflects that of the full report, covering the main points to emerge from each of the 12 chapters, which are presented in four parts.

Part 1 Setting the scene

The first part of the report covers the main contextual issues and policy frameworks, and the background to the pre-retirement initiative. It also introduces the national evaluation.

Chapter 1 National and European contexts

In common with other European countries (and beyond), England's population is ageing. The number of people aged over 60 years outnumbers those under 16 for the first time in history. Those in the mid-life age group (50–65 years for the purposes of this study, although other studies cover

those born between 1945 and 1965) form one of the largest cohorts of the total UK population, at 29% (17 million).

The benefits of adopting a life-course approach to improving health and wellbeing in later life are set out in European and World Health Organization policy frameworks on 'active ageing'. A number of studies and government reports have also set out some of the main challenges and goals for meeting European directives and guidance, while addressing national priorities around regional variation and inequities in health, employment and education (among other variables) in mid- and later life.

In addition, a significant body of evidence suggests that targeting people at times of transition (eg in mid-life) is an effective strategy for engaging and supporting people in making decisions and changes (eg financial planning and management, work, lifestyle and health) for improving health and the prospects for an active later life.

Chapter 2 Introducing the Pre-retirement Health Initiative

In terms of its origins, funding and management, the Pre-retirement Health Initiative falls in the policy area of health, and more specifically the NHS. It is most often linked to Standard 8 of the National Service Framework (NSF) for Older People (Department of Health, 2001), but it is also clearly associated with the NHS Plan, and in particular its vision for preventive healthcare (Department of Health, 2000).

Pilot projects joined the Pre-retirement Health Initiative in two waves. Three projects initiated their activities in the first quarter of 2001, following a literature review and mapping exercise that identified these projects as having potential for development in an area where little other activity appeared to be taking place. The first three pilot projects were:

- **Hull and East Riding Health Promotion Unit.** This project was hosted by Hull and East Riding NHS Trust, with a primary objective of producing a resource pack targeted at people in the mid-life age group; a training pack; and training courses on use of the resource pack.
 - **North Nottinghamshire Health Authority.** The aim of this project was to offer four-day courses on a broad range of issues concerned with health, benefits and pre-retirement. The primary target group included people working for local NHS and local authority agencies; the business sector, concentrating on the main industries in the area; and unemployed people in the mid-life age group.
 - **Agewell Project, Age Concern, Sandwell.** This project, based in and around Sandwell, West Bromwich, worked in conjunction with Workwell (a regional, multi-sector initiative focused on improving employment opportunities and experiences) with the aim of designing and offering health checks to employees of small and medium-sized enterprises located in the area. It also sought to offer opportunities for these employees to become involved in physical activities, and to produce an information pack on pre- and post-retirement.
- Following an open bidding process between April and July 2001, five further pilots were funded.
- **East Devon Primary Care Trust.** This project covered a predominantly rural area. The original aim was to offer health checks and advice on health and financial matters for four target groups: employees of small businesses; farmers; community residents; and people with learning disabilities. In the event it proved impossible to address the needs of the latter group. A range of community development strategies were adopted to reach the other groups.
 - **Guy's and St Thomas' NHS Trust.** The project was hosted by this NHS Trust but implemented in community settings across the borough of Southwark, south London. The main activities offered through the project included developing and establishing a website; training in IT and use of the Internet for people aged 50–65; and establishing social activity groups. A specific aim was to address the needs of more marginalised and isolated people, including people from black and minority ethnic communities and unemployed people.
 - **Beth Johnson Foundation, North Staffordshire.** The main aims of this project were to develop a greater understanding of the health beliefs of the target population; to develop a community-based advisory service; and to train lay peer advisers to provide health advice to local people in the target age group. The project used a community development approach in four localities, three of which were receiving a service by the end of the funded period.
 - **Osteoporosis Dorset.** This project covered a relatively densely populated area. The original aim of the project was to offer pre-retirement health checks for women aged 56–65 currently registered with three GP practices, two of which ultimately participated. The checks included heel bone scans and a range of specific diagnostic processes (blood test, urinary tests) carried out by a trained technician. An additional aim was to link these medical

interventions to a wider range of information and advice about healthy lifestyle issues and opportunities in the localities covered by the pilot.

- **Hackney Age Concern.** This project was led by Age Concern in Hackney. It aimed to offer health checks and the development of individual health plans to people aged 50–65 living in the area. It also aimed to produce a comprehensive guide to health promotion services and health-promoting activities available in the borough. A major goal was to facilitate access to local health and leisure facilities, and to focus on specific groups experiencing fewer opportunities for improving health and wellbeing,

Although originally a 'health' policy, it became apparent from the work of the pilots that improving health and wellbeing depends on a wide range of variables and circumstances. Not least of these are the different contexts and environments, both in which people live, and in which policies are formulated, disseminated and implemented.

The range of interventions and mechanisms developed to aid this implementation and deliver public services to local populations extend far beyond traditional and familiar NHS and local authority service provision. They encompass local amenities (both public and privately owned, funded and delivered), and products/goods and employment opportunities available through local business and enterprises.

Chapter 3 Introducing the national evaluation

The aim of the national evaluation was twofold:

- To provide learning to inform the roll-out of pilots and the development of standards for pre-retirement health advice and services
- To contribute to a framework for both national and local self-evaluation tools.

To achieve these aims the evaluation adopted a hybrid approach based on two methodologies: realistic evaluation, focusing on establishing the major contexts, mechanisms and outcomes (CMOs) of the pilot projects; and theories of change, identifying and making explicit the underpinning assumptions and local theories as to why certain interventions will lead to desired outcomes for specific target groups. The evaluation consisted of a series of four phases, spanning the period September 2001 to September 2003. It developed a framework to work with the pilot projects and the local evaluations to examine and capture what works, for whom, in which circumstances, and why, across all eight sites during the period of their development work.

The approach and style of working was developmental: each phase of data collection and analysis was used as the basis for fine-tuning the design of, and approach to, each subsequent phase. This offered a powerful means of exploring important questions and lessons across a number of diverse projects, contexts and populations. Part 2 describes the evaluation in more detail.

Part 2 Our journey of discovery

This section sets out the main components of the evaluation, and describes and illustrates how building the evidence base grew over the four phases of the work. The four phases of the evaluation comprised:

- Orientation – a mapping phase aimed at building an understanding of the pilots' contexts, mechanisms and anticipated outcomes
- Exploring the pilots' theories of change – through workshops with representatives of the pilots and their partners
- Testing the theories of change – using interviews with project service users and partners
- Refining the theories of change – through three workshops held with a range of stakeholders in the Pre-retirement Health Initiative, to inform the development of a strategic framework for improving the health of people aged 50–65.

In addition, we reviewed the final reports from the pilots' local evaluations as part of an analysis of evaluation methodologies and outcomes. This analysis was used to develop a framework for both national and local self-evaluation tools.

Chapter 4 Understanding contexts, mechanisms and outcomes and their theoretical underpinnings

This chapter draws on the findings from the first two phases of the evaluation. The process of mapping and developing an understanding about the CMOs for each of the pilot projects highlighted the presence of, and relationship between, a number of important features, including:

- Economic characteristics
- Socio-demographic characteristics
- Area of projects' influence
- History of work, specifically health-promoting work, with people in mid-life
- Organisational and, importantly, system effectiveness
- Nature and type of partnership arrangements

- Aims and objectives of projects
- Interventions and activities undertaken and approaches adopted by each pilot
- Methods by which these were examined, and measures of impact assessed through local evaluations.

This web of simultaneous factors and influences is complex, both in each pilot and across all eight pilots (Figure 2, page 30).

Four theories of change were identified during phase 2 of the evaluation: engagement, empowerment, social interaction and partnership. These can most simply be thought of as falling into two principal categories: psychosocial theories of change; and theories that emphasise the benefits (and requirements) of partnership working. Although some theories were evident across all eight projects, others related to particular approaches or types of activity (eg theories of social interaction).

The psychosocial theories of change were primarily concerned with two processes seen by pilots as central to successful client journeys: engaging clients; and engendering in them a sense of empowerment. These theories of change are not new – articulated in various ways, they have long been enshrined as central tenets of health promotion and several of its contributory disciplines. This does not mean, however, that identifying and exploring them in the context of this evaluation is simply reinventing the wheel. Precisely because psychosocial theories are so embedded in health promotion, they have arguably become taken for granted and unquestioned. Also, they have not previously been extensively explored in relation to health-promoting activities designed for and experienced by this age group.

Chapter 5 Learning from the local evaluations

The experiences of the comprehensive evaluation programme (local and national) accompanying the Pre-retirement Health Initiative illustrate the importance and benefits of adopting a multi-layered and theory-based approach to evaluation. This framework of evaluation is important for evaluating policies that seek to enlighten practitioners and policy-makers about how they can use the lessons from successful pilot initiatives.

Issues remain about how well prepared policy and practice audiences may be for this kind of approach. The temptation to wait for the results of evaluations focusing on pre-determined volume measures (how many people received what kinds of interventions over what period) still prevails. The complex nature of outcomes is still less well understood. In addition, the links between CMOs are more complex, as is

their relationship with the specificity of objectives and scale of ambitions.

To develop a framework for future evaluation programmes of this nature, a model of evaluation is proposed which is based on theory-driven approaches (such as theories of change), and which incorporates five major factors, including impact and process assessments (see 'Towards a model of pilot evaluation', page 35).

Part 3 What works, for whom, in what circumstances, and why?

This part of the report draws on phase 3 of the evaluation to set out the main findings and conclusions derived from the interviews with pilot participants (users) and partners through a process of testing and refining the theories of change presented in Part 2.

Chapter 6 Understanding the pilot participants

The summary box opposite summarises lessons from our analysis of interviews with pilot participants.

Implications for understanding what works, for whom and why?

- Health promoting services, information and activities can be effectively targeted at people in mid-life (50–65 years); this age group see themselves as a forgotten generation
- Accessibility of these services strongly determines whether they will take up the opportunities/services available
- Provision of a free health check is a significant motivator for engagement, stimulating interest and curiosity
- A desire for financial information and advice is a strong motivating factor
- Health issues can just as effectively be 'hooked' to a gateway service focusing on financial issues as vice versa
- Combinations of services and activities (eg individually tailored pre-retirement/planning courses coupled with health checks for those who want them) can be a potent mechanism for improving the health and financial wellbeing of working people in this age group
- Need (and perceived need) can be a strong motivator for engagement in deprived areas; targeted services (eg in deprived areas of high unemployment) can have the potential to address health inequalities for specific groups
- Women will extend their engagement to other agencies providing health-promoting and desirable activities following uptake of more targeted interventions that meet these needs
- Service settings are crucially important for engaging people; the appropriateness of the setting will depend on the type of service delivered and the circumstances of the target group
- Primary care is an appropriate setting for delivering clinically oriented services to women in relatively affluent areas
- The workplace is an appropriate setting for engaging men in full-time employment and was effective in Sandwell in engaging female Asian workers
- The use of community settings where people normally come together, which can be easily accessed, and with which local people identify is an effective way of reaching marginalised groups, isolated people and those living in rural locations
- A welcoming atmosphere created by staff with well developed inter-personal skills is crucial for engagement in both informal and formal settings
- Engaging target groups that services and professionals can find difficult to reach can be enhanced by involving them in identifying needs, shaping and developing services, and enhancing their personal contributions
- When alerted to previously undiagnosed conditions, women will extend their engagement to other health services
- Knowledge gain is important and beneficial in contexts such as introduction of information about new issues (eg financial planning); detection of previously undiagnosed conditions (eg empowering women to engage in informed dialogue with health professionals); and introducing people to previously unknown agencies
- Reinforcing and validating pre-existing knowledge is a potent mechanism for achieving behaviour change in other contexts
- Providing opportunities for women living in deprived areas to engage in social activities with their peers can directly, and indirectly, lead to improvements in mental and physical wellbeing
- Social interaction is also a potent mechanism for generating a sense of empowerment among this target group.

Chapter 7 Understanding the pilots' partners and partnerships

The findings from interviews with the pilots' partners that are most relevant for shaping the strategic framework presented in Part 4 are summarised in the box below. The summary emphasises an understanding of the central role and potential added value of strong, effective and locally determined partnerships and partnership arrangements.

Chapter 8 Refining the underpinning theories of change

The following summarises the main points and cross-cutting themes that emerged when the pilots' theories of change were refined through the phase 4 workshops.

Developing local knowledge and understanding about needs and preferences

- Success is more likely, or more readily achieved, when a comprehensive needs assessment is undertaken before embarking on project development.

Messages for understanding what worked for partners

- Clear purpose, goals and parameters for the work of the partnership, but with flexibility built into arrangements from the start, ensuring adaptability to meet changing local and organisational circumstances
- Shared clarity about aims, intended outcomes, outcome measures and secondary benefits
- Clear working and organisational arrangements, including leadership, facilitation, communication, operation, provision of services and activities, resource allocation and decision-making processes
- Partnerships can assist local agencies in overcoming traditional barriers between service sectors, and in developing good inter-personal relationships
- Major partners should be engaged from the beginning – in formulating ideas; in developing bids and funding proposals; in designing the suite of services/information; and in delivery, review and future development
- Considerable time and effort are required where partnerships have to be built from scratch
- Wherever possible, partnership arrangements should build on and exploit existing networks and contacts, but opportunities for more spontaneous collaboration should not be dismissed or overlooked as they arise
- Information and activities made available by partner agencies can encourage a range of people to take up health checks and other services offered
- Partners are valued sources of advice, information and contacts
- Partners can promote project services and signpost current (and potential) service users/participants to them
- Effective partnership working can stimulate further developments in and across partner agencies
- Partnerships are central to sustaining pilot project activities, and are an important vehicle for mainstreaming health-promoting activities
- The same principles of effective partnership working apply to commissioning/funding partners as they do to providers/deliverers
- Effective partnership working requires each partner agency to be flexible and adaptable, and to tailor their services to meet emerging as well as identified needs and preferences.

- When needs assessments actively involve members of the target group, eg in focus groups or carrying out surveys, engagement of the target group is facilitated.
- Needs assessments that address the target groups' contexts – historical, social, economic and biographical – as well as specific health/retirement needs help to ensure that information is meaningful and coherent to the people concerned.
- Specific efforts to reach disadvantaged groups need to be made if health inequalities are to be addressed.
- Engaging people in assessing needs and developing services is worthwhile and is particularly important for engendering ownership, but is an ambitious aim which takes time to achieve on any significant scale.
- Careful attention needs to be paid to the diverse situations in which people find themselves and the diverse range of opportunity and preferences that exist – this is a crucial part of any local needs assessment but is often overlooked, and without this intelligence it is difficult to develop appropriate and sensitive approaches towards engagement and empowerment, particularly for hard-to-reach groups.

Developing a portfolio of services, activities and interventions

- One model, approach, intervention or activity will not suit all the requirements of all target groups, across different communities, living in different localities, and influenced by various contextual and historical factors. What is needed is a range of services encompassing information, advice, specific interventions (eg general as well as more specialist health checks), physical and social activities, opportunities for learning and education, and practical help with planning and developing personal strategies for understanding and managing change and transition.
- The eight pilots offer valuable lessons for understanding which interventions and services are effective for meeting the needs of different groups in various situations. While some of these lessons can be generalised, others require further exploration to determine how they could be transferred (eg across different groups and contexts), and/or to assess their long-term impact.
- The information and advice that people in mid-life seek is not just about retirement per se, but is more about this stage in people's lives, where decisions about current and future work and income are dominant, but are not the only issues that occupy and challenge people on a day-to-day basis.

- A range of settings is required, depending on the nature of project activities and the specific target group (eg women in Hackney and Dorset benefited from different formats). Privacy needs to be ensured in public or communal community settings (East Devon). Security of valuable equipment, such as computers, can be problematic in community settings (Southwark).

Outstanding issues that require further work

- Increasing engagement and active participation of people in this age group from black and minority ethnic communities.
- Extending engagement with agencies and activities for different target populations, other than in the contexts and for those target groups outlined above.
- Returning to the labour market was a concern for unemployed respondents that none of the projects fully addressed.
- Appropriate settings for delivering clinically oriented services to men and to people living in deprived areas.
- The potential for providing access to IT, and the training required to use it, for people who are unlikely to have Internet access at home or at work.
- Other educational and personal development issues were raised in interviews with pilot participants that require further exploration, in terms of their perceived and potential benefits for improving health and wellbeing for this age group.
- Extend opportunities for group work and social activities in deprived areas to larger numbers, and to men; and review whether health benefits (as experienced by women in Hackney and Southwark) are achievable.
- Men's health in this age group requires further exploration in relation to both physical and mental health and wellbeing; and appropriate settings, venues and formats for individual and group activities and services.
- A need for sharper focus on mental health and wellbeing in health improvement and prevention work – there are important links between good physical health and wellbeing (Southwark and Hackney) which, in turn, influences mental health; those experiencing the benefits of physical activity also indicated that they changed their behaviour in other respects (diet, social interaction).

Part 4 Modelling the future

This final section of the report sets out the strategic framework that we suggest needs to be adopted at a regional and local level, supported by a clear cross-governmental policy on active ageing that takes a life-course approach, with a clear focus on targeting the needs and circumstances of people in mid-life.

Chapter 9 Targeting health improvements and reducing health inequalities for people in mid-life

The first three sections of this report demonstrate the benefits of targeting health improvement activities at people in mid-life. A significant number of the participants interviewed for the evaluation shared their sense of feeling neglected in terms of understanding about their circumstances, aspirations and needs. The different transitions participants were experiencing meant they were receptive to information and advice, practical ideas, and opportunities for participating in a range of activities and services aimed at improving their personal situation and overall wellbeing.

For those involved in shaping and delivering the work of the local projects, there were a number of challenges in securing commitment and resources for sustaining the work they had begun (or developed) through this initiative. One of the most important lessons was the need to demonstrate how the activities either delivered or contributed to the achievement of existing performance targets and national standards across different industry and service sectors. The main challenge here is in raising the profile and status of longer-term targets, to which all agencies are required to contribute, but which have less currency than more quantifiable, volume-based measures around specific treatments and interventions.

A second lesson is the need for a multi-faceted approach to service development and delivery, to respond to the range of contexts and situations in which people live, work and experience family and community life throughout their lives; and in which policies are formulated and implemented, and services are delivered. There is no single model of service design and delivery that will meet all needs, in all situations, at all stages of life.

This picture of diversity and complexity highlights the need for much clearer cross-government direction and a joined-up policy framework for health improvement in mid- and later life. A common theme that resonated from all three of the phase 4 workshops was the lack of clear leadership and direction at national and regional levels; and the need for an

explicit steer on investing in health-promoting activities for people in mid- and later life. There is a sense of confusion, stemming from that lack of clear leadership, about where this agenda fits in terms of government policy, regional and local implementation, and investment plans.

A clearer national policy and strategic framework should adopt a life-course approach to health and wellbeing encompassing education, employment, social networks and interaction, community development and economic regeneration, support for those with significant caring responsibilities, and targeted health interventions. Practical information and help with personal financial planning and management was also highlighted as a major concern for people in mid-life.

The framework suggested in Chapter 10 is intended to illustrate how initiatives and developments at different levels, and in different government departments, could be integrated to mobilise a powerful force for change.

Chapter 10 A strategic framework for promoting health and opportunities for improving wellbeing in mid-life

The framework described here represents a regional strategy that underpins and guides local plans for developing and delivering a range of services and interventions to meet the needs and aspirations of local people aged 50–65 years. At the heart of the framework are the four theories of change identified during phase 3 of the evaluation: engagement; empowerment; social interaction; and partnership. These theories are both inter-related and distinctive in their own right (see Figure 3, page 64).

The following four principles are the central, guiding features of the strategic framework:

- Maximising engagement through providing a spectrum of information and advice services, interventions and activities focused on achieving health improvement for the local population aged 50–65 years
- Adopting empowerment strategies and approaches that maximise individual potential, and that harness personal and collective contributions to local and regional developments
- Increasing and improving opportunities for social interaction, and activities that promote interaction
- Building and sustaining locally relevant and effective partnerships across the range of stakeholders, agencies, organisations, businesses and employers who have an interest in, and influence over, the health and wellbeing of local people in this age group.

For these principles to become embedded in policy and practice, five mobilising sets of activities (elements) need to be established, as set out in the box below.

The five framework elements

- Planning and scoping
- Designing and laying foundations
- Investing, developing and commissioning
- Delivering and participating
- Evaluating and giving feedback

The components that make up the strategic framework are captured in Figure 4 (page 65). We have called the framework ‘the ship’s wheel’ – a metaphor for direction, leadership, partnership, and a journey of discovery into the characteristics, needs and effective strategies for promoting health and wellbeing in mid- and later life.

A commentary on the relationships between these elements and levels of action follows in the next chapter.

Chapter 11 Navigating the five elements

This chapter sets out the lessons from the pilots in relation to the five elements outlined above.

Planning and scoping

The projects demonstrated the benefits of knowing and understanding the demographic and socio-economic contexts affecting people on an individual as well as a collective basis. The following steps summarise activities to ensure the characteristics of the local population are understood, specifically the cohort of 50–65 year olds:

- Completing a health needs assessment adopting the interactive, community-based approach advocated by the HDA (see guidance available at www.hda.nhs.uk).
- Engaging the local population, and these target groups, in further development work to promote ownership and trust, and to engender confidence and interest in future activities, services and interventions
- At the same time, involving partner agencies who have either experience and expertise in the identified areas/issues, or contacts and networks among the 50–65 year old cohort and specific target groups, and who can contribute in terms of time, commitment, resources, venues, promotional materials and media

- Achieving sign-up and commitment in terms of investment, time and active participation requires sound leadership across partner agencies.

Designing and laying foundations

Even during the early stages, it is important to address some of the essential design features highlighted by the experiences of the pilots:

- To achieve the required multi-faceted approach effectively, investment in building a locally sensitive partnership(s) is vital to reach and sustain engagement with people in the target age group
- While recognising the lead role of PCTs and strategic health authorities in identifying, responding to and improving the health of their local populations, the experience of the pilot projects highlighted that this is not the responsibility of one agency alone
- What is more important is the nature and strength of the local partnerships that exist, the quality of relationships between partners, and the greater opportunities that exist through harnessing and using collective services, information, access points, venues and networks
- This is not only a collective in terms of what is provided; it is a collective in terms of responsibility, commitment and investment. It needs to involve local authorities, regional assemblies and development agencies, local businesses and enterprises, and local communities
- The notion of ‘social capital’ is the kind of approach we believe needs to be adopted at regional and local levels to address the health improvement priorities for the target age group
- A major objective should be to provide a free service, at least at the first point of contact, specifically in deprived communities where the health gap will be greater and more complex
- This first gateway should offer a combination of services including a range of information (financial, health-related, leisure/fitness or lifestyle, housing and benefits, local amenities and activities); general as well as specific, tailored advice; and health-related checks
- The initial point of contact should vary depending on the needs and characteristics of the local population and the target groups identified
- The experiences of pilot participants and partners highlighted some important lessons for local authorities about how information on local resources and facilities is accessed, and by whom; and how recent developments of one-stop shops and contact centres could be applied to ensure the needs of this age group are catered for

- There is a particular need to address the gap in relevant, accessible and practical financial information for the 50–65 age group; the source of information was highlighted as influencing potential participants
- As well as a desire for more information, the importance of advice and practical help to help plan, reflect and try things out has implications for different providers, especially in providing activities and services in different settings
- Major health issues that need to be targeted in this comprehensive range of services include: stress, mental health and mental ill health; specific issues for men (eg prostate cancer) and women (eg osteoporosis, menopause); weight, diet and nutrition; keeping fit and physically active
- Mental health, wellbeing and stress constituted a significant area of need and interest from participants – activities and opportunities for social interaction, improved relationships and links to community/neighbours/friends, and strategies for reducing the negative impact of competing pressures, were highlighted as beneficial
- The value of physical activity and exercise was emphasised by a number of respondents, particularly women – the perceived and actual benefits identified for women need to be extended and tested for men; primary care practitioners (not just GPs) should be mindful of local opportunities that they can tap into and engage with proactively as part of their role in tackling health inequalities and the local health improvement agenda.

Investing, developing and commissioning

This crucial element of the strategic framework will ensure the early preparatory work is translated into responsive, accessible and acceptable services that effectively meet the needs (and preferences) of local people in mid-life.

- An important lesson from the pilots' experiences is the value and cost-benefit of developing new services, as opposed to building on existing services to meet identified needs and priorities; this is important in terms of considering the workforce and skills required to deliver services
- Further work to extend the reach of such initiatives, and to address health inequalities in particular, may require more explicit commitment from local partners, including pooling of resources and expertise to achieve this; there is a clear role here for local strategic partnerships
- Access to community development and growth funding has facilitated innovative and effective partnerships in

some of the most deprived local authority areas in England

- The role of primary care trusts (PCTs) in securing future investment in, and development of, health improvement services for the target age group should be a more explicit priority.

Delivering and participating

The activities associated with this more tangible element of the strategic framework are concerned with a number of practical tasks that will ensure provision of a suite of services through locally determined mechanisms, taking account of specific access issues for the local population and identified priority/target groups.

- The setting, venue, style and approach of local services and staff were important determining factors for project participants and project partners
- There is a need for a mix of communal and private facilities, as well as a variety of types of locally accessible venues that people know and use, and where people choose to congregate
- The focus needs to be on creating informal, non-clinical environments (even in clinical settings) and thus on the quality of interactions between service staff and service consumers
- The venue and style of service must be tailored to local situations, populations and target groups – this will be more easily achieved through using the networks, contacts and venues of partner organisations and agencies, including local businesses, trade unions, community facilities and domestic residences, as well as statutory premises
- Information should be provided in a range of formats and via different media; the source of different types of information needs to be considered to ensure it is credible, noticeable, relevant, and connected to messages or other information provided for specific groups
- A good prognosis for sustaining involvement and engagement in the longer term is ensured through the provision of gateway or signposting services which hook people into other activities, interventions or information.

Evaluating and giving feedback

A multi-stranded approach to evaluation can provide evidence of effectiveness and knowledge for replication purposes. An accountability function is served by demonstrating not just that resources are spent as intended, but that they are spent well. The following points relate to local evaluations where no national evaluation is

commissioned. Where a national evaluation is commissioned, they provide a starting point for agreeing an appropriate division of labour between national and local evaluators.

- Impact assessment: ensure the approach and methods adopted are based on principles and practices of impact assessment. It is important for services to generate evidence of their impact on specific populations – what worked, and how powerfully. The use of robust pre/post assessments can provide good evidence of impact; but impact can also be assessed qualitatively. A commitment needs to be made to partners and other stakeholders, by developing and agreeing criteria for effectiveness and assessing impact from a range of perspectives.
- Timescale for the evaluation: in many cases this requires a commitment to evaluate impact beyond the funded period of services, especially pilots. If some of the anticipated change is expected to occur post-pilot (or funding period), then data collection and evaluation should be timed to assess post-pilot impact.
- Understanding processes of implementation: for knowledge transfer to occur, evaluation needs to examine the factors associated with successful implementation. However, providers and commissioners (whether of a project, pilot or mainstream activity) should also routinely collect a basic minimum data set concerning the age, gender, ethnicity and social class of recipients.
- Understanding the dynamics of change: knowing whether something works and how powerfully it does so is insufficient unless the evaluation can also identify how and why it works. This requires a commitment to some form of theory-based evaluation, in which initial assumptions and expectations about how the pilot might work are made explicit and the roles of anticipated change mechanisms are tested.

Chapter 12 Setting sail: applying the framework at national, regional and local levels

For the elements of the strategic framework to be addressed coherently and effectively, a number of important actions and responsibilities fall under the remit of various stakeholder groups operating at national, regional and local levels. In this final chapter we identify four main routes through which these actions could be addressed:

- Refining, applying and disseminating the evidence base of what works, for whom, and why, through a nationally driven and supported demonstration phase
- National direction and guidance, through clearer cross-government policy and identifiable leadership on

promoting healthy, active ageing adopting a life-course approach

- Regional implementation and leadership for mobilising important strategic and commissioning partners and the appropriate partnership machinery to take this forward locally; harnessing and pooling investments and securing commitment; overseeing population needs assessment; identifying and agreeing priorities; setting out and supporting the achievement of local implementation goals and targets
- Local initiative and action to take forward developments, implement regional and local strategies and develop locally responsive partnership arrangements for delivering a range of services and activities to meet identified needs, and to achieve national, regional and more locally determined goals and priorities.

Part 1 Setting the scene

This first section sets the scene by describing the contexts and scope of the Pre-retirement Health Initiative and of the national evaluation. Chapter 1 examines the national and European policy contexts in which the initiative was located. Chapter 2 introduces the initiative, and presents an overview of the eight pilot projects, their origins and initial aims. Chapter 3 turns to the national evaluation and considers its scope, design and methods.

1 National and European contexts

Our ageing world

The age structure of England's population is following global trends – we live in an ageing world. The UK census in 2001 confirmed what we have known to be true since the previous 1991 census – that the proportion of the population over 60 has increased to such an extent that there are now more people over the age of 60 than there are children. The 2001 census by area for England and Wales identified that the proportion of people aged 15 and younger is 18.9%, while the proportion of people aged 60 and over is 20.76% (Office of National Statistics, www.statistics.gov.uk).

A range of responses and approaches can be observed with regard to our ageing world. These span the spectrum of attitudes, from a somewhat negative and pessimistic view that equates age and ageing with ill health and an increasing financial burden on the welfare state, to those who take a more optimistic and proactive stance. The latter is exemplified by the underpinning principles and goals of World Health Organization (WHO) strategies and European Union directives and guidance on active ageing – the latter requiring all EU member states to produce a national strategy on active ageing (European Council, 2001).

The European policy context

The European policy framework sets out a clear challenge to member states to adopt a life-course approach to active ageing. This recognises that different population cohorts are not homogeneous, and that individual diversity tends to increase with age. Interventions that create supportive environments and foster healthy choices are important at all stages of life. Research increasingly shows that the origins of risk for chronic conditions such as diabetes and heart disease begin in early childhood or even earlier. This risk is subsequently shaped and modified by socio-economic

status and experiences across the whole lifespan. The risk of developing health-related problems and chronic and disabling conditions continues to increase as people age. But a number of factors are now well known as major factors in increasing the risk, such as tobacco use, lack of physical activity, inadequate diet, and other established, so-called adult risk factors. There is a need to address these factors throughout the life course. In addition, the European Employment Guidelines on Developing a Policy for Active Ageing (European Council, 2001) set out explicit requirements for member states to address discrimination and mechanisms for improving employment opportunities for older workers (over 50 years).

The benefits of a life-course approach advocated in *Active Ageing: A Policy Framework* (WHO, 2002) are summarised in Box 1. These, it is argued, are more likely to be realised when health, labour market, employment, education and social policies simultaneously and consistently support active ageing.

Box 1 Benefits of a life-course approach to healthy active ageing

- Fewer premature deaths in the highly productive stages of life
- Fewer disabilities associated with chronic diseases in older age
- More people enjoying a positive quality of life as they grow older
- More people participating actively as they age in social, cultural, economic and political aspects of society – in paid and unpaid roles and in domestic, family and community life
- Lower costs related to medical treatment and care

The literature on transitions and the life course has shown that people are receptive to new information, ideas and advice (particularly about their health) during periods of transition. They are more likely to try new things, to reflect, and to identify potential and actual benefits (Phillipson, 2002). People in mid-life¹ are typically in a period of transition in their lives due to many, often competing, factors:

- Changing work circumstances
 - Changing or new caring roles
 - Heightened awareness of own mortality
 - Changing physical and health issues
 - Changing economic circumstances (due to a combination of some or all of the above, especially changing work circumstances).
- (Granville, 2002)

So the mid-life age group, experiencing a number of simultaneous transitions, is an important target group in terms of focusing attention for improving health and reducing health inequalities – most notably around inequalities in life expectancy, health, employment and educational opportunities, and other influences on quality of life and wellbeing in later years (Mann, 2001). As a result of these transitional experiences they are more likely to be receptive to information, ideas, opportunities and practical advice/guidance that focus on improving health and increasing opportunities for participating in health-promoting activities.

The mid-life age group

Mid-life has attracted a great deal of interest over recent years in terms of policy (eg New Deal 50+); research and development (eg the Transitions After 50 programme hosted by the Joseph Rowntree Foundation; the Pre-retirement Health Initiative funded by the Department of Health); political and socio-economic studies (eg a recent Demos publication, Huber and Skidmore, 2003; the Cabinet Office publication *Winning The Generation Game*, 2001); and attempts to engage regional assemblies and organisations in exploring mechanisms and local policies for ensuring equality of opportunity and contribution, eg Regions for All Ages (Age Concern England/English Regions Network, 2003).

Two phenomena have influenced this growing interest. First, a recognition that the prevailing negative and economically driven response to the challenges associated with an ageing population is no longer appropriate or sustainable.

The following quote from *The New Old* captures a more optimistic and inclusive stance, similar to the approach European member states are being encouraged to adopt, which until now has been a marginal voice:

'... there is a cardinal error in projecting today's expectations and assumptions on tomorrow's numbers. The result is a public debate that is highly negative, focused almost exclusively on the economic and fiscal dimensions of an ageing society at the expense of its wider, and deeper, social, cultural and political implications.'

(Huber and Skidmore, 2003)

Second, a point equally well made by the Demos report is the growing understanding that today's generations of people in mid- and later life are not the same as tomorrow's. A narrow and ungenerous attitude toward ageing will no longer be tolerated. In particular, the current generation of people in the mid-life age group – more popularly known as the 'baby boomers' (Huber and Skidmore, 2003) – are seen as being instrumental in shaping future policies and attitudes around age and ageing. As well as experiencing the kinds of transitional experiences outlined above, this cohort is seen as representing a watershed of both public and political opinion.

So who are these important and influential mid-lifers? And are they all equally blessed in their ability to shape future political, economic and social debates? It is important to know something about the numbers (people aged 50–65 represent one of the largest cohorts of England's age profile), and about the characteristics of this age group. Numbers alone will not provide the intelligence required to address the challenges and opportunities for improving health and reducing health inequalities in mid- and later life.

Twenty nine per cent (17 million) of the UK's population today were born between 1945 and 1965. This generation has lived through and experienced a number of profound developments and changes that previous (and future) generations have not: the birth of a welfare state; the growth of mass education; the sexual revolution of the 1960s and 1970s; and the rise of an increasingly consumerist society. Added to this are global developments such as the lack of large-scale (worldwide) military conflict, and the rapidly changing communications and computer technology industries. While the Demos report (Huber and Skidmore, 2003) shows that this is also one of the most divided and diverse generations, it does not fully address the causes and consequences of inequalities that exist in both experience and opportunity. These inequalities can be observed in and

1. There is no agreement about when 'mid-life' starts and ends; for this evaluation, mid-life refers to people aged 50–65 years.

across all ages and stages of life, but those affecting the mid-life age group are all the more profound when the range of transitional experiences is factored in. Some of the main differences experienced are identified as:

- Age and formative influences (depending on which phase of the baby boomer generation you were born into)
- Wealth (employment, unemployment, income and pensions)
- Longevity (including major variables such as health, wellbeing and social class)
- Education (including access to primary, secondary and higher education, and differences in rates and types of qualification)
- Gender (covering the pay gap between men and women, and differences in educational attainment)
- Ethnicity (highlighting the greater cultural and ethnic diversity of this generation compared to earlier generations)
- Politics (indicating a theme of liberalism, but also a decline in party identification and consequently a more fluid electoral environment).

Work and retirement in mid-life

One of the most striking features of relevance to our evaluation is around work, employment, unemployment and, of course, retirement. Nationally, one third of people aged between 50 and state retirement age are not in work – not always voluntarily. This has been estimated to cost the national economy £31 billion in wasted skills and experience, in addition to the impact on individuals, their families and local communities. Initial research in the East of England has shown the importance of addressing this trend to ensure that economic growth targets for the region are achieved. Other research in the North West and North East has shown the importance of addressing housing and health policies in the light of ageing (Pitura, 2002; Age Concern England/English Regions Network, 2003). The report *Winning the Generation Game* (Cabinet Office, 2000) was the first to highlight the range of issues surrounding people aged 50–65 years, including:

- Most people leaving work early do not appear to have done so voluntarily
- Most of these are far from rich – almost half receive most of their income in state benefits, and early exits from work contribute substantially to poverty
- People who leave work early often experience growing disillusionment and exclusion – they do not generally replace paid work with community activities or other

forms of employment (eg contract work or self-employment)

- The drop in work rates of people aged over 50 since 1979 costs the UK economy about £16 billion a year in lost GDP, and costs the Exchequer £3–5 billion in extra benefits and taxes (Walker, 2001).

A recent study of the impact on mid-life men and women of combining work and family life illustrates the inequalities that can arise for people in mid-life as a result of caring responsibilities. One in five mid-life women who have ever had caring responsibilities reported that, on starting caring, they stopped work altogether; and another one in five reported that they worked fewer hours or could only work restricted hours, and earned less money. When the statistics relating to those counted as family or unpaid carers are taken into consideration, these findings illustrate the need to reappraise the relentlessly positive mantra of the baby-boomer generation. There are 6.8 million carers in Britain, the majority of whom are aged under 65 years (80%, Office of National Statistics, 2002). The likelihood of caring for a sick, disabled or older person increases with age, rising from 8% of 16–24 year olds to a peak of 24% of people in mid-life² (Evandrou and Glaser, 2003).

This experience of juggling multiple roles, sometimes referred to (for people aged over 65) as the ‘sandwich’ generation (Adams, 2003), has recently gained more attention in relation to people in mid-life, eg through a series of research projects funded by the Joseph Rowntree Foundation programme, Transitions After 50. One of these projects, ‘Informal care and work after fifty’ (Mooney and Statham, 2002), highlights significant numbers of people in the mid-life age group who combine work with caring responsibilities for grandchildren, older relatives or their own children. They conclude that, without more resources to support carers, the largely unresourced and unrecognised contributions of this ‘pivot generation’ will not be sustainable. Flexible working hours, the opportunity to reduce hours or take a career break without incurring financial penalties, and good-quality, affordable support for carers and care recipients would help employees to combine work and care.

One of the major transitions facing people reaching and during mid-life is retirement. The government publication *Building a better Britain* (Department of Health, 1998) emphasised the need for better health promotion and increased opportunities for older people, eg to enable them

2. In Evandrou and Glaser’s (2003) study, mid-life was taken as 45–64 years; information from the British Family and Working Lives Survey 1994/95 was used to examine the impact of caring responsibilities on employment and subsequent state and private pension entitlement.

to access voluntary work, adult education and local amenities (libraries, museums, etc). The government also endorsed the 18 principles adopted by the United Nations General Assembly in 1991, which focused on the wellbeing of older people. Principle 3 suggests that older people should be able to participate in determining when, and at what pace, they withdraw from the labour market. The range of studies and reports commissioned through the Transitions After 50 series explores people's experiences, decisions and constraints as they pass from active labour market participation in their middle years towards a new identity in later life. Each report in this series looks at particular issues relating to work, income and activities beyond work during this period of transition. *Forging a new future* (Barnes *et al.*, 2002) highlights four major themes arising from a number of in-depth interviews with people aged 50–65 years in the UK:

- Problems and coping strategies in adjusting to retirement
- Importance of family and friendship networks in later life
- Impact of unexpected events such as redundancy, ill health or bereavement
- Policies needed to help people make the most of their retirement.

The majority of studies in this series focus on the opportunities and challenges associated with changes in work and income experienced by people in transition between paid employment, other forms of employment tenure, and retirement. Very few focus on the importance of health and wellbeing as prerequisites for taking up the opportunities that do exist, for developing coping strategies for managing change and the periods of stress and challenges that arise, and for the prospects of enjoying a healthy, active later life.

Health and wellbeing in mid- and later life

The NSF for Older People (Department of Health, 2001) emphasises the need to promote an active and healthy life in older age. In particular, Standard 8, 'Promoting a healthy and active old age', includes a number of targets at local and regional levels for increasing opportunities and decreasing inequity of access to resources to promote the health and wellbeing of older people. One of the major implications of the large increase of people in the 50–65 age cohort today is the subsequent increase in people over the age of 80 that will occur in the 2020s. There is a wealth of literature setting out the increased risks to health and wellbeing for people aged over 80, in terms of both physical and mental ill health. With regard to planning for and achieving a healthy and active older age, it follows that more attention should be

given to addressing the needs of people aged 50–65 years – not only for today's cohort of mid-lifers, but on an ongoing basis.

Following the publication of the NSF, the HDA completed a literature search and mapping exercise in relation to pre-retirement health (Lethbridge, 2001). This revealed that pre-retirement planning and provision of support services for people aged 50–65 is inconsistent and, on the whole, underdeveloped across the country. Although the exercise concluded that no service conforms to the ideal (whatever that is), some areas were identified which, with support as pilot sites, could further develop their services.

The Pre-retirement Health Initiative was announced shortly afterwards. Chapter 2 introduces and sets the scene for this important initiative, before leading onto the background, aims and objectives of the national evaluation in Chapter 3.

Summary: messages and lessons

In common with other European countries (and beyond), England's population is ageing. The number of people aged over 60 outnumbers those under 16 years for the first time in history. Those in the mid-life age group (50–65 years for the purposes of this study, although other studies span those born between 1945 and 1965) form one of the largest cohorts of the total UK population, at 29% (17 million).

The benefits of adopting a life-course approach to improving health and wellbeing in later life are set out in European and WHO policy frameworks on active ageing. A number of studies and government reports have set out some of the major challenges and goals for meeting European directives and guidance, while also addressing national priorities around regional variation and inequities in health, employment and education (among other variables) in mid- and later life.

In addition, there is a significant body of evidence suggesting that targeting people at times of transition (eg in mid-life) is an effective strategy for engaging and supporting people to make decisions and changes regarding a range of factors (eg financial planning and management, work, lifestyle and health) for improving health and the prospects for an active later life.

It is important to stress that the mid-life age group is not a homogeneous cohort, but spans a wide range of experience and life stages. People in their early 50s, those in their late 50s and those in their early and mid-60s have different

experiences and expectations – and this will also change over time with future cohorts of mid-lifers.

The Pre-retirement Health Initiative was announced under the banner of two major health (specifically NHS) policy frameworks: the NHS Plan (Department of Health, 2000); and the NSF for Older People (Department of Health, 2001). Standard 8 of the NSF focuses on promoting a healthy, active older age. Today's baby boomers are tomorrow's older people; those aged 50–65 years in 2003 will reach their 80s in the 2020s. Achieving a healthy older age for this group therefore depends on addressing the needs of people in mid-life now.

2 Introducing the Pre-retirement Health Initiative

Policy context

The Pre-retirement Health Initiative falls in the health, and more specifically the NHS, policy area in terms of its origins, funding and management. It is most often linked to Standard 8 of the NSF for Older People (Department of Health, 2001), but it is also clearly associated with the NHS Plan, in particular its vision for preventive healthcare (Department of Health, 2000).

Aims and objectives

The overall aim was to inform a national roll-out of pre-retirement health advice and services for people aged 50–65 years. This was to be achieved through the development and evaluation of a programme of pilot sites across England.

The HDA was commissioned to undertake the national steering role, supporting the development of work taking place in and across the pilots through its core role of identifying the evidence base of what works to improve people's health and reduce health inequalities. Developing new guidance and informing future policy for shaping practice was a main aim of the HDA's work through this initiative.

While originating from a clear NHS policy area, the initiative has covered and addressed a range of diverse issues and concerns, taking a broad approach to understanding and addressing health and health-promoting activities. It therefore spans multiple policy contexts and priority agendas. Its work touches many different stakeholder groups, both those who have an interest in and those who have influence over the work of participating pilots, and the future direction and investment in health improvement and development issues for this age group (and all life stages).

One of the most significant, and simultaneously simple and complex, messages to come out of the work, even during its earliest stages of implementation, is the need for this broad approach to health and wellbeing to be adopted far more widely than it has been to date – especially for people in mid- and later life. This means exploring and developing supporting and enabling policy frameworks that extend well beyond the NHS, health organisations and health service delivery.

Policy landscape

The work of the eight pilot projects, and of the HDA in supporting them, has not taken place in a vacuum. A number of influential and constantly changing drivers are shaping the ways in which local, regional and national agencies address the health and wellbeing of their populations. This includes how they respond to specific age cohorts and communities, as well as demographic, geographic and socio-economic characteristics.

The policy and practice landscape has altered over the course of the initiative and of this evaluation. Some of the current policy and practice drivers, and associated priorities, challenges and opportunities surrounding health improvement activities for people in mid-life are outlined in Box 2.

The pre-retirement pilots

Pilot projects joined the Pre-retirement Health Initiative in two waves. Three projects initiated their activities in the first quarter of 2001, following the literature review and mapping exercise referred to above. These first three pilot projects were:

Box 2 Policy and practice drivers for the pre-retirement health pilots

- The increasing focus on promoting independence and active, healthy ageing for older people (Standard 8, NSF for Older People; the forthcoming Audit Commission report on Promoting Independence and Prevention; the work of the Association of Directors of Social Services, Better Government for Older People and the Nuffield Institute for Health on Healthy Ageing and Healthy Communities)
- Lessons from national improvement programmes (including service delivery improvement programmes as well as health improvement programmes): modernising programmes for the NHS, local authorities and local government; the significance of national targets and performance indicators; the implications of recent policy and practice guidance on reducing health inequalities, specifically the recent Programme for Action published by the Department of Health (see final bullet point); the emphasis on partnerships and whole-system working; the potential impact of the new general medical services and personal medical services contract; responding to broader public health issues and the implications for new public health roles)
- Public participation, involvement and empowerment, including the increased emphasis on self care and the informed patient
- The requirement for national strategies on active ageing for all member states of the EU
- Increased devolution and the role of regional development agencies and regional assemblies, coupled with neighbourhood renewal/regeneration programmes
- The government's green paper on Pensions, and the potential implications of a flexible decade of retirement and changing employment opportunities
- Life-long learning and the range of, and access to, educational opportunities
- Support for unpaid/family carers in this age group, especially for working carers, most of whom are aged 50–65
- *Tackling Health Inequalities – A Programme for Action* (Department of Health, 2003c; see second bullet point) sets out a three-year plan for delivering the targets first established in the 2002 Cross-cutting Spending Review; meeting the 2010 national health inequalities target on life expectancy and infant mortality; and addressing the wider causes of inequalities in the years beyond. This highlights, among other things, the central leadership role of the NHS in preventing illness and providing effective treatment and care, and in reducing inequalities more generally.

- **Hull and East Riding Health Promotion Unit.** This project was hosted by Hull and East Riding NHS Trust, with a primary objective of producing a resource pack targeted at people in the mid-life age group; a training pack; and training courses on use of the resource pack. The target population for the project, as stated in the final report, included: '... members of the public, employed people approaching or thinking about retirement'.
- **North Nottinghamshire Health Authority.** This project covered Ashfield, Bassetlaw, Mansfield and Newark and Sherwood in terms of geographic area, and was hosted by the North Nottinghamshire Health Authority, later Ashfield Primary Care Trust. The aim of the project was to offer four-day courses on a broad range of issues concerned with health, benefits and pre-retirement. The primary target group included people working for local NHS and local authority agencies; the business sector, concentrating on the main industries in the area; and unemployed people in the mid-life age group.
- **Agewell Project, Age Concern, Sandwell.** This project, based in and around Sandwell, West Bromwich, worked in conjunction with Workwell (a regional, multi-sector initiative focused on improving employment opportunities and experiences) with the aim of designing and offering health checks to employees of small and medium-sized enterprises in the area. It also sought to offer opportunities and services for these employees to become involved in physical activities. In addition, the project intended to produce an information pack on pre- and post-retirement. A community development approach was adopted as a specific element of the project, seeking to reach employees in their communities as well as in the workplace.

One of the HDA's main objectives was to explore pre-retirement health issues through a wide range of pilot projects exploring different aspects of promoting health and reducing health inequalities. A further five sites were therefore selected through an open bidding process between

April and July 2001. Taken together, the eight resulting pilots reflected: geographic coverage; a mix of rural as well as urban localities; and a focus on activities in deprived areas for people aged 50–65 years in lower socio-economic groups. The latter was achieved by ensuring pilot projects examined locality-specific areas of need for the target age group, and a spread of more specific target groups in the overall mid-life cohort. The five additional pilot projects were:

- **East Devon Primary Care Trust.** This project covered a predominantly rural area in East Devon. The aim was to offer health checks and advice on health and financial matters for four target groups: employees of small businesses; farmers; community residents; and people with learning disabilities. A range of community development strategies were adopted to offer accessible services across this largely rural area, and to engage these specific groups.
- **Guy's and St Thomas' NHS Trust.** The project was hosted by this NHS Trust, but implemented in community settings across the borough of Southwark, south London. The main activities offered through the project included developing and establishing a website; and training in IT and use of the Internet for people aged 50–65. A related aim was to establish groups where social activities would also be promoted. This project also adopted a community development approach to reach people in the target age group living in the borough, with a specific aim of addressing the needs of more marginalised and isolated people, including people from black and minority ethnic communities and unemployed people.
- **Beth Johnson Foundation, North Staffordshire.** The main aims of this project were to develop a greater understanding of the health beliefs of the target population; to develop a community-based advisory service; and to train lay peer advisers to provide health advice to local people in the target age group. The project used a community development approach in four localities: Bentelee, Biddulph, Blurton and Chesterton.
- **Osteoporosis Dorset.** This project was led by Osteoporosis Dorset, and covered a relatively densely populated area spanning Bournemouth, Christchurch and Poole. The aim of the project was to offer pre-retirement health checks for women aged 56–65 currently registered with three GP practices, including heel bone scans and a range of specific diagnostic processes (blood test, urinary tests) carried out by a trained technician. An additional aim was to hook these more medical interventions to a wider range of information and advice about healthy lifestyle issues and opportunities in the localities covered by the pilot.

- **Hackney Age Concern.** This project was led by Age Concern in Hackney, and aimed to offer health checks and the development of individual health plans to people aged 50–65 living in the area. It also aimed to produce a comprehensive guide to health promotion services and health-promoting activities available in the borough. A major goal was concerned with facilitating access to local health and leisure facilities, focusing on specific groups experiencing fewer opportunities for improving health and wellbeing, including unemployed women, and women who had experienced mental health difficulties in this age group.

Complexity and diversity

The Pre-retirement Health Initiative was therefore multi-layered and multi-faceted. This diversity of geography, local aims and target groups, interventions and approaches was intended to increase the span of opportunity, while exploring aspects and features that were particularly effective for reaching the stated goals and groups in question. The extremes of rich and poor, measured via standardised deprivation scores, were a central component of this initiative, indicating the benefits of targeting health inequalities work at the areas and groups in greatest need.

An important dimension of this complexity was the range of players or stakeholders involved. In addition to the target groups described, each pilot project was managed through a multi-agency project team, assisted by a steering group and lay people from the local target group; supported by a network of local partners and a national project development team based at the HDA; and examined and explored through two levels of evaluation. The latter encompassed a local evaluation team for each pilot project, and the national evaluation team whose remit was to examine the evidence and identify major lessons emerging from across all eight pilots.

There were therefore three principal groups of players: advisers, implementers, and evaluators. Each of these had two sub-groups: those who operated at a national level, and those who operated at local level, as illustrated in Box 3.

Summary: messages and lessons

Although originally a health policy, it has become increasingly apparent through observing the work of the pre-retirement pilots (and responses to them) that improving health and wellbeing, and opportunities to experience better health and wellbeing, are dependent on a wide range of variables and

Box 3 Main players in the Pre-retirement Health Initiative

Main players	National	Local
Advisers	Expert reference group, project board, lay advisory group	Local steering groups Role of lay advisers (often integrated in former)
Implementers	Project management team based at HDA working with and across pilots	Eight local project teams Role of local project coordinators
Evaluators	National evaluation team based at King's College London working across the eight pilots	Eight local evaluators working with each pilot project

circumstances. Not least of these are the different external and internal contexts and environments in which people live, and in which policies are formulated, disseminated and implemented.

Additionally, the range of interventions and mechanisms developed to aid this implementation and deliver public services to local populations extend far beyond traditional/familiar NHS and local authority service provision. They encompass local amenities (both public and privately owned, funded and delivered), and products/goods and employment opportunities available through local business and enterprises.

The combination of all these factors and features of national, regional and local landscapes influences wealth, health, and individual and population wellbeing. Policies, plans, mechanisms and activities designed to promote better health and reduce ill health, and the impact of disabling conditions, must therefore take account of, and span, all these features.

The three primary settings in which the eight pilots operated (workplace, NHS and community settings) illustrate this point well. There is a need to harness the resources and skills that are represented across these different aspects to gain the added value they promise. This requires a whole-systems approach that extends far beyond 'health and social care' to deliver a range of services, support, information and advice to meet the needs, circumstances and aspirations of the local population. It requires a range of partnerships and alliances, whose activities and contributions are organised and coordinated through one overarching partnership mechanism.

All the pilots focused on the specific needs of their local communities, particularly those in disadvantaged or deprived neighbourhoods. To engage and develop locally responsive and acceptable services, a range of activities and

interventions were developed, using identified hooks to draw people in and secure commitment to the project in question from potential partner agencies (and potential funders).

The notion of using 'hooks' or 'lures' – locally identified motivators for participating in health-promoting activities and services – is a major theme of this report. Such hooks operate at all levels: individual, group, population/community, practitioners, services, systems, political and policy levels.

3 Introducing the national evaluation

Aims and objectives

The national evaluation of the initiative, combined with the local evaluations commissioned by each of the eight pilot sites, was intended to identify which interventions and approaches work (are most effective in achieving stated aims and objectives), for whom, and why. The results were to be translated into a specification for pre-retirement services for people in mid-life that will contribute to improving health and wellbeing in later life – while also reducing inequalities in health and opportunities for an active older age.

The aim of the national evaluation was twofold:

- To provide learning to inform the roll-out of the pilots and the development of standards for pre-retirement health advice and services
- To contribute to a framework for both national and local self-evaluation tools.

Specific objectives identified to achieve these aims included:

- To scope the potential delivery mechanisms, structures and processes for the service
- To identify main development and implementation issues in different models
- To begin to identify elements of good practice to inform a framework for service provision
- To begin to identify indicators of success which will contribute to an evaluation framework
- To assess the extent to which such an initiative will make a difference in provision in the locality
- To assess the added value gained by having such an initiative.

The national evaluation was intended to be developmental in nature, feeding in important issues and lessons that emerged at six-monthly intervals through a series of interim,

written reports, and through regular dialogue with both the HDA project management team, and each of the eight pilot projects and local evaluators. Regular meetings took place with the HDA team and project manager; with project teams (mainly through evaluation activities such as workshops, interviews, focus groups, and attending learning network meetings on specific issues and themes); and quarterly meetings between the national evaluation team and the local evaluators. Members of the national evaluation team attended the HDA's lay advisers' group meetings on two occasions.

Overview of pilot areas and activities covered

Southwark

Southwark is the second poorest of the eight pilot sites (after Hackney), ranked eighth in the Index of Local Deprivation³ for 1998. The borough is culturally and ethnically diverse. Fewer than two-thirds of the borough's population are white. The second largest ethnic community is comprised of black Caribbean and African people. In distant third place is the population of Asian descent, at 4%. The population in the area is much younger than the national average, with a quarter aged between 45 and 64 years (the national average is at least a third). The two predominant industries are wholesale and retail trade; and real estate, renting and business activities. A third of those working are employed in these two areas. The NHS is also a significant employer. Almost a quarter of the population in the borough have no academic qualifications – the lowest proportion of all pilots, and lower than the national average.

3. The Index of Local Deprivation is calculated by creating six separate domain scores. The six domains are: income; employment; health deprivation and disability; education skills and training; housing; and geographical access to services (DETR, 2000, pp.19–22).

Southwark Active has developed a website (www.southwarkactive.co.uk) focused on health issues relevant to the target age group; made contact with a range of local organisations and community groups to publicise the site; and provided IT training to 47 people in the target group. Those who made contact with the project were invited to take part in activities such as walks around places of interest in the local area.

North Staffordshire

Stoke-on-Trent⁴ is a large, industrial area that is quite densely populated, and is ranked 48 in the Index of Local Deprivation for 1998. It is ethnically homogeneous; the 2001 census indicates that 96% of the population are white. The second largest minority ethnic population comprises Asian communities (Indian, Pakistani, Bangladeshi and other), which make up less than 3% of the total population. The two main industries in the area are manufacturing and wholesale, and retail trade. The NHS and local authority together constitute the third largest employer. This picture is in sharp contrast to the 1991 Census data, which revealed that mining ranked among the three most important economic activities. Currently, mining is the second least common economic activity, implying increased unemployment over this period and possibly also indicating numbers of people who retired early and/or were forced to change employment. Of the eight pilots, Stoke-on-Trent has the second largest proportion of people over 16 years with no academic qualifications. Those with no academic qualifications and those with level 1 qualifications together make up 57% of the population over 16.

The project in North Staffordshire targeted the 50–65 age group in four disadvantaged communities. Following a needs assessment aimed at understanding the health beliefs of people living in the four communities, volunteer peer advisers were recruited and trained to provide health advice to others in their age group. By the end of the pilot period in March 2003, a community-based advisory service was in place in three communities.

East Devon

East Devon is one of ten districts of Devon County Council, and is sparsely populated. The area is ranked 280th in the Index of Local Deprivation for 1998. East Devon has a fundamentally homogeneous population: 99.2% are of Caucasian origin. There is no distinguishable minority

ethnic community in the area. The age structure of the area shows that the proportion aged over 45 years represents more than half the total population (53.6%). Fifteen per cent of the population are older than 75 years, twice the national average. The economic structure and employment patterns in East Devon are more varied than for other pilots. Government employment represents a quarter of the area's total employment; in distant second place is the wholesale and retail trade industry. Agriculture represents 4.69% of employment, three times the national average. Twenty-six per cent of the area's population have no educational qualifications, and approximately 44% have either no educational qualifications, or qualifications at level 1.

As was seen earlier, the East Devon project Fifty-something... Fit for the Future initially aimed at four groups in the target age range: farmers and agricultural workers; small businesses; long-term unemployed; and people with a learning disability. Following a six-month needs assessment, including consultation with the main individuals involved with those groups, it was decided that involving people with a learning disability was not feasible in the project's timescale. On the basis of the needs assessment, three main service components were identified for delivery in community-based drop-in sessions: a health check carried out by a nurse; specialist advice from the Citizens Advice Bureau; and psychosocial preparation for retirement. Twenty-six sessions, attended by a total of 225 people, were provided in a range of settings across East Devon.

Hull and East Riding

The localities covered by the pilot project working across Hull and East Riding are densely populated. In terms of recognised deprivation scores, Hull ranked 26 and East Riding 275 in the Index of Local Deprivation for 1998. The overwhelming majority of the population are white (98.7%). There is no single representative minority community. The age structure shows that the middle cohorts of the population are in the majority. People aged 20–44 years make up a third of the area's population, while 42% are aged over 45 years. The economic structure of the areas covered by the pilot project is represented by three main industries: the public sector, with 25%; manufacturing, 18%; and the wholesale and retail trade industry. Agriculture represents a significant proportion at almost double the national average, second only to East Devon in this initiative. More than half the people in this area have either no qualification, or qualifications only at level 1.

The project in Hull and East Riding focused on the development of resource materials for use by individuals in the target age group, or by organisations working with

4. Stoke-on-Trent includes the city of Stoke-on-Trent and Staffordshire Moorlands. It became a unitary authority in 1997; before this it was a district council falling within Staffordshire County Council.

them. A resource pack, a CD-ROM and a trainers' handbook to support delivery of pre-retirement workshops were produced, each covering 12 themes: health, activity and exercise, mental wellbeing, loss, social contact, relationships, employment opportunities, leisure, hobbies, volunteering, time and structure, and finance. Three thousand copies of the resource pack were distributed across the locality. Two hundred people attended pre-retirement workshops, and 50 were trained as trainers in their own organisations.

Dorset

The areas in East Dorset covered by this pilot project (including Bournemouth, Christchurch and Poole) are densely populated and ethnically homogeneous: 97.6% of the population are of Caucasian origin. The two largest minority ethnic groups are those categorised as mixed (0.89%) and Chinese (0.68%). The age structure for these localities shows that 45.6% of the population are aged over 45 years. The service industry is prevalent in this part of Dorset. Wholesale and retail trade (17.98%) and financial intermediation (8.22%) are the two main employers other than the public sector. The percentage of people with no academic qualifications is slightly lower than the national average (25.99%), and the second lowest of all the pilot sites. The proportion of people with qualifications at levels 2 and 3 is higher than for the national average or for the other seven pilots.

The original aim of Osteoporosis Dorset was to work with three local GP practices. Discussions with potential partners identified difficulties in engaging one practice in the project. Plans were adjusted to reflect a more focused approach with the two remaining practices, to deliver health checks to women aged 56–65. The checks aimed to promote lifestyle changes that would improve health in relation to osteoporotic fractures, cardiovascular and cerebrovascular disease and diabetes. Of 1,146 women invited to attend for a check, over 1,000 attended. The women filled in a self-completion questionnaire before their appointment. Data from the questionnaires were entered on specially developed software, along with data from the health check itself, and analysed to determine the risk for each individual. Low-risk clients were provided with written lifestyle advice, specifically produced to support the health check. In addition to the written lifestyle advice, clients at a moderate level of risk were invited to attend a lifestyle workshop. Individuals at high risk were referred to either the practice nurse or their GP for follow-up. All patients were invited to attend a health fair involving local agencies supporting relevant health promotion initiatives, eg stop smoking, weight watchers, etc.

North Nottinghamshire

The area defined as North Nottinghamshire encompasses Ashfield, Bassetlaw, Mansfield, and Newark and Sherwood. This area comprises more than half the county, but only a third of the county's population. The population is fundamentally white (98.6%). No one minority ethnic community predominates. About a third of the population are aged between 44 and 64 years. More than half the population either have no qualifications, or have only attained level 1. The two main industries in the area are manufacturing and wholesale, and retail trade. The textile and mining industries were previously strong but have been in decline over the past three decades. As a result, a large proportion of this workforce have either retired, became unemployed or had to re-skill and change direction.

The North Nottinghamshire pilot offered four-day workplace pre-retirement courses based on an approach – Coping with Change: Focus on Retirement – developed by the Centre for Health and Retirement Education. The courses first enabled participants to define the issues they wanted to address, then covered the issues identified through structured discussion and participatory learning. A final session, held four to six months later, allowed participants to review and reflect on their experiences and share the changes they had made. Eight four-day courses were run, six for NHS organisations, one for a district council, and one for the Citizens Advice Bureaux. In addition, two one-day courses were organised for older, unemployed people through the Department for Work and Pensions and an adult education college. Approximately 160 people attended the courses.

Hackney

Hackney is one of the poorest areas of the London metropolitan area. It is densely populated and ranked fourth in the Index of Local Deprivation for 1998. Hackney's population is the most diverse of all the pilot areas. The majority of the population are white (59.4%), with significant numbers from minority ethnic communities including: black communities (black Caribbean, African and others) at 24.66%, and Asian communities (Indian, Pakistani and Bangladeshi) with 8.59% of the total population. The age structure of Hackney's population differs from that of the other seven pilot areas, being significantly younger and consisting of three main cohorts. Those aged 15–44 years make up 51.71% of the population; those over 45 years, 26.1%; and those younger than 14 years, 28.39%. The latter is higher than the national average. The public sector is the

major employer, with around a third of all jobs, followed by real estate, renting and business services at 21.55%.

The AgeWell project in Hackney offered people in the target age group a medical check and the opportunity to complete a broader lifestyle questionnaire. These informed the development of a personal health plan, with follow-up support and alternative therapy 'taster sessions' available to help people to implement their plan. A focus group attended by six to eight people was formed to monitor the effects of these health-promoting activities. A total of 40 people participated in the project, of whom 22 had a medical check, 34 completed a lifestyle questionnaire and 39 developed a health plan. In addition, a guide to local services for older and disabled people was published, and project participants produced a video illustrating their involvement with the project and the benefits they had experienced.

Sandwell

Sandwell is part of the West Midlands Metropolitan County. This area is densely populated, with 3,142 inhabitants per square kilometre. Sandwell is ranked 263 in the Index of Local Deprivation for 1998. The population is ethnically diverse. About 15% of the area's population are of Asian and black origin. Almost half Sandwell's population are aged 45–64 years. The two main industries are manufacturing and wholesale, and retail trade. In these industries there is a prevalence of small and medium companies which are the main providers of employment. The past three decades have seen a marked decline in the manufacturing industry.

The Looking Forward project in Sandwell focused on the health needs of older workers aged 50–65 in small to medium-sized enterprises, with a particular focus on people from black and minority ethnic communities. Four health-check events were held in three different settings: two industrial estates; a textile company; and an engineering company. In addition, a leisure pass scheme was piloted within one company, and an exercise programme was provided for older workers within a second company. A health information resource pack and video were also produced by the project.

These snapshots of the eight pre-retirement pilots demonstrate the diverse range of contexts, priorities, activities and interventions that were supported and developed through the Initiative. Summarising this diversity, Table 1 presents the important characteristics across all pilot sites.

Rationale and approach

A hybrid approach was adopted for the national evaluation, based on two main methodological frameworks: first, we used a 'realistic' evaluation design as described by Pawson and Tilley (1997); second, we adapted the theories of programme change approach, based on the work of Weiss (2000).

Realistic evaluation design

This method was selected by the HDA and outlined in the tender specification for the national evaluation as the preferred methodological approach. The reasons, supported by the experiences of the national evaluation team in undertaking this study, are twofold:

- More traditional evaluation designs were deemed inappropriate for evaluating this project, as the outcomes of health promotion initiatives are likely to be long term and influenced by a range of external variables for which it is not possible, or necessarily desirable, to control; although traditional evaluation designs can shed light on what is or is not effective, they are unable to answer the crucial questions of why something works, for whom and in what circumstances
- In contrast to traditional designs, realistic evaluation examines the mechanisms through which initiatives achieve particular outcomes in certain contexts, described by Pawson and Tilley (1997) in terms of 'context, mechanism and outcome configurations'.

The national evaluation team's interpretation and application of these terms is summarised below.

- External contexts: we mapped out a socio-demographic and economic characterisation of each pilot project location and its area of influence, to offer explanations about the extent to which an area's particularities either limited or facilitated the project's success. We also identified the range and types of wider community initiatives that existed locally in order to place the pilots in the context of wider policy priorities set out by both public and independent sectors in relation to the target population, people aged 50–65 years.
- Internal contexts: we explored the infrastructures and wider organisational processes, systems and cultures of the pilot projects and of their host organisations; the history behind the development of the pilots' work; and whether there was a local history of working in and around pre-retirement health issues and with this age group.

Table 1 Summary of pilot characteristics

Project	Area of influence	Host organisation	Activities
Hull and East Riding	City of Hull and the East Riding	Hull and East Riding NHS Trust	Resource pack Training; training pack
North Nottinghamshire	Ashfield, Bassetlaw, Mansfield, Newark and Sherwood	North Nottinghamshire Health Authority, later Ashfield PCT	Four-day training course on health, financial, benefits, social interaction, etc.
Sandwell	Sandwell	Agewell, at Age Concern Sandwell	Health checks in the workplace Physical exercise programme in the workplace Resource pack Leisure pass programme
East Devon	East Devon	East Devon PCT and located within Council of Voluntary Service, East Devon	Health checks and advice to community residents and farmers
Osteoporosis Dorset	Bournemouth, Christchurch and Poole	Osteoporosis Dorset	Health checks to women aged 56–65 in three GP practices Lifestyle workshops; Health fair
Hackney	London Borough of Hackney	Age Concern Hackney	Health checks for community residents Individual health plans Physical exercise as part of individual health plans
Southwark Active	London Borough of Southwark	Guy's and St Thomas' Acute Trust	Establishment and development of website IT training for community residents aged 50–65 Promotion of physical and social activities
North Staffordshire	City of Stoke-on-Trent and Staffordshire Moorlands	Beth Johnson Foundation	Understand health beliefs of target population Develop community-based advisory service Training of peer advisers

- Mechanisms: we identified the range of potential and actual mechanisms for each pilot, including details about their programmes of work, partnership building, management arrangements and levels of resourcing. We approached this task by assuming that all mechanisms may be read as potential mechanisms. As the study (and the pilots) unfolded, our interest increasingly focused on whether, and how, the pilots were able to animate these mechanisms to achieve their stated aims and objectives.
- Outcomes: our objectives with regard to project outcomes were to determine each pilot's criteria for success and ascertain what targets had been set; the specificity of locally determined aims and objectives and desired outcomes; their arrangements for local evaluation; and the underlying assumptions and core values in relation to longer-term impacts the pilots and their partners were trying to achieve. It was recognised that health outcomes (as usually defined) are often long term, and would be difficult to attribute to the pilot projects with any

certainty. We therefore focused on projects' individual and organisational impacts, including the impact on the local target populations and on major partners.

Impact on the target populations was examined across all eight projects in terms of:

- Attitudes to, and feelings about, retirement and health in older age
- Decision-making in relation to retirement and health issues
- Intended and actual steps taken in relation to retirement and health issues
- How far perceived support needs were met.

Impact on partner organisations was examined in terms of:

- Policies and approaches adopted, both during and since the pilots' work
- Numbers of people and type of target populations reached
- Opportunities for, and types of, support provided.

Theories of programme change: why use the theory of change model?

Health and social policy programmes attempt, among other things, to ameliorate negative social conditions and improve health and wellbeing. In so doing, any programme, policy initiative or project will carry implicit assumptions, as well as more explicit theories, about why the adopted approach may be better than others at achieving stated aims and objectives (eg bringing about changes in health and social conditions). Making these assumptions explicit has potential benefits for both the programme (in terms of programme planning and improvement) and the evaluation (understanding why programmes work and attributing outcomes).

Theory-based evaluations offer an alternative to the more experimental model for assessing causal attribution. As Davidson (2000) points out, theory-based evaluation has raised the need to increase our understanding about the causal mechanisms of social programmes. For some, such as Weiss (1995), the theories of change model suggests that articulating these assumptions (or theories) at the outset of a programme, and gaining agreement by all stakeholders, reduces problems with causal attribution. The theories of change approach specifies how activities will lead to short- and longer-term outcomes, and identifies the contextual conditions required for success. Although this strategy cannot eliminate all alternative explanations, it does align programme stakeholders with a standard of evidence that will be convincing for them. Davidson (2000) concurs, suggesting that the standard for evaluation should be similar to a legal standard of 'beyond reasonable doubt'.

As elsewhere in the evaluation literature, an abundance of terms are used to describe this approach, often interchangeably. These include programme theory (Bickman, 1997); theory-based evaluation (Weiss, 1995); theory of change (Pawson and Tilley, 1997); and programme logic (Funnell, 1997). Weiss (1995) sets out her interpretation, and rationale, for theory of change evaluation as follows:

'The concept of grounding evaluation in theories of change takes for granted that social programs are based on explicit or implicit theories [assumptions] about how and why the program will work. The evaluation should surface those theories and lay them out in as fine detail as possible, identifying all the assumptions and sub-assumptions built into the program. The evaluators then construct methods for data collection and analysis and track the unfolding of the assumption. The aim is to show the extent to which program theories hold. The evaluation

should show which of the assumptions underlying the program break down, where they break down, and which of the several theories underlying the program are best supported by the evidence' (Weiss, 1995: 66–67).

Weiss (2000) later defined a theory of change as a combination of implementation theory (how the programme was implemented) and programme theory (the underlying psychosocial mechanisms of programme participants). It is this definition of theory of change that was adopted to underpin the national evaluation of the Pre-retirement Health Initiative.

Four phases of the evaluation

The national evaluation consisted of an evaluative framework that combined realistic evaluation and Weiss's definition of theories of change as follows:

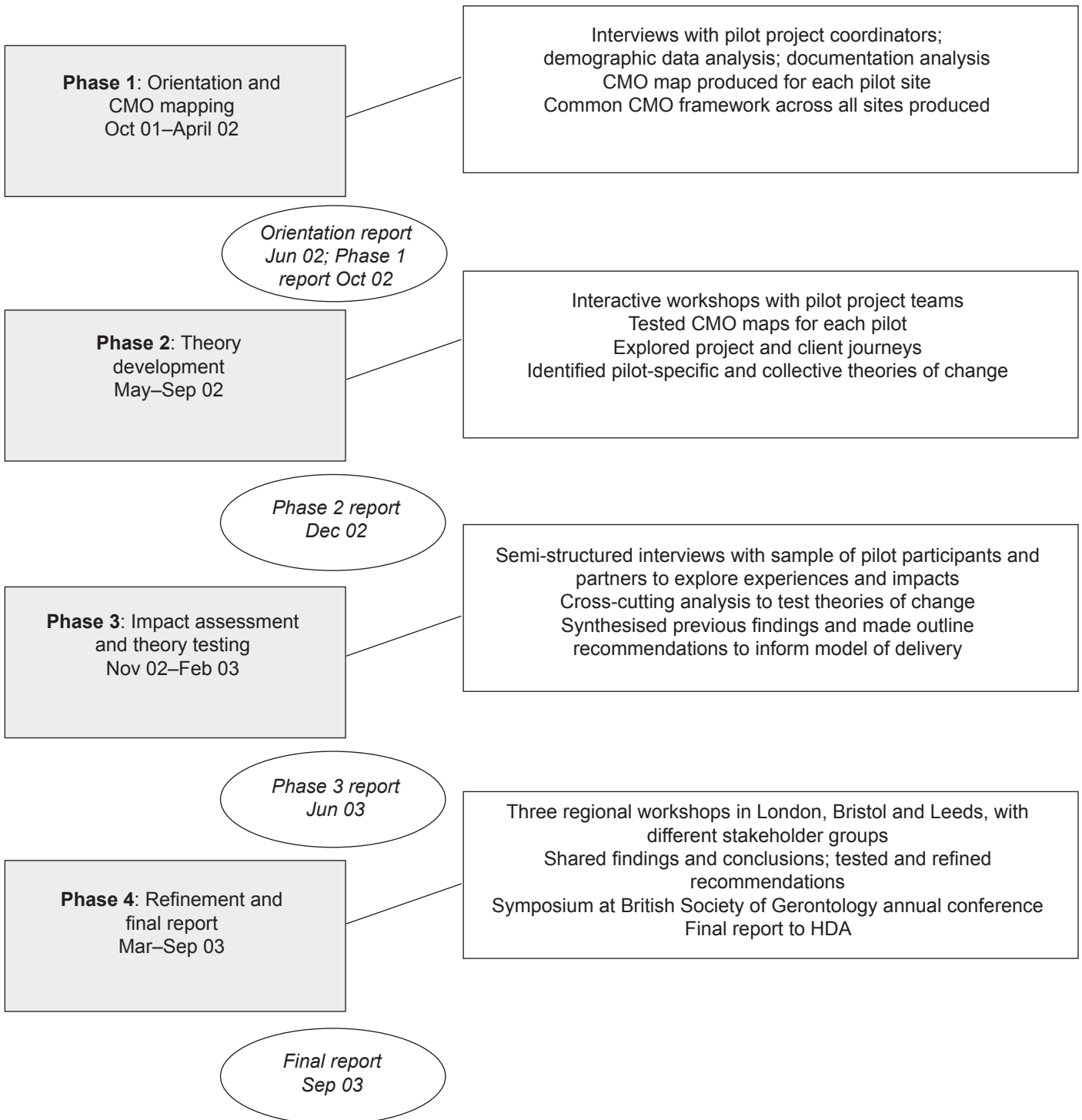
- Phase 1 (October 2001–March 2002) began to develop implementation theory through a mapping exercise that examined each pilot's CMOs
- Phase 2 (April 2002–October 2002) built on that implementation theory and developed an understanding of the potential psychosocial mechanisms as perceived by pilots and their partner organisations
- Phase 3 (November 2002–March 2003) considered these mechanisms from the perspective of each pilot's participants and each pilot project's partners, to produce a more comprehensive programme theory
- Phase 4 (June 2003–September 2003) synthesised the findings from the previous three phases and explored these, together with outline recommendations (implementation theory and programme theory), in discussion with a wider group of stakeholders in three regional workshops held across England.

Appendix 1 contains a detailed picture of the methodology, aims, data sources and collection processes, analytical frameworks, timescales and sequencing of each of the four principal phases of the national evaluation. Figure 1 summarises this information in a flow chart depicting when and how each phase took place, and how the story of the pilots' journeys and achievements unfolded over the period of the evaluation.

Summary: messages and lessons

The national evaluation adopted a hybrid approach based on two methodologies, realistic evaluation (focusing on establishing the contexts, mechanisms and outcomes of the pilot projects); and theories of change (identifying and

Figure 1 The four phases of the national evaluation



making explicit the underpinning assumptions and local theories for why certain interventions will lead to desired outcomes for specific target groups).

The evaluation consisted of a series of four phases spanning the period September 2001 to September 2003. It developed a framework to work with the pilot projects and local evaluations to examine and capture what works, for whom,

in what circumstances, and why, across all eight sites, during the period of their development work.

The approach and style of working was developmental: each phase of data collection and analysis was used as the basis for fine-tuning the design of, and approach to, each subsequent phase. This offered a powerful means of exploring important questions and lessons across a number of diverse projects, contexts and populations.

Part 2 Our journey of discovery

This section sets out our evaluation journey, working with the eight pilot sites and the HDA project team to reach a point where we could explore, with some confidence, the emerging theories of change underpinning the work of the pilots (individually and collectively).

Chapter 4 explains the CMO mapping exercise undertaken in phase 1 of the evaluation, and examines the four main theories of change identified with the pilots during phase 2.

A major aim of the national evaluation was to contribute to the development of a framework for evaluating future initiatives of this type. Drawing on the evaluation reports produced for each pilot project, and on communication throughout the initiative with the local evaluators, Chapter 5 examines the messages and lessons learned from the local evaluations commissioned by each pilot project.

4 Understanding contexts, mechanisms and outcomes and their theoretical underpinnings

Creating a CMO map for the pilots

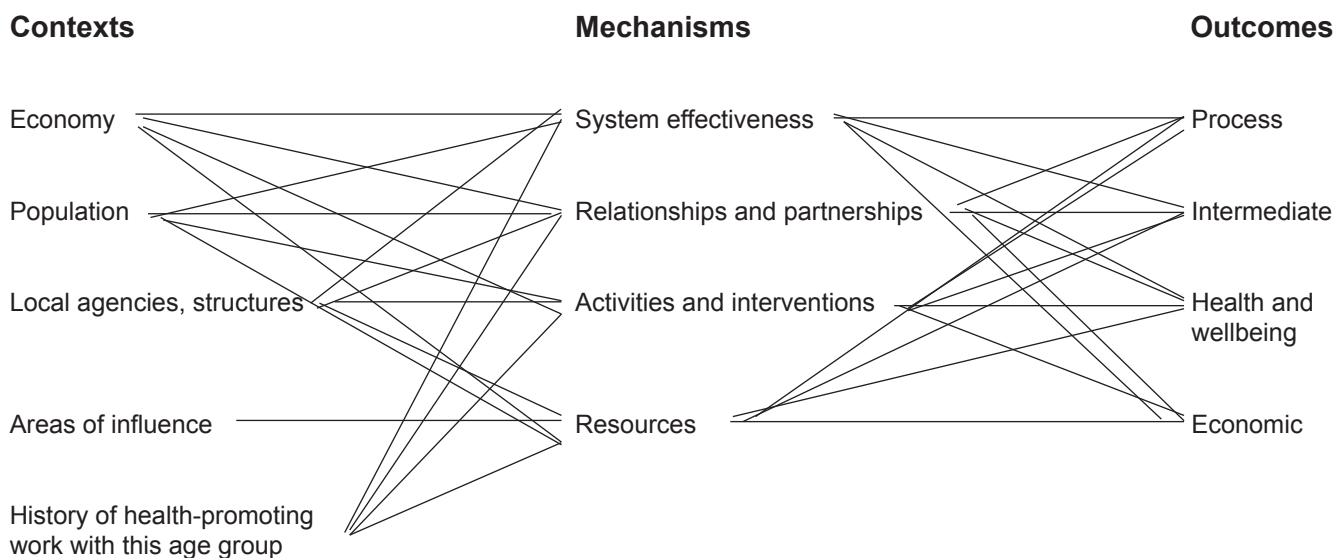
The process of mapping and developing an understanding about the CMOs for each of the pilot projects highlighted the presence of, and relationship between, a number of main features including:

- Economic characteristics
- Socio-demographic characteristics
- Project's area of influence
- History of work, specifically health-promoting work, with people in mid-life
- Organisational and, importantly, system effectiveness
- Nature and type of partnership arrangements
- Aims and objectives of the projects
- Interventions and activities undertaken and approaches adopted by each pilot
- Methods by which these were examined, and measures of impact assessed through local evaluations.

This web of simultaneous factors and influences is extremely complex, both within each pilot and across all eight pilots. Figure 2 illustrates this web as a matrix of the most significant common features that need to be considered in initiatives and project work of this kind, and in taking forward similar activities in and across mainstream services and developments. This CMO matrix (or map) depicts the two-way influence between these different features.

A CMO map was produced for each pilot project, and shared with project coordinators and members of their team to correct and refine its content. This map translated each of the headings shown in Figure 2 to the local circumstances of each pilot project. For the sake of brevity, we have not included these maps in this report. They marked an important stage in the journey of discovery, rather than the final destination which is the focus of this report. For the purposes of exploring the right-hand column, labelled 'Outcomes', the evaluation focused on those processes

Figure 2 The CMO matrix for the pilots



and indicators that projects adopted to achieve their stated objectives and aims (proxy measures of outcomes to be achieved).

From CMOs to theories of change

Four theories of change were identified during phase 2 of the evaluation. These related to engagement; empowerment; social interaction; and partnership. We return to these overleaf ('Underpinning theories of change', page 32). During this important phase of the evaluation, interactive workshops were held with pilot project teams and stakeholders whom they had chosen to invite.

The aim of these workshops was to explore two central issues:

- Implicit and explicit theories (or assumptions) pilots had developed in relation to how change in the pilot projects themselves was brought about
- Implicit and explicit theories pilots had developed about their clients (or participants) – who they were, how they would experience the projects, and what impacts the projects would have on them.

Workshop participants were asked to articulate these theories as journeys. The journeys in question covered the time from the beginning of the project to the end of the Department of Health-funded pilot period in March 2003. While it was understood that the effects of the pilots might (and probably would) extend beyond that time, we were primarily concerned with the perceptions of pilot stakeholders about the impact of the pilots during the Department of Health-funded period.

Data from these workshops therefore represented a snapshot (albeit a useful one) of the implicit and explicit thinking of local stakeholders in relation to their pilot project's approaches and activities. Their (and our) thinking evolved during and after these workshops. For instance, national and local contexts were in a continual state of flux, with new policy and practice developments taking place that influenced both how the pilot projects proceeded (especially post-March 2003), and how the teams and participants experienced them. In some instances the workshop process itself influenced the thinking and approach of project teams and their stakeholders. On at least two occasions, we were told that the workshop had provided a useful vehicle for stakeholders to explore fully their different assumptions and expectations; that this had not happened before; and that they wished they had explored those issues earlier in the process.

The analysis of these journeys focused on understanding the collective journeys of the pilots, then the collective journeys of clients (as perceived by the pilot stakeholders). In our analysis we examined the project journeys under the following headings:

- Underpinning values
- Starting points
- Major project activities
- Estimation of what the pilot will have achieved by March 2003.

Client journeys were examined under the following headings:

- Who the client is and where s/he starts from in relation to the project
- How the client experiences the pilot
- Estimated impact of the pilot projects on clients by March 2003.

What did we find?

Overall, pilot stakeholders were able to articulate project journeys that were underpinned by a strong set of value-based assumptions about why the project was needed and what might be delivered, including:

- Addressing unmet needs, in particular addressing health inequalities and improving access to services
- Adopting a comprehensive approach towards, and definition of, health
- Using gateway services/resources to enable clients to access other services
- Involving clients in identifying their own needs, setting their own goals and/or developing and running aspects of the project
- Providing services in accessible settings.

In some cases, projects were not able to explain why they had decided on their particular approach, as opposed to those adopted by other projects, but in the main they stated a clear rationale. While the approaches adopted were diverse, they were underpinned by a core set of project activities, including:

- Needs assessment
- Providing health checks
- Providing information and/or training relevant to health and wellbeing
- Using a range of media and settings in which to provide services/activities
- Partnership building

- Establishing mechanisms for obtaining advice from partners on project development
- Project promotion.

The workshop participants were also able to describe in some detail who they perceived their clients to be; how they envisaged clients experiencing their project; and the positive impacts they hoped their clients would experience. The overall impression gained about clients' collective journeys was that these were viewed as a relatively straightforward linear process, and that clients' contexts – historical, social, economic and biographical – were not explicitly recognised or acknowledged. This was in contrast to some pilots' view of their own journey as anything but linear. It also contrasted with the emphasis placed, by some projects, on taking clients' social context into account when determining the location and nature of project activities.

It may be that it was simply easier for stakeholders to articulate their project's journey than to put themselves in their clients' shoes, as we were asking them to do. Equally, it may be that because the projects' journeys were explored first, participants' concentration and energy were somewhat depleted by the time we came to explore clients' journeys. The impression formed was that clients' journeys were perceived as being firmly embedded in the projects' journeys, rather than the other way around. However, taken together, both project and client journeys proved valuable in illuminating the theories of change underlying the projects' approaches and activities. These are presented and explained in Chapter 5.

Underpinning theories of change

In terms of the types of theories of change identified by Carol Weiss (2000), the majority of theories that emerged from our analysis can most simply be thought of as falling into two principal categories: psychosocial theories of change; and theories that emphasise the benefits (and requirements) of partnership working.

Although some theories were evident across all eight projects, others related to particular approaches or types of activity (eg theories of social interaction). Box 4 summarises each of these in turn; Appendix 2 outlines the theories in more detail, together with the questions we posed for exploration with the pilots during phase 3.

The psychosocial theories of change were primarily concerned with two processes seen by pilots as central to successful client journeys: engaging clients, and engendering in them a sense of empowerment. One further theory

Box 4 Underpinning theories of change

1 Psychosocial theories of change:

- Theories of engagement
- Theories of empowerment
- Theories of social interaction

2 Theories of partnership:

- Benefits of partnership working
- Benefits of partners' involvement
- Nature and type of involvement
- Perceived value of projects (to partners)
- Sustainability through partnership

related to the perceived health benefits of social activity and interaction.

During the early phases of the study, the data obtained suggested that although partnership building was seen as an important activity for all the projects, in some cases the associated activities involved (eg what does 'partnership' mean?) needed to be more clearly articulated. How do pilots characterise their approach to partnership building, and how do their approaches differ from others? There was a potential risk, otherwise, that in treating partnership as a taken-for-granted benefit, stakeholders may attribute different meanings and intentions to it, with unforeseen implications for pilot processes and impacts.

These theories of change are not new; articulated in various ways, they have long been enshrined as central tenets of health promotion and several of its contributory disciplines. This does not mean, however, that identifying and exploring them in the context of this evaluation is simply reinventing the wheel. On the contrary, precisely because psychosocial theories are so embedded in health promotion, they have arguably become taken for granted and hence unquestioned. In addition, they have not previously been extensively explored in relation to health-promoting activities designed for and experienced by this age group.

5 Learning from the local evaluations

In this chapter we review the approaches taken to the local evaluations of the pilots. First, we provide an overview of the evaluations; next, we identify some of the main themes to emerge from the review; finally, we synthesise what has been learned from the approaches adopted by the local evaluations, including learning from the local evaluators themselves (obtained during phase 4 of the national evaluation), and offer a potential model for future evaluation of such projects.

Overview of approaches to local evaluations

Appendix 3 provides summary information about the approaches taken by the pilot projects to their local evaluations. A description and commentary are provided in this section.

Evaluation design

The evaluations varied in their scope and complexity, and most were multi-faceted in design. Four distinct types of design emerged: pre-/post-intervention assessments; action research approaches; objectives-based evaluation; and narrative approaches. Some were underpinned by a conceptual framework or quality model. Guidance for undertaking the local evaluations was provided by the HDA. The local evaluators were also supported throughout their work by the national evaluation team.

Six of the evaluations reported project-monitoring data, and some had devised an activity-logging system. However, although activity-monitoring data were collected, not all pilots appeared to do this routinely. Four evaluations were distinctly oriented towards a process approach, involving not just process as activity (project monitoring), but also process as dynamics, in which they sought to determine the factors associated with successful implementation and those that hindered progress. Some evaluators reported that

process evaluation was the most important approach to take, given that the lifespan of the pilots was too short to see measurable impacts, and that the nature of the intervention – particularly concerning community-based approaches – precluded the possibility of a traditional outcomes assessment.

Nevertheless, all eight pilots incorporated some intermediate outcome/impact evaluation. These typically focused on user satisfaction as a proxy measure of success and, in some cases, on self-reported behaviour change and increased uptake of services. Some also sought to identify outcomes in terms of improvements in health, either as self-reported by respondents, or in terms of clinical indicators such as changes in blood pressure.

None of the pilots attempted any form of economic analysis.

Methods

All eight pilot evaluations employed multiple methods of data collection, although few used these as a means of corroborating their evidence or refining their analysis. All used surveys of some description; five used semi-structured interviews; three used observation techniques; and two used focus groups. Other data collection methods included workshops, documentary sources and a project coordinator's diary.

Stakeholder involvement

The range and nature of stakeholder involvement varied considerably in the evaluation process. While all pilot evaluations included service users in their assessments, only five reports included an evaluation of partner involvement, and only four incorporated the views of pilot staff. Other stakeholder groups involved in the evaluations were steering group members (three pilots), and non-participants (one pilot).

Types of data collected

All the evaluations collected activity data, although the range varied. Typically, pilots collected data on the numbers of: events held; pilot users; health checks carried out; agencies involved; venues used, and so on, as well as an impressive array of needs assessment data concerning health beliefs, disease risk factors, distance travelled, etc. Data on socio-economic and demographic characteristics were collected by most pilots, although few did so routinely and comprehensively. This is surprising, given that a stated policy aim of the pre-retirement scheme was to reduce health inequalities, and also given the general need to evaluate whether there was variation in the ways different sub-groups of users in each pilot experienced and benefited from their services.

Summary of measures of success

Measures of success included process measures to capture the progress of pilot implementation, satisfaction, changed attitudes to health and retirement, self-reported behaviour change, self-reported health improvement, and some clinical measures.

Major issues to emerge

These are considered in relation to:

- Relationship between local and national evaluations
- Impact of challenges at the local level on the evaluations
- Partner involvement.

Relationship between local and national evaluations

The local reports identified differing views and experiences among the local evaluators concerning the relationship between local and national evaluations. Three local evaluations used data and analysis generated by the national evaluation to augment their own work. In one instance the national data were used as corroborating evidence to support the conclusions of the local evaluation, and in all three cases the availability of the national data allowed the local evaluation to use their resources elsewhere.

One evaluator commented:

‘Provisional analyses of interviews with eight participants of the service are incorporated throughout the report ... The national and local evaluations were able to work cooperatively to avoid duplication.’

On the other hand, two of the evaluation reports referred to concerns about duplication of effort at local and national levels, although one of these evaluations used service-user data from the national evaluation in lieu of collecting their own. Neither provided concrete examples of how, or how far, duplication had occurred, and the impression was of pilots that felt over-evaluated, rather than of any significant duplication.

A second concern of one pilot revolved around sensitivity to the local context: it was thought that requests from the national evaluation to interview project participants might deter their ongoing participation. There were also some tensions, especially during early phases of the work, relating to the level of detail and accuracy captured about each pilot's work in the six-monthly reports produced by the national evaluation team. These tensions were addressed through collaborative working between the national evaluation team, the HDA project team, the local evaluators and the pilot project teams, on an ongoing basis. These tensions were, perhaps, an inevitable consequence of such a complex and multi-layered initiative. In particular, they highlight the need to be explicit about the purpose and role of local as opposed to national evaluations. The lessons drawn out in this chapter are intended to inform similar developments by sharing our experiences in undertaking evaluations of this nature.

Impact of challenges at local level

As well as capturing the implementation of the pilots, the local evaluations also had to respond to the various challenges they faced. These included delays in implementation, where the evaluation needed to extend the original data collection timescale to allow sufficient lead-in time for project activities. They also included situations where a pilot had been unable to implement activities for the achievement of a specific objective, and the evaluation was therefore unable to pursue the objective further.

Partner involvement

Given that all the pilots referred to the importance of partnership working, it is surprising that so few evaluations included an assessment of partners' perceptions of the pilot. As there is unlikely to be a unitary definition of success, evaluation teams should consider involving all stakeholders in agreeing evaluation criteria and process.

Towards a model of pilot evaluation

Taken together, the range of approaches to local evaluation was impressive. It is proposed that future evaluations of similar schemes need to combine these approaches into one overall model of evaluation, adapted to meet local circumstances, to achieve a greater degree of consistency both in approach and in terms of a common data set. While the content of such data sets would always vary (given the diversity of contexts and target groups covered across these eight pilots), impact assessment in particular would be aided by ensuring a core data set was established and used to guide both data collection and analysis of outcomes achieved. A multi-stranded approach to evaluation can provide evidence of effectiveness and knowledge for replication purposes. An accountability function is served by demonstrating not just that the money was spent as intended, but that it was spent well.

The following points are made in relation to local evaluations where no national evaluation is commissioned. Where a national evaluation is commissioned, they are intended to provide a starting point for agreeing an appropriate division of labour between national and local evaluators.

- Impact assessment: it is important for pilots to generate evidence of the impact of their schemes on a specific population – what worked, and how powerfully it did so. The use of robust pre-/post-assessments can provide good evidence of impact. Mixed quantitative and qualitative methods give a fuller picture of impact.
- Timescale for the evaluation: in many instances this requires a commitment to evaluate impact beyond the funded period of the pilot. If some of the anticipated change is expected to occur post-pilot, then evaluations should be funded to assess post-pilot impact
- Understanding the processes of implementation: for knowledge transfer to occur evaluation needs to examine the factors associated with successful implementation. However, pilots also need to collect routinely a basic minimum data set concerning the age, gender, ethnicity and social class of their recipients.
- Understanding the dynamics of change: knowing whether something works, and how powerfully it does so, is insufficient unless the evaluation can also identify how and why it works. This requires a commitment to some form of theory-based evaluation in which initial assumptions and expectations about how the pilot might work are made explicit and the roles of anticipated change mechanisms are tested.

- A commitment to multiple stakeholders in developing criteria for effectiveness and assessing impact.

Summary: messages and lessons

The experiences of this comprehensive evaluation programme (drawn from both local and national evaluations) illustrate the importance and benefits of adopting a multi-layered, theory-based approach to evaluation. The hybrid approach of realistic evaluation and the theories of change model offered a powerful combination for exploring important questions and lessons across a number of diverse projects, contexts and populations. Both models are essentially grounded in the experiences of people working at local level, and enabled the evaluation team to observe, capture and analyse the range of situations and interventions covered by this initiative.

While offering valuable insights into what works, for whom, and why, this approach was also at times an uneasy marriage. We moved from working closely with individual pilots to develop a CMO map for their project, to a composite matrix of common contexts, mechanisms and (intended) outcomes. We then switched to exploring underlying assumptions and local theories of change (the 'how' and 'why' questions), which were not always easy to articulate or understand. Despite these difficulties, we concluded that this framework of evaluation is important for evaluating policies that seek to enlighten practitioners and policy-makers about how they could use the lessons from successful pilot initiatives.

Issues remain, however, about the extent to which policy and practice audiences are prepared for this kind of approach. The temptation to wait for the 'results' of evaluations focusing on pre-determined volume measures (how many people received what kinds of interventions over what period) still prevails. The complex nature of outcomes is still less well understood. In addition, the links between contexts, mechanisms and outcomes is even more complex, as is their relationship with the specificity of objectives and scale of ambitions. To develop a framework for future evaluation programmes of this nature, a model of evaluation is proposed based on theory-driven approaches (such as theories of change), which incorporates five major factors, including impact and process assessments.

In addition, during phase 4 we asked local evaluators to share their lessons from working with the pilots (and the national evaluation) in the form of advice that could be offered to others embarking on similar evaluation journeys. Their responses are summarised in Box 5.

Box 5 Messages from local evaluators

- Make the purpose of the evaluation explicit in terms of its objectives, its approach and processes, its role in development, and in assessing impact
- Clarify the role of evaluators and their relationship with project implementers and developers, eg if taking up a consultancy role
- Demonstrate these relationships and milestones by mapping the evaluation process against the development process, to understand better how each contributes to the other
- Recognise the politics of evaluation, how powerful they are, and consider how they might be managed
- Consider and agree the nature and timing of reports and reporting arrangements, eg verbal, written, graphic; clarify purpose of interim reports as building evidence and feeding into development processes; clarify difference between interim and final reports
- Emphasise the value of collecting and using mixed sources of data and data analysis (quantitative and qualitative); vital aspects and experiences can be missed if one method of data collection and one main data source are used
- A greater percentage of pilot resources need to be ring-fenced for evaluation, and evaluation should be built into project development from the start
- The dynamic nature of evaluation is crucial – there is a need for rigour, but equally for adaptability to respond to emerging issues and changing contexts
- Use evaluation methods that are seen as valid and relevant for different partners (eg local were businesses familiar with the European Foundation for Quality Management's Excellence Model (EFQM) as an accredited quality management tool in Sandwell, so this was adopted for purposes of local evaluation)
- Be clear about the roles and expectations of national and local evaluations where such an approach is employed; where both levels of evaluation are used, local evaluations could focus on data collection and monitoring, including follow-up reviews, while national evaluation informs development of tools used in, as well as across, participating projects.

Part 3 What works, for whom, in what circumstances, and why?

This section sets out the main findings and conclusions derived from the interviews with pilot participants and partners through a process of testing and refining the theories of change presented in Part 2. Here we draw on phase 3 of the evaluation, which also synthesised important issues and messages that emerged during the previous two phases.

We have used this analysis to inform the development of a strategic framework for promoting health and improving wellbeing in mid-life, presented in Part 4.

The first chapter of Part 3 outlines the main messages arising from interviews held with pilot participants. This is followed by an analysis of messages from, and influential factors identified by, the pilot partners. The third chapter returns to the theories of change outlined in Part 2, and presents our conclusions about their fit from these two perspectives. Finally, Part 3 ends with a summary of cross-cutting themes (that do not neatly fall into the framework of the theories of change), lessons and outstanding issues worthy of further development and evaluation.

In the phase 3 interim report, we made extensive use of verbatim quotations to illustrate the themes that emerged from interviews with the samples of pilot participants and pilot partners. In the interests of brevity, we include only brief quotations here. The full phase 3 report is available from the HDA.

6 Understanding the pilot participants

This chapter presents the main messages arising from interviews held with a sample of pilot project users (pilot participants).

The samples

Although our aim had been to interview around 15 people who had used each pilot's services, we were unable to achieve this at some sites due to difficulties experienced by the pilots concerned in arranging access to their users. In total, we interviewed 143 participants across the eight pilots. Particular access problems occurred in the case of three projects. In Sandwell, problems in accessing the workforces with which the Looking Forward project engaged meant we were unable to carry out any interviews, and were dependent instead on responses to questionnaires distributed to participants in the various events and programmes. In North Staffordshire, the volunteer lay advisers had only just begun work in their communities at the time of phase 3 data collection, and although we were able to interview the advisers themselves, we were unable to interview any users of their advice services. In Southwark, theft of the project's computing equipment meant contact details for many people who engaged with the project were lost, and we were able to interview only three people.

Appendix 4 contains a detailed breakdown of the sample, including the following characteristics: number of respondents per pilot project, gender, ethnicity, age and/or age range. This illustrates that the great majority of respondents for whom data were available were white females (72 women and 30 men). Around three quarters of respondents were in the target age group of 50–65 years. The remaining quarter were those younger than 50 years who attended the health checks in Sandwell, and the lay advisers in North Staffordshire, some of whom were younger than 50.

Messages about prevailing attitudes and perceptions

Attitudes to mid-life and retirement (and looking to the future)

Information about participants' thoughts about or experiences of retirement (as this was the original focus of the pilots and the national evaluation) – and more generally about the future – was obtained for six of the eight pilot sites⁵. Across the six sites for which information was available, four main themes emerged:

- Access to relevant information
- Attitudes towards retirement
- Planning for retirement and growing older
- Adjusting to retirement.

Access to relevant information

A lack of information relevant to life after retirement (and/or the future) was identified as an issue by many of those interviewed. Taking first those respondents who were still working or had retired from employment, most of the participants from North Nottinghamshire did report receiving information from their employer about their pension status, but only four respondents across the other five sites reported receiving any information. As in North Nottinghamshire, the emphasis of the information described by these respondents was, for the most part, on financial issues. Only one respondent, in East Devon, described a more comprehensive approach, in this case covering health and leisure issues as well as financial matters. Financial information was greatly appreciated by those who had access to it, and this was a

5. Questions about these issues were less relevant for the lay advisers in North Staffordshire as they were not all in the pre-retirement age group; no data were available for Sandwell project participants.

main theme for respondents in Dorset. Elsewhere, however, respondents would have welcomed a wider range of information, eg as one North Nottinghamshire respondent put it: 'On what's out there for me to do when I retire'.

For unemployed respondents, access to information was a particular concern, as this comment from one of the women interviewed in Hackney illustrates:

'It's a bit of a panic this retirement age coming on. Information I know is there but I don't know exactly what to do because I'm not sure what I want and what should I go for.'

Attitudes towards retirement

In contrast with current commentary on this subject, which suggests a mixed approach and attitude towards work and retirement as people grow older (Lissenburgh and Smeaton, 2003), none of the people we interviewed spoke of looking forward idealistically to an idyllic retirement. Depending in large part on their employment context and status, respondents' attitudes to retirement ranged from those who had no wish to retire, to those who wished to phase out employment gradually. Among both groups financial issues were a major concern, particularly for unemployed respondents whose emphasis was not on retirement but on getting back to work. Others were concerned to maintain physical and/or mental activity, or reported enjoying their working life too much to consider retirement.

Planning for retirement and growing older

For most respondents, their financial arrangements following retirement were a major concern. In addition, however, looking after their health to enjoy life in later years was important for respondents at most sites, and this theme was particularly emphasised in North Nottinghamshire and Dorset. Only a small minority of respondents thought there was little

they could do in this respect, suggesting that genetic factors, or simply the aging process, could not be counteracted. In contrast, several respondents specifically emphasised their personal responsibility for looking after their health. For those people with particular health concerns, taking responsibility for looking after themselves was especially important.

Adjusting to retirement

Several respondents who were still working expressed concerns about the transition from work to retirement in terms of having a purpose in life and a structure to their day. Equally, many respondents who had already retired echoed these concerns in describing their struggle to make the adjustment to retirement. Others spoke of challenges such as having to adjust to spending more time with their partner, maintaining friendships, and adjusting to a different financial situation.

These latter concerns echo the work of Karen Rowlinson at the University of Bath (Rowlinson, 2000) who explored people's views on, and current plans for, their future lives. She found that even if people were willing and able to think and plan ahead, their capacity to do so was often limited by economic insecurity and lack of resources. Those with secure (and high) incomes felt they were more able to plan ahead. Those with less secure (and low) incomes felt they had less capacity to make plans. In addition, a current research study led by Sue Arthur at the National Centre for Social Research (due to be published this autumn) examines the green paper 'Simplicity, Security and Choice' in relation to people approaching retirement or experiencing early retirement.

Returning to the evaluation, across all six pilot sites where information was available, only one respondent (in North Nottinghamshire) described a smooth adjustment to retirement, and even this respondent recognised a need to increase her daytime activity:

Site	Stress/ mental health	Men's health	Women's health	Weight/ diet	Fitness	Occupational health issues	General slowing down	Specific health problems
East Devon	✓	✓		✓	✓	✓	✓	✓
Hull and East Riding	✓		✓	✓	✓		✓	
Dorset			✓	✓			✓	✓
Hackney	✓		✓	✓	✓		✓	✓
North Notts	✓	✓		✓	✓			✓
Southwark	✓	✓		✓	✓	✓	✓	✓
North Staffs	✓							

Table 3 Motivation for using services

Site	Free and accessible	Curiosity	General concerns	Specific health concerns	Financial concerns	Support for project
East Devon	✓	✓		✓	✓ (farmers)	✓
Hull and East Riding		✓	✓			✓
Dorset	✓		✓			
Hackney	✓	✓	✓	✓		
North Notts	✓		✓		✓	
Sandwell	✓ (leisure pass)		✓			
Southwark	✓		✓	✓		✓

‘I am luxuriating at the moment ... I’ve plenty of social life in the evening ... but in the daytime I haven’t had a lot of social life so far ... I’m going to be helping with the luncheon club at church, with cooking eventually ... I am going to take up some voluntary work with child bereavement support, as well as my St John Ambulance work.’

Perceptions of important health issues

Table 2 summarises respondents’ perceptions of the main health issues facing this age group for the sites where this information was available. It should be noted that several people pointed out how large the age range (50–65 years) is, with different issues facing people at different stages in this cohort. This table, and the data in Tables 3–5, do not include comments from participants in North Staffordshire, as respondents from this pilot were lay advisers to future potential participants, rather than current service recipients.

For several respondents, growing older and retirement represented important life stages and changes when their health might be more at risk, eg as a result of factors associated with the menopause, or because of stress associated with caring not only for grown-up children who might be experiencing problems such as divorce, but also for ageing parents.

For other respondents working life could be, and for some was, a source of great stress. This was particularly the case for farmers participating in the East Devon pilot, who spoke at length about the stress they experienced resulting from the difficult financial climate in which they worked. In addition, their recent experience of the foot-and-mouth crisis had contributed to a sense of social isolation among a group who could already be relatively isolated.

Valued sources of health information and advice

Responses to a question about the sources of advice project users typically consulted varied considerably, particularly in relation to GP consultations. Perhaps unsurprisingly, those with a chronic health condition saw their GP regularly, and regarded this as their primary source of advice. Equally, most of the women interviewed in Dorset reported that they would consult their GP in the first instance if they had a health concern (‘It’s no good going to an amateur’), as did three quarters of the Asian textile workers who returned questionnaires in Sandwell. Other participants were less inclined to consult their GP, including almost three quarters of all respondents in Sandwell. Although two of the farmers interviewed in East Devon had in fact consulted their GPs, they nevertheless thought the independent nature of farming meant others would be reluctant to do so.

Other reasons for not consulting a GP included:

- Access difficulties
- Perception that GPs dealt only with ill health (Sandwell)
- Not wanting to burden the GP (Dorset and East Devon).

Alternative sources of advice included colleagues or family members who were health professionals, and the lay press. The range and sources of primary care advice and health-promoting interventions for this age group will need further exploration in the light of the recently published General Medical Services contract for general practitioners, other primary care professionals, the NHS and patients. Lessons from the modernising work of the National Primary and Care Trust Development Programme (NatPaCT) in improving access to and responsiveness of primary care organisations are also relevant for health-promoting activities that target this age group.

In terms of broader potential alternatives, farmers in East Devon suggested that if health issues were promoted through organisations such as the National Farmers' Union, farmers might be more inclined to listen. A community theatre approach focusing on stress among farmers in the context of the BSE and foot-and-mouth epidemics also appeared to have had some impact.

Themes reflecting experiences of participation

Motivation for using the pilot service(s)

Table 3 summarises the main reasons given by respondents as to why they had taken up the services offered by the pilot projects across the seven sites where this was relevant⁶.

The fact that pilot services were provided free of charge, and were accessible in terms of timing and/or location, were significant factors at most sites. General concerns about retirement and/or health were a further significant motivating factor, as was curiosity or general interest at three sites.

In North Staffordshire, the majority of the lay advisers spoke of wanting to help people and 'share something good'. Most also thought the role would fill a gap in local services for the target group. For one of the retired advisers, a further motivation was the opportunity to use the time she had available to do something practical in her community.

In Sandwell, the two employers in companies where health checks were offered both indicated that one of their reasons for holding the health-check events was to improve workers' morale. In one case, an additional reason was that the employer had concerns about workers' health and wanted to find ways of reducing sickness absence. In the other case, the employer wished to be seen as a caring employer. Likewise, the rationale of the employer in the company where a leisure pass was made available was to offer an incentive to workers to improve their morale as well as their physical health. This employer was also interested in increasing the levels of physical exercise to reduce risks of back pain and other muscular-skeletal disorders.

The great majority of people who participated in the exercise programme in Sandwell said they did so because they enjoyed participating with friends, and also because they had no time for exercise outside work. A small number added

6. In North Staffordshire the lay advisers' principal motivation for involvement was to provide a service they regarded as potentially beneficial to end-users.

that they wanted to keep healthy and fit, but this was of secondary concern in comparison to the perceived social benefits.

Expectations of the pilot services

At two of the pilot sites, East Devon and Dorset, service users were well aware of the pilot status of the projects and framed their expectations in that light, emphasising their recognition that a pilot could not be expected to get everything right first time, and that the intention was to learn from experience. At both sites, respondents also saw the projects' pilot status as linked to improving services for their age group. Their specific expectations revolved around the provision of reassurance and advice, including opportunities to discuss issues other than those that were the project's immediate focus; and around facilitating access to other services and activities. Enabling participants to overcome health problems was also mentioned by one respondent in Dorset. For the East Devon farmers, however, expectations were closely linked to their particular context and concerns:

'I presume obviously a lot of people have got stressed out and certainly got a crisis haven't they?'

'It was something like people having hard times in farming and the health of the farmer and different things and they had this meeting in the community college in town.'

At other pilot sites, notably Hull and East Riding and North Nottinghamshire, assistance with planning for retirement was the primary expectation, although both the NHS and council workers in North Nottinghamshire had been unsure what to expect.

In both Hull and East Riding and Hackney some respondents had thought the involvement of employment projects as pilot partners meant assistance would be provided with work opportunities, which in the event was not forthcoming. Also, particular problems had clearly arisen in Hackney where participants' expectations, from their perspective, had been raised and not met. Whereas they had expected that activities would be developed by the project to support them in achieving their health plan goals, no such activities had been developed. Similarly, participants had expected access to alternative therapies to be ongoing, but these were offered only as 'taster sessions'. Respondents attributed these problems in part to a change of project coordinator, and in part to the project having over-ambitious aims to begin with. One of the women interviewed did echo the views of participants in East Dorset and Devon about the need to take into account the project's pilot status.

In North Staffordshire, the lay advisers had similar expectations to those of participants in other localities regarding the potential of their role. This included enabling people to start planning for retirement, and signposting them to other services and activities. Only one adviser mentioned the project's pilot status, and did not expand on this in terms of learning about what worked.

In Southwark, respondents' expectations of the project were naturally related to the potential benefits of the Internet:

'Well I think the biggest reason was that I've got grandchildren and they do it and they come to stay with me and they want help and I couldn't give it to them but with the computer, not only was I helping them they were helping me.'

Overall, respondents' expectations were in line with the aims of the projects locally. But health improvement, a major aim nationally, did not emerge from their accounts of their expectations at several sites. This was particularly the case where pilots were building on pre-existing work on other issues, and had added health improvement activities when they achieved pilot status.

Perceived value of the projects

With few exceptions, the people who took part in the study greatly appreciated every aspect of the services provided by the pilot projects, and clearly valued them highly. Where criticisms were made, these related to specific aspects of a project, and the respondents affected also made many positive comments. In Sandwell, one respondent indicated that the health check had been of little benefit to him personally, but nevertheless said he would recommend it to a friend. Similarly, although some of the women in Hackney were critical of the perceived lack of support in implementing

their health plan, they were very positive about their involvement in the focus group and saw the project as having considerable potential.

For many respondents, the primary value of the projects lay in addressing the needs of an age group that they felt was generally neglected. This was a recurring theme across projects. The following extract provides an illustration:

'I think at my age you're in a group of the forgotten few really, you know they do an awful lot for younger people and children and once you get over a certain age as a pensioner then you get a lot more support then. But I think for my age group there's not a lot going you know, we're sort of forgotten really.' (East Devon)

Table 4 summarises some specific aspects highlighted by respondents as particularly valuable.

The approach taken by the projects to engaging their target groups was particularly valued, with the inter-personal skills of project staff, the relative informality of the projects, and sharing information with others singled out for comment almost everywhere.

In addition to these common themes, the settings in which services were delivered were commented on favourably by several respondents. In East Devon, the use of community venues such as pubs was appreciated once early problems with privacy were resolved. One farmer had particularly appreciated a home visit from project staff. Conversely, in Dorset the women interviewed thought the primary care setting appropriate for this particular project. In North Nottinghamshire, respondents appreciated the fact that pre-retirement courses were held outside the workplace, while in Sandwell take-up of the health checks suggests the workplace was an appropriate setting for this activity,

Site	Access to information	Access to other services and activities	Approach to engaging people	Highlighting health and other issues	Social interaction with peer group
East Devon	✓	✓	✓		
Hull and East Riding	✓		✓		
Dorset		✓	✓	✓	✓ (workshop)
Hackney				✓	✓
North Notts	✓	✓	✓	✓	✓
Sandwell	✓		✓	✓	
Southwark	✓	✓	✓		

Table 5 Benefits and perceived impact						
Site	New knowledge	Existing knowledge reinforced	Changed attitudes – health and retirement	Life planning	Behaviour change	Health benefits
East Devon	✓	✓	✓	✓		
Hull and East Riding	✓	✓	✓	✓		
Dorset	✓	✓	✓		✓ (4)	
Hackney				✓	✓ (6)	✓
North Notts	✓	✓	✓	✓	✓ (5)	
Sandwell Extend and leisure pass	✓		✓			✓
Southwark	✓				✓ (1)	

perhaps particularly for men, who were in the majority at the health checks held on an industrial estate and at an engineering company.

The self-directed, participatory nature of the courses in North Nottinghamshire was also highly valued. In Hackney, however, one respondent suggested an expert-defined health plan would have been preferable to the user-led approach taken: ‘An awful lot of us are thinking, well come on, you’re the experts, give us a clue here’. In Dorset, the women interviewed commented favourably on the provision of expert health information and advice. Finally, for respondents in Devon and Dorset, reducing the burden on GPs and providing easier access to health advice other than through GP surgeries were aspects singled out for comment.

Perceived impact

With few exceptions, all the participants interviewed were able to identify clear benefits resulting from their involvement. Those who were less clear had either a personal explanation or other positive experiences to share, as follows:

- In two cases, one in Devon and one in Southwark, respondents who thought the projects had had little impact explained that they already had a healthy, active lifestyle
- In Hackney, several people thought further ongoing support was needed for the project to fulfill its potential, but they were also able to identify clear benefits
- Similarly, in East Devon some respondents thought the project would have had more impact had it been able to develop and sustain a wider programme of activities in their communities, but again identified clear benefits

- In North Staffordshire, the lay advisers thought their project had considerable potential that had yet to be realised at the time data collection was carried out.

Table 5 presents the common benefits identified by participants in seven localities (this question was less relevant for the health advisers in North Staffordshire). Responses to the health-check questionnaires in Sandwell are considered separately overleaf, as are some themes relating to only one or two projects.

Gains in knowledge identified by several respondents in all localities where information was available included:

- New awareness of health problems (Dorset; North Nottinghamshire)
- Ways of ameliorating known problems (East Devon)
- Increased knowledge regarding financial issues (East Devon; Hull and East Riding; North Nottinghamshire)
- Increased knowledge of the benefits of exercise and healthy eating (Dorset)
- Increased awareness of the leisure activities available (Southwark; North Nottinghamshire).

For most respondents in East Devon, Hull and East Riding and Dorset, though, the validation and reinforcement of existing health-related knowledge appeared to be more significant than knowledge gains. Those who commented on this had found it reassuring to learn that their own knowledge concurred with that of experts. However, increased or reinforced knowledge and changing attitudes do not necessarily lead to behaviour change, and fewer respondents in fewer localities indicated that the projects had made an impact in this important respect. The changes identified included increased physical activity (Dorset; North Nottinghamshire; Hackney; Southwark), healthier eating

(Dorset; North Nottinghamshire), and taking action in relation to retirement planning (North Nottinghamshire). The impact on one service user in Southwark was particularly striking:

‘I’ve been on one of the project coordinator’s walking projects. Now I don’t bus if I can walk ... I’ve just basically changed the way I eat and I walk a lot more, I’ve always walked a lot and then I sort of got lazy when I had the accident and sort of stopped it and now I’ve started again I just love to walk around now and I do feel better at the end of the day for it.’

In some projects activity of various kinds was a core project mechanism. Participants in the Sandwell leisure pass and exercise programmes all identified benefits in terms of increased fitness and general wellbeing. In Hackney, despite their criticisms, the women who participated also spoke vividly of the health benefits they thought had resulted, particularly for their mental health:

‘Well my mental health is much better, which has helped my physical health because now instead of saying I’m too tired to go out I’ll say right I’m going to go out and I’m going to meet so and so.’

A further theme to emerge from Hackney is worthy of particular note. This concerned the extent to which most of the women felt empowered by their involvement in the project. It was perhaps this sense of empowerment, illustrated by the following extract, which enabled them to voice their criticisms as forcefully as they did:

‘I find I do have a voice and that people are prepared to sit and listen to me and I’m also able to listen to other people as well ... So my mental health has really improved a great deal ... also confidence that I’m taking part in quite an important focus group and quite an important project really and I’ve got my say ... Now about nine months ago I wouldn’t have bothered volunteering ... I’ve stopped drifting. It’s given myself a shake and think oh wow you know there is life after retirement.’

It was particularly clear from the interviews in Hackney that participants had a real sense of ownership of the focus group. Examples were given of activities that had been initiated by group members, and of the potential for collaboration between them. Conversely, in East Devon the restricted capacity of the project to sustain activity in local communities, and thus generate a sense of ownership, was commented on by some respondents. Further specific themes included the reassurance of having no identified health problems (Dorset), and making use of the services of other agencies, such as the Citizens’ Advice Bureaux and Farm

Crisis Network, with a presence at the events organised by the project (East Devon).

In Sandwell, only one questionnaire respondent indicated that they had not found the health check and advice beneficial. In terms of what had been most beneficial, respondents singled out (in order of priority):

- Advice offered
- Knowing their weight, and discussions about this
- Urine, eye and blood pressure tests provided.

Four respondents commented that the health check was helpful because it gave them peace of mind. Two singled out the fact that someone who was not in a hurry was listening to them; and two male respondents particularly appreciated the information provided on prostate problems.

In response to a question about whether they thought participation in the health check events would lead them to make changes in their lifestyle, 58% of those who responded to the question ($n = 67$) answered positively. However, only four specified the changes they intended to make. These included losing weight, and making an appointment with the GP to follow up concerns raised by the health checks. Only seven respondents indicated that they definitely would not be making any changes. The remainder indicated that this was a possibility ($n = 21$). Again, good intentions do not necessarily lead to behaviour change; because we were unable to follow up service users, we were unable to address this major question over time.

Summary: messages and lessons

Box 6 summarises the specific lessons from this analysis for shaping national, regional and local responses to promoting health and wellbeing in mid-life.

Box 6 Implications for understanding what works, for whom, and why?

- Provision of a free health check is a significant motivator for engagement, stimulating interest and curiosity
- Service settings are crucially important for engaging people; the appropriateness of the setting will depend on the type of service delivered and the circumstances of the target group:
 - primary care is an appropriate setting for delivering clinically oriented services to women in relatively affluent areas
 - the workplace is an appropriate setting for engaging men in full-time employment and was effective in Sandwell in engaging female Asian workers
 - use of community settings where people normally come together, which can be easily accessed, and with which local people identify is an effective way of reaching marginalised groups, isolated people and those living in rural locations
- A welcoming atmosphere created by staff with well developed inter-personal skills is crucial for engagement in both informal and formal settings
- Engaging target groups that public services and professionals find difficult to reach can be enhanced by involving them in identifying needs, shaping and developing services, and enhancing their personal contributions
- When alerted to previously undiagnosed conditions, women will extend their engagement to other health services
- Knowledge gain is important and beneficial in contexts such as:
 - introduction of information about new issues (eg financial planning)
 - detection of previously undiagnosed conditions (eg empowering women to engage in informed dialogue with health professionals)
 - introducing people to previously unknown agencies
- Reinforcing and validating pre-existing knowledge is a more potent mechanism for achieving behaviour change in other contexts
- Providing opportunities for women living in deprived areas to engage in social activities with their peers can directly, and indirectly, lead to improvements in mental and physical wellbeing
- Social interaction is also a potent mechanism for generating a sense of empowerment among this target group.

7 Understanding pilots' partners and partnerships

We turn now to the second group of stakeholders: those who will determine whether the messages from the Pre-retirement Health Initiative are heard, learned and applied, and those who will shape the future delivery of services, interventions and opportunities for promoting and improving health and wellbeing – the pilot partners.

Appendix 5 contains details about the range of partner organisations from different sectors involved in each pilot area, and those that were interviewed as part of this evaluation. A total of 55 partners were involved in the pilots across all eight sites, ranging from five partner agencies in Southwark, to nine in Sandwell. Twenty-six of these partners were voluntary organisations; eight NHS organisations; seven local authorities; five private companies, businesses or other organisations from the private sector; and three were educational institutions.

Twenty-four partner organisations were involved in interviews with the national evaluation team during phase 3 of the evaluation. Our intention was to interview as many representatives from partner agencies as possible in the time available, but this proved difficult to achieve. Sample sizes varied from zero partner organisations interviewed from East Devon, to five (each) from North Nottinghamshire and North Staffordshire. Concerted efforts to engage partner organisations in these interviews continued well into June, but by this time we were two months beyond the funded pilot period; those initiatives that were carried forward were entering a new phase of development, and others had stopped or paused while future arrangements were still in negotiation. Access to local authorities and educational institutions was particularly difficult. Contact was eventually made with one partner organisation in East Devon, but this representative felt they had little of relevance to contribute to the evaluation.

Despite these difficulties, the discussions held with those partners who were able to participate revealed important features and identifiable benefits from their involvement in the pilot projects. As highlighted in Chapter 2 ('Policy landscape', page 18), the importance and desirability of partnerships in relation to projects' work was an undisputed aspect of the pilots. We were interested in identifying the specific features and mechanisms of partnership building and partnership working that pilots (and their partners) were adopting; in understanding why these particular approaches had been adopted; and in observing what benefits were experienced (or could potentially be experienced) both from the participating partner agencies and the projects themselves.

The first section of this chapter presents the findings from our interviews with the sample of pilot partners. The second section outlines a number of important aspects of partnership building and partnership working, synthesised from all four phases of the evaluation. This includes a summary of relevant findings from the rapidly expanding body of literature on partnerships, which are then applied to the picture of partnerships and partnering activities that emerged in and across the pilot projects. The third section draws out some of the main messages for exploring, developing and examining the effectiveness of partnerships for future developments and for mainstreaming pilot activities, and other health-promoting initiatives aimed at people in mid- (and later) life. These messages are presented as characteristics of partnership that need to be addressed in developing a strategic framework (or model) of health-promoting activities and services for people in mid-life.

Interviews with the pilot partners

Four aspects of partnership were explored with the sample of project partners, as follows.

Type and nature of involvement for partner organisations

Table 6 summarises the range of different types of involvement that partner organisations entered into with the pilot projects, as described by respondents. As explained, no information was available for East Devon.

In the majority of cases, partners' involvement was facilitated through membership of a project steering group. Additional partnership activities included providing venues in Southwark and North Staffordshire, and identifying volunteer lay advisers in North Staffordshire.

Perceived value of the projects

All the partners we spoke to clearly valued the pilot projects highly and regarded them as a success. The only difficulties described in building partnerships occurred in East Devon, Hackney and North Staffordshire.

In East Devon, the project coordinator's account of the problems experienced suggests these stemmed from:

- Lack of pre-existing partnerships on which to build
- Initial lack of clarity about the messages to be conveyed
- Difficulties in communicating across service sectors.

In Hackney, problems in engaging GPs as partners were believed to have stemmed from:

- Lack of appropriate information targeted specifically at GPs
- Not addressing this during the early stages of the project's development.

Other project partners in Hackney also explained that they had not been involved in the initial stages of drafting the bid

for pilot status, suggesting that this had resulted in an initial lack of clarity about aims and about the remit of the steering group. Even so, they regarded the project as valuable, as this extract illustrates:

'The things I've been talking to you about – I think they are of great interest and it certainly doesn't detract at all from the value of being a partner with Age Concern or being involved with the project.' (voluntary agency)

In North Staffordshire, early problems revolved around reconciling the community development approach of the project with the aim of producing something which, at that stage, was described as an audit tool (the needs assessment tool). However, partners explained that this issue had been successfully resolved at steering group meetings, and they too valued the project highly.

Elsewhere, although some suggestions for improvements were made, praise for the projects was largely unequivocal.

Benefits of involvement

For most partners, the motivation to become involved with the pilot projects had stemmed from a concern to:

- Develop their own work in similar areas
- Extend their knowledge and networks
- Promote the development of services to users of their own services.

In turn, the benefits of involvement most frequently identified by the pilot partners also related to these same issues.

For those partners who had been concerned to develop their own work in similar areas to the pilots, the following examples illustrate the benefits experienced:

Site	Consultation/advice/ planning	Providing information/ contacts	Providing services	Promoting the service/signposting participants
Hull and East Riding	✓	✓	✓	
Dorset	✓	✓		✓
Hackney			✓	
North Notts	✓	✓		✓
Sandwell	✓	✓		✓
Southwark	✓	✓	✓	
North Staffs	✓	✓		✓

- Partners in Sandwell and Southwark who were working with older people were keen to reach the younger age group targeted by the pilots, and were enabled to do so
- In Hull and East Riding and Southwark, partners had been able to make use of the resources developed by the pilots with their own service users
- For GPs in Dorset, the pilot's impact in prompting them to extend their own health improvement services was seen as a major benefit. As one GP put it:

'I think probably our perception of it [lifestyle training] has changed and we are more likely to offer lifestyle than we did in the past, probably through the osteoporosis work that was done here. I think it made us more aware and that we now have the facilities to do it.'

Similarly, in both Hackney and North Nottinghamshire, partners described how they had been able to extend the services they provided as a result of their involvement with the pilot projects.

At three sites (Hull and East Riding; North Staffordshire; Sandwell) partners singled out the extension of their own knowledge or networks as a significant benefit, while in Dorset, North Nottinghamshire and again in Sandwell, the provision of a new, high-quality service to partners' own service users was singled out.

Sustainability issues

The issue of whether the projects' work could be sustained beyond the pilot phase was a major concern for project coordinators and teams throughout the course of their work. At the time of writing, none of the pilots had secured funding to enable their project itself to continue. Box 7 provides a picture (as at May 2003) of the projects that have

been successful in continuing all or some aspects of their work. This is taken from information contained in the final report produced by the HDA project team (Granville, 2003).

In addition, partner agencies in some localities were either using or planning to use resources developed by the projects (Hull and East Riding; North Staffordshire) or had developed their own services for the target population (Hackney; North Nottinghamshire).

Thus partnerships emerged as an important mechanism for sustaining local (and regional) work with the target population, through mainstreaming pilot activities in partner agencies' own work.

Major aspects of partnerships and partnership working

Definitions of partnership and explanations of partnership working abound in the literature, particularly over recent years in the public policy research and evaluation literature. For our purposes we have selected one main working definition of partnership as the foundation for exploring the different aspects of partnership development and working arrangements adopted by the pilots in this initiative. Glendinning (2002) suggests that partnership consists of:

'... a particular type of relationship in which one or more common goals, interests and/or dependencies are identified, acknowledged and acted on but in which the autonomy and separate accountability of the partner organisations can remain largely untouched.'

Hudson's definition (1997, 1999) is also helpful in highlighting the major elements of partnership building where there is a continuum of activities that will move a

Box 7 Work in progress across the eight pilot areas

- Southwark: Guy's and St Thomas' has found a suitable community organisation, Blackfriars Resettlement, with similar objectives to Southwark Active, to take over the project; they are currently awaiting a decision about further funding from the Neighbourhood Renewal Fund
- Hackney: Hackney Age Concern has been considering options for sustaining the focus group as a powerful voice for influencing service provision for the mid-life age group in the borough; a local community college has now agreed to host the focus group, and has offered logistical and secretarial support to the women participating in this group
- North Staffordshire: Beth Johnson Foundation has funding from the local PCT, as part of an ongoing NHS funding stream to the charity to employ a part-time community worker to support and train peer advisers
- North Nottinghamshire: pre-retirement work has become the responsibility of the older people's health promotion lead in the PCT
- Sandwell: Sandwell Age Concern has secured funding until December 2003 to continue the work, although overall the team has reduced; further funding is being sought locally from a range of sources.

given organisation, agency and/or project from isolation through encounter, communication and collaboration to integration. Collaboration is regarded as one of the most important phases of partnership building.

One of the dominant features of the pilot projects that surfaced during the early stages of the evaluation was the importance and attention given to building partnerships. An aspect of this process was the set of activities that project coordinators (in the main) embarked on to initiate and secure engagement from relevant partner organisations. In this way, the process of partnership building was not dissimilar to the stages of engagement that emerged as one of the four theories of change in relation to pilot participants during phase 2 (see Appendix 2; Chapter 8, 'Partnerships and partnering', page 56).

Close examination of each pilot's partnering activities revealed five features that appear to have influenced the nature and effectiveness of the partnerships that were developed, which are discussed below.

Common (coterminous) geographic boundaries

Geography was a primary factor for pilots in identifying potential partners to support their work. All eight pilot projects defined their geographic area of influence at the outset. While some encompassed one or more local authority districts, others focused on specific local communities. In the case of Osteoporosis Dorset, the delimitation was yet more focused, in that female patients aged 56–65 from two GP practices were identified as the target group.

Local history of partnership working

Agencies in all eight pilot localities had some experience of partnership working involving both statutory and voluntary organisations prior to the pilot projects becoming established. This varied between pilots both in length and nature of experience, and in the degree of formality that existed in these partnerships. The range of experience can best be seen by comparing Sandwell, where extensive and sophisticated partnership arrangements spanned more than two decades, with East Devon, where the history of working in partnership across sectors and industries appeared to be in its infancy – particularly around health-promoting activities for this age group and for the locally determined target groups (eg farmers and people with learning disabilities). In Sandwell, extensive experience of partnership work had both advantages and disadvantages. On the plus side, the organisations concerned had valuable experience of the time and resources required for effective partnership working. On

the other hand, the sheer number of partnerships in which they were already engaged, or were being asked to join, placed significant demands on them. As one voluntary sector representative put it: 'Sometimes we felt like [we're] being partnered-out'.

Unsurprisingly, in view of the limited timeframe of the pilot phase of this initiative, a history of partnership working in both the geographic and content areas of influence proved to be a distinct advantage for the pilots.

Changes in local service and system contexts

During the first year of the pilot phase of this initiative, local health authorities in England underwent a significant restructuring involving their replacement by PCTs, usually serving a smaller population, and therefore larger in number, together with the establishment of strategic health authorities serving larger catchments, and therefore fewer in number. For many pilots, the result was that initial contacts they had made were lost and new relationships had to be built with the new organisations, with all the attendant demands on time and resources required to communicate the project's aims and implementation strategies to people who were not necessarily aware of them. For time-limited projects this was an onerous task that placed considerable strain on their capacity to deliver their aims and objectives.

Four of the projects (Osteoporosis Dorset; Hull and East Riding; Hackney; Southwark Active) were not directly affected by the reconfiguration of health authorities and primary care organisations as, by the time these projects started, the relevant PCTs were already established. The wider implications of restructuring were felt most strongly by the Agewell project in Sandwell, and by the pilots in North Nottinghamshire and North Staffordshire. Both the latter pilots experienced not only the creation of new organisations and accompanying structures, systems and processes, but more importantly, a shift from one larger health authority to two smaller PCTs covering the same geographic area.

Implications of pilot status (timescales and tenure of work)

Interviews with the pilot projects' partners indicated that, in some cases, the projects' pilot status impeded partnership building, in that potential partners could be reluctant to commit the required time and resources to a two-year (or less) initiative where the longer-term future was unknown. The workshops conducted with project teams and partner organisations in phase 2 highlighted that this level of uncertainty was a deterrent for some partner organisations.

Some pilots were able to share more positive experiences of exploring their aims, strategies, possibilities and opportunities for sustainability (as a result of working in partnership) with potential partners.

These experiences illustrate the need for transparency of objectives and activities, creativity in thinking about shared solutions to common concerns, and early involvement in shaping ideas and strategies. Once health practitioners based in the GP practices in Dorset became aware of the potential benefits for their registered patients – and, importantly, that these benefits did not imply a greater workload or time commitment from them – they were willing to become involved in the Osteoporosis Dorset pilot project. In East Devon, the project was based at the local Council of Voluntary Service offices, although the host organisation was the PCT. This created some difficulties in getting the message across to the health community, and effectively limited the participation of the NHS in the project. The location and status project activity was as important as their timeframe and status.

Degree and experience of partnership working among host/lead organisations

While the projects' host organisations were all experienced in collaborative ventures and partnership building, some were more experienced than others.

- Osteoporosis Dorset had been working with the local PCT for some time in testing and promoting the use of hip protectors for women, and this experience placed them in a positive light with the statutory sector. They had also established contacts which they called on in implementing this project.
- The project in Sandwell had been involved in a number of community development activities with a range of partners, including an association of retired people (Agewell). This network was actively engaging older people in a range of activities and local developments aimed at improving local communities, as well as contributing to local service and policy initiatives. Through this work, Agewell had built a number of well established contacts with community leaders and other organisations working in the area.
- In Hackney and East Devon, the host organisations had been developing health-promoting activities with and for older people, but had not previously targeted the 50–65 age group. This meant these projects constantly had to explain their purpose and rationale because both community residents and organisations identified the

host organisations' work with older age groups. This may have deterred some potential partners from joining the initiative.

In six of the eight pilots, some of the organisations participating in local steering groups were also involved in implementing the pilots' work. However, it was not clear how this contribution differed (in respect of partnership building and working) compared with the two pilot projects for which this was not the case. Four projects also engaged with partner organisations that were not part of the local steering group, but were specifically involved in delivering the service(s) being offered to the target group through the project. In these cases, partners were asked to participate because of the nature of their work, their own target populations, and their strong ties to the communities in which the projects were operating.

The main source of funding for all the pilots' activities came via the pilot initiative (devolved to the host organisation from the HDA). No information was available about the amount of time or other resources contributed by partner organisations in addition to this funding. As the host organisations held the purse strings, they had more leverage and control over resource allocation than the other agencies involved in the work through the partnerships developed. This aspect was not explored in depth with pilots, but work carried out by Hudson (1999, 2000) suggests that equity in the contribution, allocation and use of resources is a significant factor in influencing the long-term viability of partnerships and partnership working.

The diverse and evolutionary nature of the pilots' work suggests that the remit and roles of participating agencies might be expected to change over the duration of the initiative. This was not the case until the end of the pilot phase, examples of which are given in Box 7, highlighting the achievements of different pilots in securing alternative funding sources and lead agencies for their work.

The fact that this was a pilot initiative, where learning and capturing that learning was paramount, also reportedly had an impact on some potential partners. The need to reach targets, especially in the statutory sector, was felt to have discouraged involvement, particularly for those projects where there was a failure to establish a two-way dialogue about how the aims, objectives and activities of the project could contribute to specific targets. In addition, some organisations were concerned about their involvement in a pilot initiative that they believed could create expectations among the target population that they would not be able to fulfil once the initiative came to an end.

Summary

The majority of the pilot projects were successful in developing interesting and, on the whole, effective partnerships, where the mechanisms of partnership building and partnership working were important features of their work. From the start, the project teams consciously aimed to move from a position of isolation to a situation where communication, collaboration and integration with a range of partners was the norm (Hudson *et al.*, 1997, 1999). Most projects established good channels of communication and achieved some level of effective collaboration. None of the projects, however, managed to reach a level where their activities and those of partner agencies were integrated during the funded period of the pilot, although steps have since been taken by a number of pilot areas to embed the work of the projects in mainstream services and agencies. The main reason given for this (which appears to be the

case for those projects that have continued beyond the pilot phase) was the limited time available in which to embed the project's activities in the core activities of their partners (or the partnership that had formed as a result of this work).

Summary: messages and lessons

Box 8 summarises the aspects that are most relevant in terms of shaping a strategic framework as presented in Part 4, and particularly in understanding the central role and potential added value of strong, effective and locally determined partnerships and partnership arrangements.

Finally, we have drawn the important messages from the literature and from the pilots' experiences into a simple framework for developing and evaluating the nature and effectiveness of partnership working (Box 9). We wanted to shed light on the critical aspects of partnership working for the pilots, taking account of the multi-faceted and diverse

Box 8 Messages for understanding what worked for partners

- Clear purpose, goals and parameters for the work of the partnership, but with flexibility built into arrangements from the start, ensuring adaptability to meet changing local and organisational circumstances
- Shared clarity about aims, intended outcomes, outcome measures, secondary benefits
- Clear working and organisational arrangements, including leadership, facilitation, communication, operation, provision of services and activities, resource allocation and decision-making processes
- Partnerships can assist local agencies in overcoming traditional barriers between service sectors, and in developing good inter-personal relationships
- Major partners need to be engaged from the beginning – in formulating ideas, in developing bids and funding proposals, in designing the suite of services/information, and in delivery, review and future development
- Considerable time and effort are required where partnerships have to be built from scratch
- Wherever possible, partnership arrangements should build on and exploit existing networks and contacts, but opportunities for more spontaneous collaboration should not be dismissed or overlooked if and when they arise
- Information and activities made available by partner agencies encouraged a range of people to take up the health checks and other services offered
- Partners are valued sources of advice, information and contacts
- Partners can promote project services and signpost current (and potential) service users/participants to them
- Effective partnership working can stimulate further developments in and across partner agencies
- Partnerships are central to sustaining pilot project activities, and are an important vehicle for mainstreaming health-promoting activities
- The same principles of effective partnership working apply to commissioning/funding partners as they do to providers/deliverers
- Effective partnership working requires each partner agency to be flexible and adaptable, and to tailor their services to meet emerging as well as identified needs and preferences.

nature of this initiative, while ensuring the resulting messages were accessible and practical. In particular, we were mindful of our overall aim of establishing a framework for future service development around health-promoting activities for people in mid- and later life.

On examining the literature, we discovered a number of studies and frameworks that address a broad range of elements, aspects, criteria or phenomena associated with partnerships and/or partnering activities. Some of these studies focus on the contextual factors that need to be considered by those engineering or leading on partnership developments (Glendinning, 2002). Others focus on the mechanisms or processes involved (Funnell *et al.*, 1995; Hudson *et al.*, 1997; Asthana *et al.*, 2002). Still others address the less tangible but fundamental questions of relationships and the changing relational maps that influence the level of readiness for partnerships, and the locale and remit of partnership arrangements (Ashcroft,

2000; Greig and Poxton, 2001a,b). In addition, these different frameworks are offered as tools that can be used either prospectively or retrospectively for assessing existing partnership arrangements; or for preparing for the development of new collaborative ventures. Relatively few offer insights into how partnership contexts and processes influence and determine the outcomes of these collaborative endeavours. The recently published HDA series *The working partnership* goes some way to address this gap (Markwell *et al.*, 2003).

For ease of use, we have synthesised the main messages and lessons from these studies, tools and frameworks to identify three categories of partnership characteristics with which to examine the experiences of pilot projects working in this field. Helpfully, if unintentionally, these categories mirror the three dimensions of Pawson and Tilley's (1997) realistic evaluation framework of CMOs.

Box 9 Characteristics for effective partnership working

Contexts for initiating and building partnerships

- Parameters of geographic and subject areas which the partnership is intended to cover
- History of partnership development and working in this area including how, and with whom, previous partnerships have been established
- Extent to which local priorities and interests shape the organisational framework and arrangements for the partnership(s)
- Previous work and experience in the approaches and activities in question (eg community development and targeting the mid-life age group)
- Track record of achievements relating to the above, and of previous partnership arrangements, particularly in relation to the approaches and activities in question
- Existence of well established networks operating in this area and the geographic area covered by the partnership (including individual as well as shared networks)
- Experience and credibility of leadership arrangements, the lead or host organisation, and the lead person coordinating partnership activities
- Specific contexts of the host/lead organisation, including the extent to which its work is undertaken in collaboration with others; the proportion of activities carried out by or with others; the nature of work undertaken in this way; with whom and for how long current partnerships have been established
- Political and personal commitments to pursuing the activities of the partnership, and degree of continuity and stability of these commitments
- Resulting sense of certainty and predictability of the partnership arrangements and activities.

Box 9 Continued

Processes (mechanisms) for developing and using partnerships

- How the early stages of the partnership/project journey were experienced and managed, including design and development of bids, strategies and funding applications; whether early negotiations included and involved partners (and if so, how many and whom); nature and style of early contacts and communications
- How the project is implemented and activities undertaken, including the personal style, nature and level of communication with the lead person (eg project coordinator); how additional partners were recruited and commitment secured (eg what criteria used to select partners and how applied); how resources are allocated and used; nature and extent of involvement of different partners in core activities of the project; clarity of organisational arrangements for the partnership (eg steering group membership and function, delivery of activities, provision of information and advice)
- How the project and partnership evolves and matures over time: length and tenure of the project; changing roles, remits and relationships as project work evolves and adapts to take account of changing contexts and circumstances; how projects move from pilot status to mainstream activities; how resourcing issues are addressed and decisions made; how engagement is maintained and developed over time.

Intended partnership outcomes (and associated partner benefits)

- How experiences of project users/participants are identified, captured and used
- Degree of shared understanding of goals and outcomes achieved (dependent on shared systems of measurement and review)
- How the project and partnership activities are monitored, reviewed and evaluated
- Whether objectives and expectations of partners and stakeholders have been clearly stated, and are reviewed over the course of the project's journey
- Degree to which these objectives and intended outcomes meet specific goals and targets of participating partners (and funders)
- How secondary outcomes or benefits are identified and captured
- How proxy measures of success are identified and used to assess performance (eg for long-term outcomes) for the partnership as a whole, and for participating partners with different remits and roles
- How benefits and outcomes of the partnership are communicated to all stakeholders, including project users, funders, evaluators, partners and other interest groups.

8 Refining the underpinning theories of change

In the previous two chapters, and in Part 2, we have described how we moved from an understanding of the pilots' CMOs to an exploration of the project and client journeys (perceived to be) taking place to bring about improvements in the choices, health and wellbeing of the target groups. Through detailed discussions with project teams about these journeys, four initial theories of change were identified, describing their underlying assumptions about what might work, for whom, and why. These theories were tested through in-depth interviews with a sample of each project's users (participants) and representatives from their partner agencies.

We analysed the above data and returned to the original theories to assess the extent to which they appeared to hold water in relation to promoting health and reducing health inequalities for people aged 50–65 years. It is acknowledged that we have generalised (using Weiss's measure of 'beyond reasonable doubt') to shape a framework that can accommodate a broad, diverse range of contexts and circumstances; populations and communities; activities and approaches; experiences and benefits.

The following sections set out the main findings about which aspects of the four underpinning theories of change appeared to hold true. We begin with an overview of the main stages and processes of engagement, followed by an analysis of the empowerment and empowering strategies employed by the pilots. We then turn to those features of social interaction and activities highlighted by participants; and we end with a review of the theory of partnership and partnership working.

Engagement

Initial engagement

The pilots' assumptions that the target population/groups in their areas would actively need and want their services, and that this would trigger their engagement with the services offered, did not generally hold true. While there was clear evidence that services were, and can be, successfully targeted at people aged 50–65 years, there was also considerable evidence that participants needed to be more actively engaged and drawn in through the use of locally and individually tailored hooks or motivators.

Where people have identified or known needs, this can be a strong motivator – but they still need to be drawn in via one or more routes (hooks). Once drawn in, they are more likely actively to pursue further activities/information/services. However, the experience of two pilots (Hackney and Southwark) suggests that mental ill health and social isolation associated with relatively deprived localities may create more specific needs that will motivate people to engage with health-promoting and pre-retirement services.

For the most part, provision of a free service is a stronger motivation for initial engagement than having or exploring specific needs. In addition, the sense of being neglected in comparison with other groups was a major underlying motivating factor for engagement for many of the pilot participants.

A desire for information, particularly financial information, is also a strong motivating factor (based on the pilots where this was provided). In addition, depending on the locally determined motivators or hooks used to draw people in (eg health needs, work-related issues, etc.) the provision of financial information and advice alongside provision of health checks appears to be an effective combination of resources.

This kind of combined (or gateway) service is more likely to hook people and engage them in health-promoting activities than the separate and dislocated provision of different kinds of information.

The source and supply of different kinds of information are also important in influencing engagement. Information from known and valued sources (such as the National Farmers' Union in the case of the farmers from the East Devon pilot) is more likely to be seen as valid and relevant. This needs to be varied to meet the specific requirements of different target groups.

Reaching different communities is complex and takes time, and particular attention needs to be paid to addressing and understanding local socio-economic contexts (what are the real priorities here for local communities?). Neither the Hackney nor the Southwark project was able to engage people from the localities' minority ethnic communities, and further work specifically targeting these communities is indicated. The success of the Sandwell project in engaging female Asian textile workers suggests that, for this group at least, the workplace can be an appropriate venue. More broadly, the Sandwell and East Devon projects suggest that it can be effective to deliver services in venues currently used and known by groups that professionals find difficult to reach.

The choice of venue and the location and style of service settings all played an important part in engaging the pilots' target groups. The settings chosen by the pilot projects were seen as appropriate by participants, and were singled out by them as an important influencing factor for their engagement. In addition, a welcoming informal atmosphere, in which the inter-personal skills of project staff played a large part, was important in engaging people.

Maintaining engagement

Keeping target groups engaged, particularly those who can be hard to reach, can be facilitated by involving these groups in identifying needs and developing services – creating a sense of ownership and, importantly, a relationship and the beginnings of an ongoing dialogue. This was a central concern for the projects in Hackney and East Devon, which experienced varying degrees of success in maintaining engagement with their target groups:

- In Hackney, the focus group approach generated a strong sense of ownership among the women involved, and they were able to go on to develop initiatives such as the video project.

- The East Devon project was not able to make as much progress as anticipated in developing local community services in the timescales of the pilot. The project found it takes time to engage people, particularly those who are relatively isolated, in identifying needs and developing services.

Extending engagement

For four projects (East Devon; Southwark; Dorset; Hackney), establishing a gateway service that would signpost users to other activities or agencies was a major goal.

- In Dorset, women identified as at risk of osteoporosis did attend the workshops provided, and advice to consult GPs was followed up, indicating that for this group these mechanisms were effective. In addition, although none of the women we interviewed had engaged with services outside the NHS as a result of attending a health fair, data from the local evaluation indicate that other women did in fact do so.
- In East Devon the project had been unable to undertake the further community development work to which it had aspired in the timescale of the pilot project.
- Delays in developing the Southwark project also limited what could be achieved, but one woman who extended her engagement from IT training to a walking group was extremely enthusiastic and clearly valued it highly, suggesting that the work of this project deserves further development and evaluation.
- In Hackney, respondents did engage with one project partner which provided valued activities, but their expectation that a second partner agency would provide assistance with re-entering the labour market was not met.

More work is required to build on this important aspect of extending and sustaining engagement, particularly to enhance our understanding about the longer-term impacts of health-promoting interventions and activities for people in mid-life.

Empowerment (and empowering strategies)

Increasing knowledge through information

Overall, evidence to support the projects' theory that providing information would lead to knowledge gain is not strong. Where knowledge was gained, this was primarily in relation to issues that were new to respondents, notably financial planning in East Devon and North Nottinghamshire, and the use of IT and the Internet in Southwark.

Where health is concerned, knowledge gain was most likely in the context of detecting previously undiagnosed conditions, as in Dorset; or introducing people to hitherto unknown agencies and activities, as in Hackney.

For most respondents health information was not new, probably reflecting mass media coverage of lifestyle issues. For these respondents, the health information provided served to reinforce existing knowledge rather than to increase knowledge overall.

Knowledge gain, empowerment, control and action

Strong evidence for a link between these four concepts emerged only from North Nottinghamshire. This illustrates that the provision of pre-retirement courses in conjunction with health checks (for those who want them) can be a potent mechanism for improving both the health and financial wellbeing of working people in the target age group.

For many participants in the North Nottinghamshire pilot, concerns about financial and leisure issues following retirement predominated. In these circumstances, health information and advice can just as effectively be hooked to a gateway service focusing on financial and lifestyle planning topics as *vice versa*.

In Hull and East Riding and Dorset, some evidence of a link between knowledge gain, empowerment, control and action emerged, but was weakened by the small proportions reporting behaviour changes.

For many other participants, the most powerful impact stemmed from the reinforcement of their existing health knowledge, in line with adult education principles. Although respondents did not explicitly identify an increased sense of empowerment in this context, it seems intuitively reasonable to suggest that the validation of existing knowledge did lead to an increased sense of control and thus, in some cases at least, to the action described by participants.

Social interaction

In Hackney there was strong evidence that the focus group and other activities developed did directly improve the women's mental and physical wellbeing. It was this social interaction, arguably coupled with reinforcement of their pre-existing health knowledge, that led to a sense of increased empowerment and hence to behaviour change.

Although the evidence available from Southwark is limited, a similar strong impact was evident in the account of the woman who had joined a walking group.

Although the benefits of social interaction were not identified explicitly as a theory underpinning the work in Sandwell, the Asian women who participated in the exercise programme provided for one company also highlighted this as a main motivating factor for their attendance. Thus at this project too, there was evidence of a link between social interaction and health improvement.

On the basis of this evidence, social interaction appears to be an effective vehicle for improving the health of women living in deprived areas. For women such as the Asian participants in Sandwell, for whom family responsibilities can preclude a social life outside the home, opportunities for social interaction through the workplace are important and effective mechanisms for improving health and wellbeing.

Partnerships and partnering

Exploring and testing the theories of partnership with pilot participants and partners identified the following ingredients for successful partnerships.

Benefits of partnership working

The information obtained from both pilot participants and pilot partners leaves no doubt that establishing effective partnerships with a broad range of local and regional agencies/organisations (and local groups) was central to the projects' success.

Many participants indicated that they took up health checks because information/advice was also available on eg financial matters (East Devon; North Nottinghamshire); or because one form of activity led to another (Hackney; Southwark). This range of services was available in large part as a result of the partnership arrangements established by the pilot projects.

The implication is that closer working relationships are required between different agencies, sectors and organisations on an ongoing basis (eg NHS and social security; voluntary sector organisations and statutory agencies; education, leisure services and NHS practitioners; NHS and local businesses).

Partners were also valued sources of advice, information and contacts for the pilot projects, and were instrumental in signposting potential users to them and promoting their services. Some partners were engaged in the early stages

of the projects' work, in population need assessments and mapping exercises.

In addition, partners described how involvement with the pilot projects had enabled them to develop their own work by:

- Extending work with older age groups to the pre-retirement age group (Sandwell; Southwark)
- Using resources developed by the pilot projects with their own service users (Hull and East Riding; Southwark; potentially North Staffordshire)
- Extending their health improvement work (Dorset)
- Developing new services for the projects' target groups (Hackney; North Nottinghamshire).

Information for potential partners (eg GPs) needs to be as carefully targeted as information for the target group itself.

Benefits of partners' involvement

The main benefits of partners' involvement in the projects, identified by both the project teams and representatives from their partners, were associated with:

- Opportunities for developing partners' own work and interests in similar areas to those addressed by the pilots
- Extending knowledge and networks
- Developing services for clients of partner agencies through the range of activities provided as a result of the projects' partnership(s)
- Providing a valuable source of advice and experience for projects.

Partner agencies' work developed in four main ways:

- Those partners already working with older people extended their work to the mid-life age group (Sandwell; Southwark)
- Using resources developed by the pilot projects (Hull and East Riding; Southwark; potentially North Staffordshire)
- Extending health improvement services (Dorset GPs)
- Developing new services for pilot participants (Hackney; North Nottinghamshire).

Nature and type of involvement with pilot projects

Four main types of involvement were described by the project teams and partners interviewed for the evaluation. These were:

- Consultation, advice and planning expertise
- Providing information and contacts

- Providing services to pilot participants
- Promoting the pilot services and signposting potential participants to them.

Additional partnership activities included the provision of venues in Southwark and North Staffordshire; and identifying volunteer lay advisers in North Staffordshire.

Whether or not pre-existing partnerships were available to build from, it was clear from the pilots' experiences that for partnerships to be effective it is important to establish a shared vision and common goals – and to give time to air, debate and resolve differences of perspective. Similarly, aims and objectives, and the scale of what can be achieved in the resources available and in the context of the approach to be adopted, need to be agreed.

In the majority of cases, partners' involvement was facilitated through membership of a pilot steering group. These steering or advisory groups provided a helpful source of information and advice to project teams and partners, provided roles, responsibilities and expectations were clear and kept under review as the work and understanding about its impact evolved.

Where a project is established under the auspices of a host organisation, that host organisation needs to be clear about the place of the project in relation to its wider remit and scope of activity, and to ensure that this is clear to all those involved.

Perceived value of projects

All the partners interviewed valued the pilot projects highly and regarded them as a success.

Difficulties in building partnerships occurred in East Devon, Hackney and North Staffordshire. In North Staffordshire these were quickly resolved; in Hackney some problems remained unresolved; in East Devon partnership building remained problematic. The project coordinator attributed this to a lack of pre-existing partnerships; lack of clarity about the messages to be conveyed; and problems in communicating across service sectors.

In addition, the pilot status of the work (and associated perceptions about limited timescales and resources involved) could act as a deterrent to some potential partners. This was particularly the case in Sandwell, where a number of simultaneous pilot initiatives and projects had resulted in competition for involvement from local agencies and businesses, and a resulting awareness that developing the appropriate relationships and partnership arrangements to

reach target groups takes time, resources, commitment and energy. Some concerns were expressed about the limited time available for building these foundations, developing and then delivering the interventions, and achieving the pilot objectives. However, this example also illustrates the possibility of overcoming such barriers through exploiting established contacts and networks, building on these previous experiences and harnessing the skills of partner organisations. It also highlights the need for caution in contexts where such networks and experiences do not yet exist.

Sustainability

In most pilot areas, the partnerships formed during the pilot phase have facilitated the continuation of at least some aspects of the pilots' work. Success is more likely, or more readily achieved, when the project is able to build on pre-existing partnerships rather than starting from scratch or reinventing the wheel and duplicating what already exists (and therefore adding to the current sense of fragmentation of pilots and initiatives in some places).

It takes time for effective partnerships to develop and mature; for projects to become established and operational; and for relationships with local communities and specific target groups to flourish. This varied from place to place (mainly for contextual reasons). An important influencing factor appeared to be the level of knowledge and intelligence about what was already available, what had been tried or provided before and, crucially, what is known to work and to be of value to potential users and partner agencies.

Delivering services in small- and medium-sized enterprises, in particular, requires long-term work to establish trust with employers. Employers' concerns about providing a service to all their employees, regardless of age, also need to be taken into account (eg Sandwell).

Partnerships are therefore seen as a central mechanism for sustaining health-promoting activities with this age group, through mainstreaming the pilot's work via the breadth and range of participating partners' own activities.

Important factors in building and sustaining effective partnership were identified from both those pilots where partnership activities are relatively straightforward, and those where difficulties were experienced:

- Achieving a shared clarity about aims, objectives and intended outcomes
- Getting to know your partners (and wider group of stakeholders), and developing good inter-personal relationships
- Building on existing partnerships/alliances, as well as developing new ones
- Clarifying expectations, roles and remits of different partners involved, as well as mutual benefits to be gained (eg facilitating achievement of industry/sector-specific performance targets)
- Harnessing and valuing different contributions, and exploiting complementary resources (eg respective networks and contacts)
- Overcoming traditional barriers in and between public service and industry sectors
- Establishing effective and acceptable mechanisms for an ongoing dialogue (shared language, appropriate use of media and forums, two-way communication and practical feedback that can be used in future developments).

In addition, in those localities where partnerships have to be built from scratch, either because a new area of work is being developed or because relevant partnerships do not yet formally exist, the time and effort required should not be underestimated. In particular, such developments cannot realistically be expected to deliver benefits on a short- or medium-term basis (under two years).

Tailoring and adapting services and activities on offer through each of the partner organisations is vital not only to meet identified or known needs, but also to respond effectively to emerging and/or hidden needs that reveal themselves over time (eg the expectation of women in Hackney that help would be available to re-enter the labour market).

Summary: cross-cutting messages and lessons

In addition to the four underpinning theories of change, our analysis reveals a number of important messages and lessons arising from the work of the pilots. While some of these lessons are also contained in the above account of the refined theories, others were more implicit and their central messages could be missed. We end this chapter with a summary of these themes, including a number of areas and specific interventions or approaches that we believe require further exploration and development.

Developing local knowledge and understanding about needs and preferences

- Success is more likely, or more readily achieved, when a comprehensive needs assessment is undertaken before embarking on project development
- When needs assessments actively involve members of the target group (eg focus groups, carrying out surveys), engagement of the target group is facilitated
- Needs assessments that address the target groups' contexts – historical, social, economic and biographical – as well as specific health/retirement needs, help ensure information is meaningful and coherent to those concerned
- Specific efforts need to be made to reach disadvantaged groups if health inequalities are to be addressed
- Engaging people in assessing needs and developing services is worthwhile and is particularly important for engendering ownership, but is an ambitious aim that takes time to achieve on any significant scale
- Careful attention needs to be paid to the diverse situations in which people find themselves, and the diverse range of opportunities and preferences that exist; this is a crucial part of any local needs assessment, but is often overlooked, and without this intelligence it is much harder to develop appropriate and sensitive approaches towards engagement and empowerment, particularly for those groups that professionals and public services find difficult to reach.

Developing a portfolio of services, activities and interventions

- One model, approach, intervention or activity will not suit all requirements of all target groups across different communities, living in different localities, influenced by various contextual and historical factors. What is required is a range of services encompassing information, advice, specific interventions (eg general as well as more specialist health checks), physical and social activities, opportunities for learning and education, and practical help with planning and developing personal strategies for understanding and managing change and transition.
- The eight pilots offer valuable lessons for understanding which interventions and services are effective for meeting the needs of different groups in different situations. While some of these lessons can be generalised, others require further exploration to determine how they may

be transferred (eg across different groups and contexts) and/or to assess their long-term impact.

- The information and advice that people in mid-life seek is not just about retirement per se, but is more about this stage in people's lives, where decisions about current and future work and income are dominant, but are not the only issues that occupy and challenge people on a day-to-day basis.
- A range of settings are required, depending on the nature of project activities and the specific target group (eg women in Hackney and Dorset benefited from different formats); privacy needs to be ensured in public or communal community settings (East Devon); security of valuable equipment, such as computers, can be problematic in community settings (Southwark).

Outstanding issues that require further work

- Increasing engagement and active participation of people in this age group from black and minority ethnic communities.
- Extending engagement with agencies and activities for different target populations, other than in the contexts and for those target groups outlined above.
- Returning to the labour market was a concern for unemployed respondents that none of the projects fully addressed.
- Appropriate settings for delivering clinically oriented services to men and to people living in deprived areas.
- Potential for providing access to IT, and the training required to use it, for people who are unlikely to have Internet access at home or at work.
- Other educational and personal development issues were raised in interviews with pilot participants that require further exploration, in terms of their perceived and potential benefits for improving health and wellbeing for this age group.
- Extend opportunities for group work and social activities in deprived areas to larger numbers, and to men; and review whether health benefits (as experienced by women in Hackney and Southwark) are achievable.
- Men's health in this age group requires further exploration – in relation to both physical and mental health and wellbeing; and appropriate settings, venues and formats for individual and group activities and services.
- There is a need for a greater focus on mental health and wellbeing in health improvement and prevention work. At the same time, there are clearly important links

between good physical health and wellbeing (Southwark; Hackney), which in turn influences mental health. Those experiencing the benefits of physical activity also appeared to change their behaviour in other respects (diet, social interaction).

Importance and nature of evaluation

- Monitoring to check the required progress is being made, and evaluation to assess whether desired outcomes are being achieved, both need to be integrated into the initiative from the outset.
- Evaluation is most likely to support success when it involves constant feedback, as opposed to the more traditional 'hands-off' approach.

(See also Chapter 5, 'Towards a model of pilot evaluation', page 35)

Part 4 Modelling the future

This final part of the report pulls together our conclusions and presents a model for focusing on and understanding the needs and circumstances of people aged 50–65 as a central mechanism for improving health and wellbeing in mid- and later life. It attempts to link the evidence about what works, for whom, and why to current and future strategies and developments around health improvement, health inequalities and interventions for delivering Standard 8 of the NSF for Older People.

Chapter 9 summarises the evidence accumulated through the work of the eight pilots, the HDA, and the local and national evaluations. Chapter 10 introduces and explains the components of a strategic framework (the ship's wheel) for promoting health and opportunities for improving wellbeing in mid-life. This will require strong leadership to harness regional and local resources, partners, communities, services, skills and activities to address particularly those areas and issues that indicate the existence of inequalities in health and opportunities for wellbeing. Chapter 10 sets out the range of activities involved for each of the five elements in Figure 4 (page 65) to drive this agenda forward in a coherent and coordinated way. Finally, Chapter 11 outlines the main issues and actions that need to be addressed through four main routes for the strategic framework to be applied. First, a demonstration phase of work to refine and disseminate the evidence base and pursue areas requiring further work; second, a clearer national policy direction, leadership and guidance; third, regional oversight and support to implement the framework at local level in the context of wider regeneration and development priorities; and finally, local partnerships to secure investments, coordinate commissioning activities and deliver a range of locally appropriate and responsive services.

We have deliberately avoided setting out a list of recommendations for action where requirements already exist. Much of what is contained in this report builds on current policy frameworks and requirements, and national strategies for reducing health inequalities. It is not our intention to add to these requirements or confuse local commissioners and providers' priorities in addressing these issues.

Instead, we focus on the need for greater clarity about local needs and aspirations; more evidence of community involvement and participation in identifying those needs; and clear leadership and partnership arrangements for harnessing resources, services and opportunities to meet those needs. Above all, we emphasise the need for a much more systematic and rigorous approach to developing a broader understanding of health for people in mid- and later life, and of a spectrum of planned services and interventions for improving health and addressing health-related needs.

9 Targeting health improvements and reducing health inequalities for people in mid-life

The first three sections of this report present the growing body of evidence (drawn from both the literature and the experiences of the pre-retirement pilots) demonstrating the benefits of targeting health-promoting activities, and specific interventions for addressing known health problems, at people in mid-life. In particular, the experiences of pilot participants in deprived communities make a compelling case for this kind of focused approach.

A significant number of the participants interviewed during this evaluation shared their sense of feeling neglected in terms of understanding about their circumstances, aspirations and needs. They experienced different transitions in relation to work and retirement, caring responsibilities, health and fitness, and changing financial prospects. This meant they were receptive to information and advice, practical ideas, and opportunities for participating in a range of activities and services aimed at improving their personal situation and overall wellbeing.

For those involved in shaping and delivering the work of the local projects – either as members of project teams or as pilot partners, or through wider mechanisms of support such as the HDA – there were a number of challenges in securing commitment and resources for sustaining the work they had begun (or developed) through this initiative. Those projects that have been successful in negotiating additional resources and/or arrangements for embedding their services in local systems and infrastructures have done so largely as a result of the partnerships and networks that were built, or extended, over the past two years.

One of the most important lessons to emerge in these negotiations was the need to demonstrate how the activities in question either delivered or contributed to the achievement of existing performance targets and national standards across different industry and service sectors (eg economic growth targets and reduction in unemployment

rates; priority planning frameworks for PCTs; public service agreements for local authorities; educational attainment for Learning and Skills Councils, etc). For service providers and commissioners, there are particular concerns around performance management and the need to demonstrate that long-term developments of health improvement activities and interventions will contribute to current, often short-term, priority targets (eg reducing waiting lists and times; take-up of screening services; reducing the number of people reliant on state benefits). The major challenge here is in raising the profile and status of longer-term targets, to which all agencies are required to contribute (eg improving life expectancy and reducing regional variations in the prevalence of chronic disease and disability), but which have less currency than more quantifiable and volume-based measures around access to and the costs of specific treatments and interventions.

A second lesson is the need for a multi-faceted approach to service development and delivery, to respond to the range of contexts and situations in which people live, work and experience family and community life throughout their lives. It is in these wide-ranging contexts that policies are formulated and implemented and services delivered. There is no single model of service design and delivery that will meet all needs, in all situations, at all stages of life.

This picture of diversity and complexity (epitomised by the tension between necessary variations to respond to local needs while addressing inequalities between regions) highlights the need for much clearer cross-government direction and a joined-up policy framework for health improvement in mid- and later life. During phase 4 of the evaluation we met a range of stakeholders from different service and public policy backgrounds (policy-makers and implementers; public health practitioners and directors; NSF Standard 8 leads; participants and project teams from the

eight pre-retirement pilots) in three regional workshops. The workshops were held to share the findings and discuss the (then) outline recommendations arising from the evaluation. An important issue raised and discussed in depth concerned the policy and practice implications of these recommendations, and messages and lessons around implementation. A common theme that resonated from across all three workshops (attended by a total of 60 people) was the lack of clear leadership and direction at national and regional levels, and the need for an explicit steer on investing in health improvement activities for people in mid- and later life. In particular there is a sense of confusion, stemming from that lack of clarity, about where this agenda fits in terms of government policy and regional and local implementation and investment plans.

In addition, and as the European policy framework (page 13) advocates, this clearer national policy and strategic framework should adopt a life-course approach to health and wellbeing, encompassing education; employment; social networks and interaction; community development and economic regeneration; support for those with significant caring responsibilities; and targeted health interventions. Practical information and help with personal financial planning and management were also highlighted as major concerns for people in mid-life, especially for women (and men) who have experienced frequent and/or long-term breaks from employment, and for those wishing to return to work after a period of unemployment.

In terms of a policy framework, the government's cross-departmental strategy for tackling health inequalities (Department of Health, 2003b) goes some way towards fulfilling this requirement. The strategy also sets out how the national targets it contains (specifically around life expectancy) link with and feed into parallel policies and frameworks for national, regional and local service development and health improvement. It includes a number of specific references to interventions and approaches to improving health and reducing health inequalities experienced in later life, with one specific reference to targeting people over 50 as an important mechanism for achieving this goal. However, it is less clear how different competing priorities for NHS resources and development capacity (eg delivering NHS reforms; alleviating acute pressures; achieving short-term NSF targets) will enable such longer-term developments and approaches to gain the profile they need for resources to be committed and partnerships secured. The need to clarify the role of PCTs and to connect primary care services, systems and staff to broader

community development initiatives is one specific example drawn from the experiences of the pre-retirement pilots.

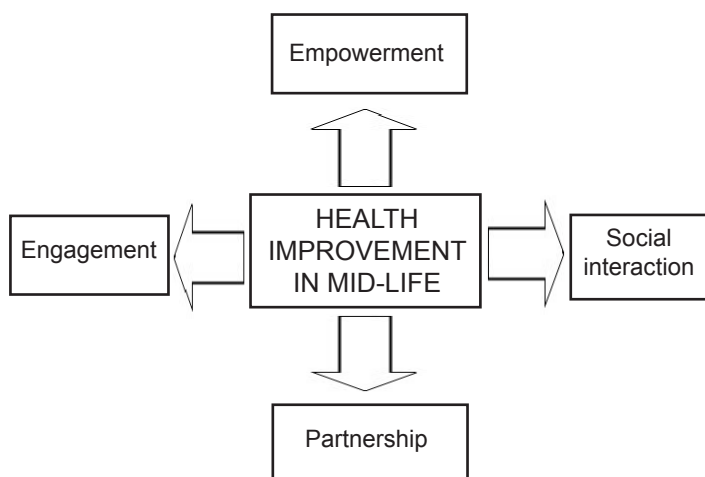
The framework we suggest in this final section illustrates how initiatives and developments at different levels and in different government departments need to be, and could be, integrated to mobilise a powerful force for change. Our main aim in presenting the framework is to ensure local plans, investment and development strategies include explicit references to improving health and wellbeing in mid- as well as later life; and that the subsequent interventions, services and activities are connected to and integrated with wider regeneration initiatives.

10 A strategic framework for promoting health and opportunities for improving wellbeing in mid-life

In this chapter we introduce a high-level (strategic) framework that can be adapted and customised to meet local needs while remaining true to a nationally derived blueprint supported by national policy and guidance. The aim is for a framework that can be used to guide local delivery in the context of a regional development and investment plan, and a clear national policy direction that both promotes and facilitates sustainable strategies for healthy, active ageing.

This framework, then, is for a regional strategy that underpins and guides local plans for developing and delivering a range of services and interventions to meet the needs and aspirations of local people aged 50–65 years, in the context of local economic, socio-demographic and epidemiological characteristics and identified development priorities. At the heart of the framework are the four theories of change – engagement; empowerment; social interaction; and partnership, identified during phase 3 of the evaluation. Translated into the framework, these theories of change become the underlying principles of health improvement strategies for people in mid-life. They are both inter-related and distinctive in their own right, as Figure 3 demonstrates.

Figure 3 Principles of health improvement in mid-life



The following four principles are the central and guiding features of the strategic framework.

- Maximising *engagement* through providing a spectrum of information and advice services, interventions and activities focused on achieving health improvement for the local population aged 50–65. Careful attention must be paid to the individual needs of local communities in determining which services and activities require development and investment, and how these might be identified, accessed, used and experienced by people in mid-life.
- Adopting *empowerment* strategies and approaches that maximise individual potential, and that harness personal and collective contributions to local and regional developments. The main issues include opportunities for individuals to increase their own personal contributions and confidence, as well as opportunities for improving the health and wellbeing of specific groups and communities (reducing health inequalities).
- Increasing and improving opportunities for *social interaction*, and activities that promote interaction, especially for unemployed women and men; isolated or marginalised people; unpaid carers; self-employed men and women; and people from minority ethnic communities. These opportunities should encompass work-based as well as community-based activities. Improving access to, and use of, different telecommunication and digital technologies that lead to ‘virtual’ social interaction (eg in remote and rural communities) should also be considered.
- Building and sustaining locally relevant and effective *partnerships* across the range of stakeholders, agencies, organisations, businesses and employers who have an interest in, and influence over, the health and wellbeing of local people in this age group. Partners operate at two levels: investors/funders and commissioners of local public

services, businesses and enterprises, including employers; and providers of services, activities, interventions and information, both mainstream, general services and those specifically focused on promoting the health and wellbeing of this age group.

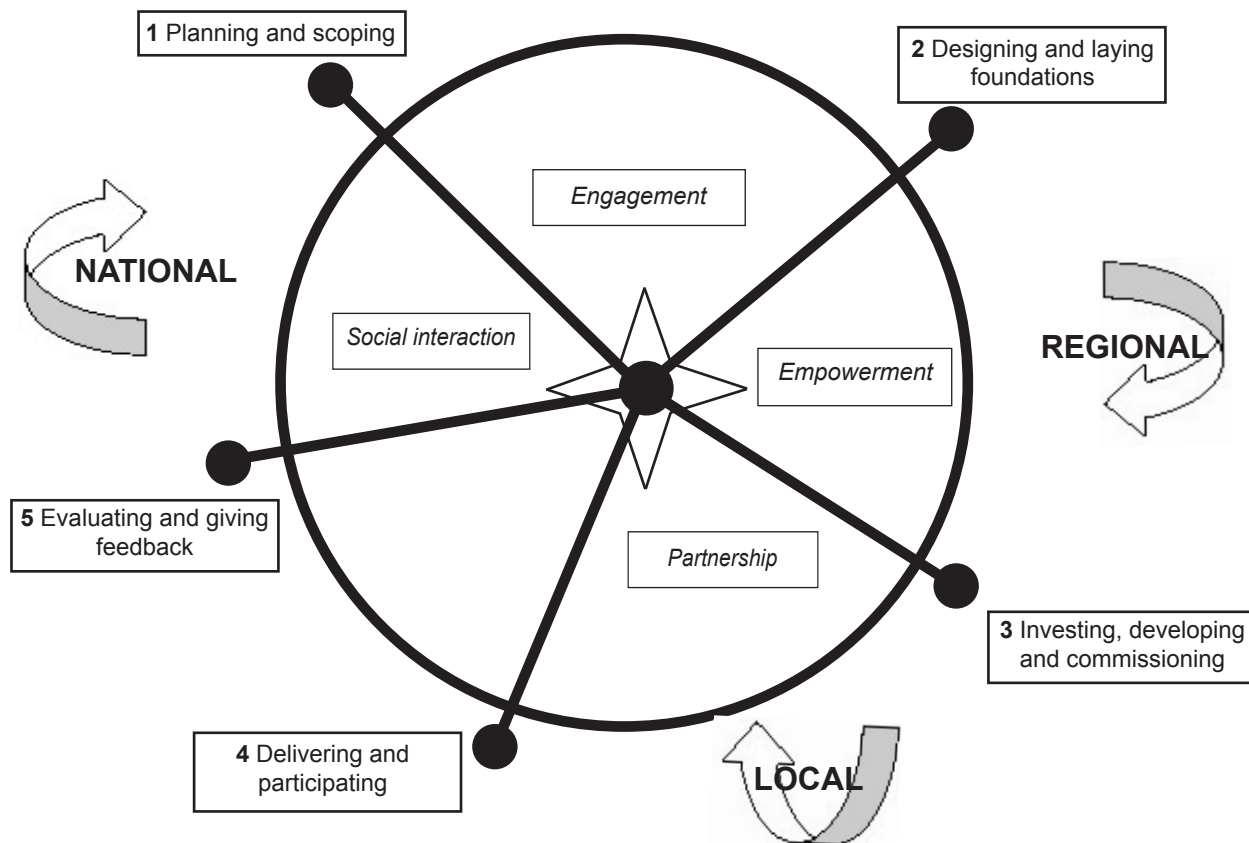
For these principles to become embedded in policy and practice, and for them to have maximum positive impact, five mobilising sets of activities (elements) need to be established. These five elements, set out in Box 10, are the enabling features of the strategic framework. Equal attention must be given to each. In addition, there is a sequential order to these activities such that progress on each element will influence the effectiveness of each subsequent stage of work. While recognising the sequential nature of these activities, it is also important to stress that, due to the realities of competing priorities, different funding streams and often conflicting commissioning cycles that operate across industries, sectors and agencies, the framework does not have to be applied as a linear development process. The results from one element, or stage, will feed into the next (this is especially significant for the first two elements), but preparatory work on all five can be initiated simultaneously. This requires strong, authoritative leadership at both regional and local levels. Whoever leads in this area of development, at both levels, needs to have the skills and capability to ensure the progress

- Box 10 The five framework elements*
- 1 Planning and scoping
 - 2 Designing and laying foundations
 - 3 Investing, developing and commissioning
 - 4 Delivering and participating
 - 5 Evaluating and giving feedback.

of specific tasks in each set of activities, while juggling and preparing for the next. Some activities will span more than one element, illustrating their inter-connectedness. What is most important is the need for a systematic approach that continuously builds, reviews and refines what is available to respond to changing contexts and local needs of current and future generations.

The four principles, five elements and three levels of action (national, regional and local) that make up the strategic framework are captured in diagrammatic form in Figure 4. We have called the framework the ship's wheel – a metaphor for direction, leadership, partnership, and a journey of discovery into the characteristics, needs and effective strategies for promoting and improving health and wellbeing in mid- and later life. A commentary on the relationships between these elements and levels of action follows in Chapter 11.

Figure 4 The ship's wheel – steering a course from mid-life to healthy active ageing



11 Navigating the five elements

This chapter maps out the specific activities included in the five elements (Figure 4). Relevant lessons and practical tips drawn from the work of the eight pilots are included in each section.

Planning and scoping

This set of activities is concerned with developing intelligence about local populations and specific target groups, and in particular with understanding the characteristics of different cohorts across the lifespan to fully understand the mid-life group in a local area. It includes the requirement to engage different groups in local population needs assessments and in identifying potential partners. Engaging partners in needs assessments is a crucial feature of this work, recognising their contribution to mapping local services, facilities and amenities against the needs and preferences identified, identifying resource pools, and agreeing high-level investment plans.

The rich diversity of pilot projects, and experiences of project participants and partners, support the view that a combination of approaches, services, information and advice is required, delivered by a range of partners through their combined settings and networks. One model of delivery or type of approach will not meet or address all needs, or be attractive to different groups and communities. This requires both greater understanding of local requirements and variations, and commitment and investment through the established and growing machinery that now exists at regional and local levels (eg regional assemblies; regional development agencies; local strategic partnerships).

Targeting and engaging the mid-life age group first requires consensus (nationally, regionally and locally) that this age group is a priority for meeting identified needs, and for

undertaking further work in those areas where needs, preferences, benefits and impact are not yet fully understood.

Lessons from the pilots

The projects have demonstrated the benefits of knowing and understanding the demographic and socio-economic contexts affecting people on an individual as well as a collective basis. The following steps summarise activities to ensure the characteristics of the local population are understood, specifically the cohort of 50–65 year olds:

- Completing a health needs assessment adopting the interactive, community-based approach advocated by the HDA to identify, assess and agree health priorities for this cohort, to clarify those target issues or groups in the cohort (see guidance available at www.hda.nhs.uk)
- Engaging the local population and these target groups in further development work to promote ownership and trust, and to engender confidence and interest in future activities, services and interventions
- Involving those partner agencies who have either experience and expertise in the identified areas/issues, or contacts and networks among the 50–65 cohort and specific target groups, and who can contribute to the work in terms of time, commitment, resources, venues, promotional materials and media
- Achieving sign-up and commitment in terms of investment, time and active participation requires sound leadership across partner agencies, not least to secure clear, shared goals, and a collective local intelligence about this cohort – its characteristics, experiences, aspirations, preferences, needs, what is likely to be effective in reaching, engaging and influencing change and improvement.

Designing and laying foundations

This element is concerned with the business of building and securing partnerships; agreeing roles and responsibilities in commissioning, providing and delivering the service/ interventions agreed (the local suite of products that will be available to improve health and wellbeing for people aged 50–65); and establishing the strategic mechanisms that will ensure partnerships work effectively and that all partners are clear about their respective roles, responsibilities and remits. These mechanisms should include how workforce development issues and plans will be addressed. Other aspects that should be considered in these early stages include the design and implementation of effective consultation processes involving local people, partners and specific groups to be targeted.

Lessons from the pilots

Even during these early stages, it is important to address some of the essential design features highlighted by the experiences of the pilots.

- To achieve this multi-faceted approach effectively, the nature of, and investment in, building a locally sensitive partnership (or range of partnerships) is central to reach and engage, and sustain engagement with, people in the target age group.
- While recognising the lead role of PCTs and strategic health authorities in identifying, responding to and improving the health of their local populations, the experience of the pilot projects highlighted that this is not the responsibility of one agency alone.
- What is more important is the nature and strength of the local partnerships that exist, the quality of relationships between partners, and the greater opportunities that exist through harnessing and using collective services, information, access points, venues and networks.
- This is not only a collective in terms of what is (and can be) provided; it is a collective in terms of responsibility, commitment and investment, eg
 - local authorities, in ensuring community development and leadership
 - regional assemblies and development agencies, in creating and facilitating opportunities to address complex and locally specific challenges for business, commerce, education, and community health
 - local businesses and enterprises, in supporting and investing in local community development enterprises and supporting employees to take up and benefit from available opportunities
 - local communities, both individually and through informal networks, as well as more formal groups and forums.
- The notion of social capital is increasingly well understood in terms of building safe and economically buoyant communities. It is the kind of approach we believe needs to be adopted at regional and local levels to address the health improvement priorities for the target age group highlighted in this report (Swann and Morgan, 2001; Granville, 2002).
- A major objective should be to provide a free service, at least at the first point of contact, and specifically in deprived communities where the health gap will be greater and more complex.
- This first gateway service should offer a combination of services, including a range of information (financial, health-related, leisure and fitness or lifestyle, housing and benefits, local amenities and activities, etc), general as well as specific and tailored advice, and health-related checks.
- The initial point of contact should vary depending on the needs and characteristics of the local population and the target groups identified (eg industry-related; women or men; minority ethnic communities; health-related conditions, etc).
- The value placed by both pilot participants and partners on signposting activities highlights some important lessons for local authorities about how information on local resources and facilities is accessed, and by whom; and how recent developments of one-stop shops and contact centres could be used/refined to ensure the needs of this age group are catered for (eg access to benefits advice; pensions advice; outlet for different sources of information).
- There is a particular need to address the gap in relevant, accessible and practical financial information for the 50–65 age group. The source of information was highlighted as influencing potential participants as to whether the content is seen to be relevant and whether it is acted on (eg financial and health-related advice from the National Farmers' Union for farmers; the role of lay advisers in North Nottinghamshire). This has implications for the production and dissemination of targeted, financial information (and advice). Financial institutions, the DSS, the Institute of Fiscal Studies, trade unions and professional associations should also consider the needs of this age group, and tailor the information and advice they provide accordingly. Information and guidance should consider and respond to the needs of men and women separately (eg the cumulative impact of career/carer breaks).

- As well as the desire for more information, the importance of advice and practical help to plan, reflect and try things out has implications for different providers, not least in the deployment of activities and services in different settings. This includes workplace settings for employers and human resource advisers; and public information services (eg Citizens Advice Bureaux) for improving access to flexible and personalised advice and support.
- Major health issues that need to be targeted in this comprehensive range of services include stress, mental health and mental ill health; specific issues for men (eg prostate cancer) and women (eg osteoporosis, menopause); weight, diet and nutrition; and keeping fit and physically active.
- Mental health, wellbeing and stress constituted a significant area of need and interest from participants. Activities and opportunities for social interaction; improved relationships; links to community/neighbours/friends; and strategies for reducing the negative impact of competing pressures (including the effect of being part of the 'pivot' generation with responsibilities that span work, family, caring for older and younger family members), were singled out as being particularly beneficial. These were also identified as aspects that were more likely to encourage people to seek out other sources of information and advice about making healthier choices and changes to personal lifestyles.
- The value of physical activity and exercise was emphasised by a number of respondents, particularly women, eg joining walking clubs, making use of leisure passes, taking part in local fitness campaigns, and trying out new activities such as yoga. The perceived and actual benefits identified for women need to be extended and tested for men. Primary care practitioners (not just GPs) need to be mindful of local opportunities that they can tap into and proactively engage with as part of their role in tackling health inequalities and the local health improvement agenda.

Investing, developing and commissioning

This crucial element of the strategic framework will ensure the early preparatory work is translated into responsive, accessible and acceptable services that effectively meet the needs (and preferences) of local people in mid-life. This involves seeking and securing agreement among partner agencies (in the first instance with those partners who represent funding and commissioning bodies) on the broad spectrum or portfolio of services and activities to be commissioned, developed and delivered; agreeing local

investment and delivery plans; clarifying commissioning intentions and service specifications to partner providers; establishing tendering and contracting mechanisms; securing agreements from all partner providers; identifying skills, expertise and experience required, and any gaps in the current workforce (across the local partnership of providers and commissioners); establishing and/or developing infrastructure requirements; undertaking marketing and market management and providing development activities.

Lessons from the pilots

- An important lesson from the pilots' experiences that needs to be addressed as part of a commissioning framework is the value and cost-benefit of developing new services, as opposed to building on existing services, to meet identified needs and priorities. This is particularly important in terms of considering the workforce and skills required for delivering services.
- Further work to extend the reach of such initiatives, and to address health inequalities in particular, may require more explicit commitment from local partners, including pooling of resources and expertise. There is a clear role here for local strategic partnerships in terms of coordinating and ensuring that partnerships continue to grow and, in some cases, that new partnerships emerge to address these issues.
- Access to community development and growth funding (eg via the Community Empowerment Fund for Local Strategic Partnerships, and the Community Chest for supporting neighbourhood renewal activities) has facilitated innovative and effective partnerships in some of the most deprived local authority areas in England (Granville, 2002). The role of PCTs in securing future investment in, and development of, health improvement services for this cohort needs to be made more explicit, eg by identifying this cohort as a priority for inclusion in local delivery plans to meet the government's priorities and planning framework targets on health inequalities; and using the new General Medical Services contract to ensure primary care practitioners are fully engaged in future developments for improving access to a range of services, information and advice through gateway health checks and healthy lifestyle plans.

Delivering and participating

The activities associated with this more tangible element of the strategic framework are concerned with a number of practical tasks that will ensure the provision of a suite of services through locally determined mechanisms, taking

account of specific access issues for the local population and identified priority/target groups. These involve: agreeing and securing contract and monitoring arrangements; setting up new activities or refining and promoting existing activities; marketing, disseminating and developing a strong media profile for the partnership and the services available through it; identifying and establishing the range of settings and venues from which services and activities can be accessed; providing information about what is available, where, for whom, and how it can be accessed; coordinating and disseminating the range of information and advice; enabling local communities and specific target groups to engage, participate in and contribute to service delivery; addressing ways of enhancing experiences and contributions to local business and employment opportunities, community environments, educational and social activities, and local public services (and increasing the likelihood of sustaining engagement, increasing confidence and ensuring empowerment); and monitoring local take-up, delivery and provider performance, including maintaining records and ensuring data collection/quality.

Lessons from the pilots

- The setting, venue, style and approach of local services and staff were important determining factors for project participants and for project partners.
- There is a need for a mix of communal and private facilities, as well as a variety of types of locally accessible venues that people know and use, and where people (both men and women) choose to congregate.
- The focus needs to be on creating informal, non-clinical environments (even in clinical settings), and thus on the quality of interactions between service staff and service consumers.
- The venue and style of service must be tailored to local situations, populations and target groups. This is likely to be more easily achieved through using the networks, contacts and venues of partner organisations and agencies, including local businesses, trade unions, community facilities and domestic residences, as well as statutory premises.
- Information will need to be provided in a range of formats and communicated/accessed via different media. The source of different types of information needs to be considered to ensure it is credible, noticeable, relevant, and connected to messages or other information provided for specific groups.
- A good prognosis for sustaining involvement and engagement in the longer term is ensured through the

provision of gateway or signposting services which hook people into other activities/interventions/information.

- Practical tips from the pilots for drawing people into activities and services include:
 - pay attention to locally sensitive details when marketing messages to target groups (eg free service, targeted to meet your needs), and feed in locally identified issues and pressure points
 - stress the availability and benefits of having a personal, tailored response to individual needs and circumstances
 - gauge the level of readiness for the target group to engage and participate and start from this position, and be persistent
 - aim to take services, activities and staff out to people wherever they typically meet, congregate and/or work, and use local facilities that are familiar and acceptable to them; options for where and how services, information and advice can be accessed can be developed once initial engagement has been achieved
 - review the skills mix and experience in teams on a regular basis to ensure emerging issues and needs can be addressed
 - ensure local partnerships for health-promoting services and activities consist of representatives from local businesses and public sector employers, community services and facilities, NHS and local authority services, voluntary and non-profit organisations, local benefits and welfare assistance schemes, and faith-based, religious and culturally specific organisations
 - if services and activities are funded via short-term, pump priming or other kinds of project funding, explore opportunities for integrating these activities, skills and resources into mainstream services and facilities at the outset, ensuring close links are established with commissioners/funders and funding bodies, and that formal communication channels (eg for sharing performance data and achievements) are established.

Evaluating and giving feedback

A multi-stranded approach to evaluation can provide evidence of effectiveness and knowledge for replication purposes. An accountability function is served by demonstrating not just that resources were spent as intended, but that they were spent well. The following points are made in relation to local evaluations where no national

evaluation is commissioned. Where a national evaluation is commissioned, they are intended to provide a starting point for agreeing an appropriate division of labour between national and local evaluators.

Lessons from the pilots

- Impact assessment: ensure the approach and methods adopted are based on principles and practices of impact assessment. It is important for services to generate evidence of their impact on specific populations – what worked, and how powerfully it did so. The use of robust pre-/post-assessments can provide good evidence of impact, but impact can also be assessed qualitatively. A commitment needs to be made to partners and other stakeholders by developing and agreeing criteria for effectiveness, and assessing impact from a range of perspectives.
- Timescale for the evaluation: in many instances this requires a commitment to evaluate impact beyond the funded period of services, especially pilots. If some of the anticipated change is expected to occur post-pilot (or funding period), then data collection and evaluation should be timed to assess post-pilot impact.
- Understanding processes of implementation: for knowledge transfer to occur, evaluation needs to examine the factors associated with successful implementation. However, providers and commissioners (whether a project, pilot or mainstream activity) also need to collect routinely a basic minimum data set concerning the age, gender, ethnicity and social class of their recipients.
- Understanding the dynamics of change: knowing whether something works, and how powerfully it does so, is insufficient unless the evaluation can also identify how and why it works. This requires a commitment to some form of theory-based evaluation in which initial assumptions and expectations about how the pilot might work are made explicit, and the roles of anticipated change mechanisms are tested.

12 Setting sail – applying the framework at national, regional and local levels

For the five elements of the strategic framework (Figure 4, page 65) to be addressed coherently and effectively, while paying attention to the four underpinning principles (page 64), a number of actions and responsibilities fall under the remit of various stakeholder groups operating at national, regional and local levels. We have identified four main routes through which these actions could be addressed:

- Refining, applying and disseminating the evidence base of what works, for whom, and why, through a nationally driven and supported demonstration phase
- National direction and guidance, through clearer cross-government policy and identifiable leadership on promoting healthy, active ageing, adopting a life-course approach
- Regional implementation and leadership for mobilising strategic and commissioning partners and the appropriate partnership machinery to take this forward locally; harnessing and pooling investments and securing commitment; overseeing population needs assessment; identifying and agreeing priorities; setting out and supporting the achievement of local implementation goals and targets
- Local initiative and action to take forward developments, implement regional and local strategies, and develop locally responsive partnership arrangements for delivering a range of services and activities to meet identified needs, and for achieving national, regional and more locally determined goals and priorities.

Demonstration phase

We believe there are sufficient pointers from the national evaluation to recommend a demonstration phase that focuses on the issues of sustainability and spread identified in this report. The leadership and oversight of this phase, we believe, rests with the HDA, in partnership with government

leads on Standard 8 of the NSF for Older People. Support from the Health Inequalities Unit will also be required to ensure the refined evidence base is disseminated and used to inform more specific guidance (eg on reaching and working with deprived communities).

Two specific benefits to be gained from a subsequent phase of work of this kind include the capacity to test the assumptions about what could be achieved for individuals and target populations, given the time and opportunities to spread, build, expand and continue the work; and the capacity to test the use of different models/approaches across different target populations, socio-economic areas and settings.

The issues of timescales referred to in this report; the need for a variety of hooks, interventions, settings, information sources, content and media; and the range of needs, experiences and preferences of the target populations in the varied contexts of the eight project sites are all important issues worthy of further exploration through three to four demonstration sites, eg addressing:

- Extending different services, and the use of different interventions applied and piloted in specific socio-economic and geographic areas, to other settings and locations (eg clinical interventions for men or for communities in a deprived area)
- Extending and building on the work that, in specific locations, was not able to become fully established (eg community development in East Devon; exploring more widely the use of IT in Southwark and other educational issues as a gateway to accessing information and opportunities, as well as the benefits of social interaction; exploring the uptake of services and resources provided by other agencies once hooked into an NHS service, as in Dorset; re-entering the labour market, as in Hackney; extending and tailoring the use of pre-retirement

courses for use in different geographic areas, as in North Nottinghamshire)

- Further work on identifying, reaching and engaging with people aged 50–65 from black and minority ethnic communities in different areas, through different mechanisms and settings; to identify needs, experiences and preferences, and to be able to answer with more certainty the question of what works, for whom, in which circumstances, and why for a broader sample of the population than has been achieved so far.
- A further specific area, that spans all of the above areas and the range of other interventions and activities developed by the pre-retirement pilots, concerns the implications for workforce and skills development across all industry and service sectors. This demonstration phase should also focus on identifying the specific and cross-cutting lessons and requirements that need to be embedded into regional workforce development confederations and the appropriate care group workforce teams at the Department of Health.

National direction, leadership and guidance

Developing joint targets and performance management arrangements

- Ensure performance targets for health improvement and associated developments across industry and service sectors are consistent and complementary
- Set clearer joint targets for improving health and reducing health inequalities, and for more specific guidance on those targets that demonstrate improvements in health and wellbeing in mid- and later life
- Make cross-cutting performance management arrangements across the NHS, local authorities, local strategic partnerships and government offices to ensure monitoring arrangements and indicators used to assess performance are also consistent and complementary
- Ensure audit and review arrangements of local services through statutory bodies (Commission for Healthcare Audit and Inspection; National Audit Office; Overview and Scrutiny Committees) include a specific remit and focus on health improvement and reducing health inequalities for people in mid- and later life.

Guidance on investment and development strategies, and access to resources

Existing policy frameworks that would benefit from more detailed supporting guidance include:

- Department of Health leads on Standard 8 of the NSF for Older People (eg to disseminate the evidence and experience base from the pre-retirement pilots, but with a broader focus on health and wellbeing in mid-life rather than a focus on retirement); and a guide to commissioning health-promoting services for people in mid- and later life, similar to that issued on commissioning services aimed at preventing falls
- Department of Health's Health Inequalities Unit, in relation to *Tackling Health Inequalities – A Programme for Action* (Department of Health, 2003b), eg how to address national targets on life expectancy by addressing the needs of people in the mid-life age group
- Department for Work and Pensions as government lead on the national strategy on active ageing (taking a life-course approach across all aspects of health and wellbeing)
- We endorse the recommendation of the Regions for All Ages programme (Age Concern England/English Regions Network, 2003) which states that national work should be undertaken to ensure that in each region there is a strategic body working on ageing, involving all regional agencies, but also developing strategies to engage with the voluntary and community sectors, and local citizens
- Experiences of the projects' participants highlight important messages for the Social Exclusion Unit in translating the lessons of recent work on mental health and social inclusion to respond and reach out to the needs of this age group.

Additional areas requiring guidance include:

- Ensuring access to different resource pools is straightforward and clearly understood at regional and local levels
- Encouraging the largest employers in public sector industries (NHS and local authorities) to adopt responsive and responsible human resources strategies aimed at improving the health and wellbeing of their employees aged over 50, eg exploring options for including specific healthy workforce indicators for people in mid-life through industry-specific quality management awards such as Investors in People, European Foundation for Quality Management's Excellence Model (EFQM), etc.

Regional actions

Planning and scoping

- Regional government offices, regional assemblies and regional development agencies need to ensure appropriate

strategic partnerships and networks are developed between economic development and regeneration agencies, strategic health authorities, NHS trusts and local authorities, for formulating regional plans for active ageing in line with the statement of intent set out in Regions for All Ages (Age Concern England/English Regions Network, 2003). The English Regions Network, in association with Age Concern England, held a national conference in March 2003 which identified the following issues that need to be addressed and taken forward by regional government offices:

- regions need to develop a strategic, whole-systems approach to ageing, involving all the major regional stakeholders working with older people and those representing them – to this we would add a life-course approach that also seeks to engage people in mid-life
- a clear vision on ageing should be developed through the Regions for All Ages programme and disseminated through networks such as the English Regions Network, the Regional Coordination Unit and the Regional Development Agencies Network, and should be adopted by the National Council on Ageing. We endorse this statement but stress the need for a life-course approach to underpin the vision, including the four principles of the ship's wheel (engagement, empowerment, social interaction and partnership)
- for regions, developing, maintaining and disseminating high-quality information about ageing is a central issue – to this we would add the range of information issues identified in this report around transition, choices, employment, carer support, health and fitness, education, and financial planning and management targeted at those in mid-life
- good practice needs to be identified and showcased
- Ensure specific arrangements and plans are in place for identifying and addressing the needs of people in mid-life as part of regional strategies on ageing
- Local strategic partnerships and strategic health authorities need to ensure appropriate local partnership arrangements are in place to support implementation of the above strategies and plans; to harness the skills, expertise and knowledge of PCTs, local authorities and public health observatories; to establish links between these overarching strategies for active ageing and local implementation of the NSF for Older People (specifically Standard 8); and to progress commissioning activities and investment decisions.

Designing and laying foundations

- Local strategic partnerships should ensure their 'LSP family' includes locally appropriate and responsive partnership arrangements to address the needs and aspirations of the mid-life age group, with particular reference to improving health and reducing health inequalities.
- At this level a commissioning partnership is required to ensure a clear commissioning plan is agreed, setting out agreed resource pools and investment plans.
- Identify a lead person at a senior level to steer and forge the relationships and networks that underpin effective partnerships; ensure important links are made with local employers and small businesses, chambers of commerce, implementation leads for NSF Standard 8, commissioning leads for older people's services, public health leads, primary care leads, trade unions and professional associations.
- Target the large public sector employers for involvement as major partners and potential role models for adopting health-promoting strategies for employees aged over 50.
- Make connections with, and learn from, developments taking place across the regions (eg Experience Works! funded by the East Midlands Development Agency and now linked with each of the learning and skills councils in the region; and PRIME, an organisation that promotes self-employment and enterprise for people aged over 50, which operates at a national campaigning level as well as developing partnerships with regional and local enterprises to deliver the support and help that is needed for potential 50+ entrepreneurs, including access to start-up funds when not available elsewhere; a network of PRIME regional development managers has already been created).

Local actions

Investing, developing and commissioning

- Ensure commissioning intentions can demonstrate clear links to NHS priority planning framework targets for NHS organisations and public service agreements for local authorities.
- Ensure funding sources and investment plans are clearly identified in PCTs' local delivery plans.
- Ensure all resourcing options are explored, eg Neighbourhood Renewal Fund, and that shared/pooled resource commitments are clarified across sectors and agencies.

- PCTs and local authorities should ensure identified needs are addressed and investment plans are clarified in local delivery plans and local public service agreements.

Delivering and participating

- Local strategic partnerships should ensure the range of locally appropriate providers are identified via the local commissioning partnership for health-promoting activities in mid- and later life.
- Employers should develop positive employment practices relating to carers' support, flexible working arrangements, opportunities for learning, skills development, health-related activities, access to occupational health services, access to independent financial and pensions advice, etc.
- Ensure involvement of local communities on local strategic partnerships and partnership arrangements established to commission and deliver health-promoting services and activities for people in mid- and later life.
- PCTs should identify the specific skills and interventions they can provide to meet identified needs.
- Employers need to review workforce profiles and identify specific requirements for those in the mid-life group.

Evaluating and giving feedback

- Agree the local model of evaluation to be adopted by the commissioning and provider partnership groups.
- Ensure regular exchange of up-to-date information between local organisations and partners, highlighting investment decisions and priorities; achievements and developments; impact and experiences; effective and mutually beneficial delivery mechanisms; and partnership arrangements.
- Collect case histories that demonstrate tangible benefits of integrated working to help convince stakeholders and partners of the added value to be gained through these approaches.

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Appendix 1 Evaluation phases, data collection and analytical frameworks

Four phases of evaluation

Phase 1: Orientation and CMO mapping

Phase 1 was concerned with composing a snapshot of each pilot site and developing an initial explanatory blueprint. Consistent with the realistic evaluation model, phase 1 set out to develop our understanding of the contexts in which each pilot was operating, the proposed mechanisms by which each functioned, and their intended outcomes. This involved the collation and analysis of documentation and data relating to each pilot project's aims and objectives; the mechanisms being used to achieve these; and their external contexts in terms of national policy and local circumstances. To augment the document analysis, semi-structured interviews were carried out with each project lead to obtain richer descriptive data on aims and objectives, and the mechanisms used to pursue these. The interviews were taped, transcribed and analysed to identify the main themes relating to each project, and themes shared across projects/pilot sites.

Three analytical aims were identified:

- To distil an initial CMO understanding for each site
- To identify the range of potential contexts, mechanisms and outcomes across the pilots to provide a tentative framework for further interrogation
- To identify the main themes in and across pilot sites.

Phase 2: Theory development

An important element of the realistic evaluation approach is to identify potential explanations for programme outcomes – why particular mechanisms might be expected to result in the desired outcomes. Two types of explanation were sought: those stemming from the research and other published literature; and those embedded in practitioners' previous and

current experience of what works for whom. In addition, interactive workshops were held with each pilot, with the aim of enabling project team members to explore and articulate why they were using their particular approach(es) to achieve their stated aims and objectives. Workshop participants were encouraged to articulate these aspects as two journeys: the one they had embarked on in designing, implementing and delivering their project's activities; and the one they envisaged their target population making. Participants were asked to discuss their work, facilitated by prompts to elicit their underlying theoretical assumptions. The discussions were taped and fully transcribed for subsequent analysis, to identify and codify potential theories to explain outcomes in and across projects. This analysis, and the results of the literature review, were then synthesised for testing during phase 3.

The analytical aims of phase 2 were:

- To develop our understanding of the CMOs for each site and refine our categorisations as necessary
- To explicate implementation theories
- To explicate programme theories, as understood by pilots and partner organisations
- To identify points of tension between the pilots' and national evaluation team's emerging theories
- To prioritise theories, or parts thereof, for further analysis.

Phase 3: Impact assessment and theory testing

Phase 3 had two aims:

- To assess the impact of each pilot on their users/ participants, and the benefits of partnership working
- To test out the theories of change underpinning each pilot's approach, as identified in phase 2.

To achieve these aims, we pursued five objectives:

- To identify pilot participants' motivations for becoming involved in the project
- To identify participants' perceptions of the main aims of the project
- To describe how the pilot engaged participants, and how they experienced it
- To determine whether the project had led to self-reported achievement of goals, improved life planning, increased support, improved knowledge about health and retirement, improved access to services, improved sense of control, health and wellbeing, community ownership and enhanced skills
- To explore the nature of the partnerships the pilot had developed.

Semi-structured interviews were carried out with a sample from each pilot project's target population (the pilot participants), and with representatives of the partner organisations involved. The sampling strategy was essentially purposeful, and thus geared to the context of individual projects. Relevant data were collected on each participant's biographical and demographic background to aid assessment of the contexts in which outcomes were, or were expected to be, successfully achieved.

Phase 4: Theory refinement

Three regional workshops were held. At each workshop the results of the preceding phases of the evaluation were fed back to participants, who were asked to reflect on the theoretical explanations put forward to explain the results of the impact assessments, and to assist in further refining these by relating them to their own previous and current experience.

Each workshop was recorded in terms of general feedback on findings and conclusions drawn, about theories of change in particular; and in terms of the outline recommendations, specifically through examples and personal experiences of other or similar initiatives/developments:

- Refinements to the theories of change put forward
- New complementary theories
- Disputed or underexplored areas requiring further research.

Dissemination

While phase 4 of the proposed evaluation was considered as a preliminary step in disseminating the study findings beyond the pilot sites and HDA teams, in addition it is proposed that a more open and interactive event is held during autumn (November/December) 2003.

Written dissemination has included briefing papers and publications in the IAHSPP's (Institute for Applied Health and Social Policy) newsletter; in the professional press (eg *Health Service Journal* and *Community Care*); and in academic journals (eg *Age and Ageing*, *Generations Review* and *Managing Community Care*).

In addition, the period between October and December 2003 will involve further collaboration with the HDA and other stakeholders in disseminating the messages and lessons from the national evaluation. This work will focus on ensuring that adequate information is provided to enable successful elements of the pilots to be replicated elsewhere. It will also include the submission of at least two articles to peer-reviewed journals describing the evaluation methodology and results.

Sources and methods of data collection, and analytical frameworks

Phase 1: Semi-structured interviews and documentary analysis

Interviews were held with project coordinators and main players at the HDA in February and March 2002. The conceptual scheme for the interview schedule was organised according to CMOs, and developed so as to allow respondents to confirm, falsify and refine our emerging assumptions. The schedule was reproduced in the phase 1 interim report (September 2002), and covered the following elements:

- Context – history of the pilot's interest in improving pre-retirement health and working with this age group, and relevant locality characteristics
- Intervention – details of goals and strategy, activities and early progress
- Mechanisms for change – main players, drivers, costs and obstacles
- Understanding outcomes – stated aims, objectives, perceived outcomes/impact, local evaluation arrangements.

A range of documentation was scrutinised (annual reports and promotional literature, planning documents, local evaluation plans and reports), collated and analysed in relation to each pilot's aims and objectives, the mechanisms being used to achieve these, and external contexts in terms of national and local policy, and local circumstances.

Demographic data were also obtained for each pilot, summarised in Chapters 2 and 3. This information was

derived from the UK Census 2001, obtained from the Office of National Statistics, www.statistics.gov.uk.

From these three sources, a CMO report for each pilot was written. All eight reports were scrutinised to identify a pool of over 40 themes and a list of all the CMOs across all pilot sites. Next, the CMOs for each pilot were mapped out, highlighting potentially crucial CMOs at each site. The emerging analysis and cross-site map were reviewed and refined by clustering the CMOs into groups of the most common themes. From this we were able to explore whether sites had similar CMOs, and also to develop our thinking about potential explanatory blueprints for individual sites. Each of the themes was written up, identifying the range of responses and experiences. This informed our analytical framework and detailed methods for phase 2.

Phase 2: Interactive workshops with pilots and local stakeholders

The process for the phase 2 analysis included the following steps:

- Producing updated CMOs for each site
- CMOs were reviewed by national evaluation team, along with all the workshop transcripts
- Emergent participant theories were mapped, identifying points where there was consensus and divergence among participants
- Emergent national evaluation team theories were mapped out and sent to pilots for comment
- On a pilot-by-pilot basis, the national evaluation team prioritised which theories, or parts, to study further in phase 3, using criteria established by Carol Weiss: those which are plausible, those concerning psychosocial mechanisms for change, those that are most critical to success, those where staff have concerns, and those where there is most uncertainty about the links in the causal chain.

Phase 3: Interviews with pilots' participants and partners

The original intention was for each pilot project's local evaluators to provide a random sample of up to 15 participants, stratified for target groups as appropriate, in agreement with the national evaluation team. In practice it proved possible to achieve a reasonable sample at five sites: East Devon; Hull and East Riding; Dorset; Hackney; North Nottinghamshire. At the other three sites there were problems in achieving the samples specified. These are

outlined below, together with information about what it was possible to achieve.

- The Sandwell pilot project's target groups were employees from small and medium-sized companies in the local area. During the life of the project, three health-check events were delivered, one in an industrial park and two with individual companies. At the request of the employers concerned, the checks were made available to all employees regardless of age. Where the event on the industrial park was concerned, it was not possible to follow up those employees who took up the offer of a health check, as no contact information was collected. In addition, one of the individual companies involved, which employed a largely female, Asian workforce, had unfortunately closed down by the time of the phase 3 data collection. Employers at the other company preferred not to provide access to their employees. After each event, however, evaluation questionnaires were handed out to those who had a health check. As an alternative to carrying out interviews, we therefore collated and analysed the information from these questionnaires to provide at least some preliminary evidence of the impact of the health-check events. A slightly different version of the questionnaire was used at the two individual companies from that used at the industrial park. While the latter included questions on the age and sex of respondents, the earlier version used at the two companies did not. Both versions did include two questions for completion only by those aged 50 or over. While this gives some indication of the proportion of respondents at the two individual companies in the pre-retirement age group, this may be an underestimate, as some respondents aged 50 or over may not have completed the two questions. Employers at the two individual companies were also given an evaluation questionnaire. Both employers returned the questionnaire, and their responses have been included in our analysis. In addition, the project was involved with two companies in the promotion of physical activity, one through the provision of an exercise programme and the other through provision of a leisure pass at reduced cost. Questionnaires were given to those who participated in these initiatives, and a brief analysis of the responses received is included here.
- The project in Southwark engaged users in two main ways: through provision of training in the use of the Internet, and through the project's website. Users engaged through either means were able to take up other project activities, such as participating in walks in the local area. Unfortunately, some difficulty was experienced in finding

an appropriate location for the Internet training, including problems with the security of computing equipment, which was stolen with the result that contact information was lost. As a result we were able to interview only two people who had received IT training, one of whom had also participated in a walking group. Development of the website was a significant part of the project's work, and the website has been operational since October 2002. However, no registration is required and therefore it is not possible to contact these users of the project's services. One person who had accessed the website did, however, make contact with the project and agreed to take part in an interview.

- In North Staffordshire, the project involved service users at two levels: as lay advisers, and as recipients of their advice. Our intention was to interview a sample from each group, but at the time we began the phase 3 data collection, the lay advisers had only just finished their training and those involved with the project were concerned that an interview at this early stage might be off-putting. However, the local evaluator did conduct interviews with six of the eight advisers. It was agreed that we could

include data from those interviews in our analysis, and this was provided in the form of notes taken by the local evaluator during the interviews she carried out. At a later stage we also carried out a similar interview with two lay advisers, both of whom had taken part in the earlier interviews with the local evaluator. We were also able to hold a focus group with all eight advisers. Unfortunately, it was not possible to interview people who received advice from the lay advisers, as the provision of advice was just beginning at the time of the phase 3 data collection.

Table A1 provides a summary of the phase 3 data collection from pilot project users.

Where partner agencies were concerned, the intention was to interview as many agency representatives as possible, with the specific aim of including a representative range of sectors in the sample. Overall, it proved difficult to obtain access to as many agency representatives as we would have wished in the time available, although efforts continued into June 2003. Access to partners in local authority organisations and educational institutions proved particularly problematic. Table A2 summarises the sources from which data were obtained.

Table A1 Phase 3 project user interviews across pilot sites

Site	User interviews by target group	Comments
East Devon	Retired (4) Farmers (3) Other occupations (4)	Data collection targets achieved
Hull and East Riding	Retired (2) Unemployed (4) Employed (3)	Data collection targets achieved
Dorset	Retired (6) Unemployed (1) Employed (5)	Data collection targets achieved
Hackney	Retired (3) Unemployed (3) Employed (2)	Data collection targets achieved
North Notts	NHS employees (7) Council employees (4)	Data collection targets achieved
Sandwell	–	Targets not achieved due to lack of access to service recipients – national evaluation relied on local evaluation data
Southwark	IT training recipient (2) Website user (1)	Targets not achieved due to delays in delivering IT training, and no registration required of website users
North Staffs	Lay adviser interviews (2) Lay adviser focus group (8) Advice recipients (0)	Targets only partially achieved due to timescale of delivering training to lay advisers – interviews augmented by local evaluator's notes

Table A2 Phase 3 data collection from partner agencies

Site	Project partners	Partner representatives interviewed	Comments
East Devon	Voluntary sector (4) NHS (2)	0	Contact could be made with only one agency, whose representative felt they had nothing of substance to report
Hull and East Riding	Voluntary sector (3) NHS (1) Local authority (1) Education (1)	Voluntary sector (3) Local authority (1)	Data collection targets mainly achieved
Dorset	NHS (3) Education (1) NHS (1) Private sector (1)	NHS (2)	Data collection targets partially achieved – representatives of both GP practices involved with the pilot interviewed
Hackney	Voluntary sector (3) NHS (2) Local authority (1) Education (2)	NHS (1) Voluntary sector (1)	Data collection targets partially achieved – difficulty obtaining access to most partners
North Notts	Voluntary sector (3) Local authority (2) Education (1) Private sector (1) Statutory sector (1)	Voluntary sector (1) Local authority (1) Education (1) Private sector (2)	Data collection targets mainly achieved
Sandwell	Voluntary sector (6) NHS (1) Private sector (2)	Voluntary sector (2) NHS (1) Private sector (1)	Data collection targets mainly achieved
Southwark	Voluntary sector (3) Local authority (2)	Voluntary sector (2)	Data collection targets partially achieved

Data from the interviews with project participants were analysed using progressive focusing techniques to identify the main themes in, and then across, target groups. The themes were then examined to assess how far the pilot's theories of change were reflected in the experiences of service users. Interviews were taped where consent was given, and fully transcribed. Data were stored and retrieved using NUD*IST software. A similar process was used for the analysis of partner interviews. Individual phase 3 reports were also sent to each pilot site.

The overarching analysis of phase 3 data synthesised the central messages and themes across all sites to refine the theories of change, and to identify outline recommendations for a future model of service development and delivery.

Phase 4: Three regional workshops with a wider range of national, regional and local stakeholders

Three regional workshops were held during July 2003 in London, Bristol and Leeds. In addition, a final meeting with local evaluators was held to share the above, and to focus on identifying the lessons and messages from conducting the local and national evaluations. Finally, a symposium presentation of the pre-retirement initiative using information from the evaluation, from one of the pilot sites (Sandwell) and the HDA project team was held, which also provided an opportunity to share findings and discuss recommendations with a wider audience. Central topics of discussion at these events included:

- What is the most appropriate and committed platform for national leadership (eg Department of Health, Department for Work and Pensions, other government departments, both individually and collectively)?
- What is the most effective and realistic role for regional assemblies and regional development agencies, and what will convince them of the need for, and benefits of, taking up this leadership role?
- What is the role of local strategic partnerships, and what do they need to help them undertake this 'sandwich' role in translating national and regional priorities at sub-regional and local levels?
- How can primary care organisations, services and practitioners be supported to address the health needs of this age cohort as a priority concern, given the focus on more acute and short-term performance targets? Which health hooks should be emphasised from this work, particularly bearing in mind the new General Medical Services contract?
- How can PCTs, as commissioners, be encouraged and helped to embed these priorities and issues in their local delivery plans, and to take a lead role in coordinating health needs assessments using an interactive, community-based approach?
- How can all the above, and local communities, be persuaded that a long-term approach and commitment is not only necessary, but most likely to reap rewards in terms of securing health improvements that are sustainable and tangible; and to continually refine and adapt what is on offer, building in flexible objectives and measures that focus on improvements over time rather than targets to be reached in one or two years (especially if starting from scratch)?

The discussion points from these workshops were documented and used to shape the final recommendations presented in Part 4 of this report.

Appendix 2 Initial theories of change and questions addressed in phase 3 of the national evaluation

Questions posed in phase 3

Theory of change	Question
<i>Engagement</i>	
That clients need and actively want the service provided, thus facilitating engagement	For which clients and in what context: - is involvement motivated by a specific or general health/retirement concern? - is the motivation more modest, eg curiosity, availability?
That involving clients in identifying their own needs, informing project development and/or providing services will generate a sense of ownership that, in turn, will keep clients engaged	Which clients, in what context, and why: - find the opportunity to be involved engaging? - might prefer an expert defined and delivered service? How feasible is it to generate a sense of ownership within the resources and time available?
That hooking a broader range of activities onto a gateway service will facilitate clients' engagement in that broader range of activities	Which clients, in what context and why: - make use of the broader range of activities? - might find attempts to draw them in beyond the gateway service intrusive? How feasible is it to provide a broad range of activities within the resources and time available?
That particular settings (eg community, primary care) provide a more effective context for engaging clients than other settings	Which clients, in what context and why: - find the use of community settings acceptable and appropriate? - find this uncomfortable or inappropriate?
<i>Empowerment</i>	
That providing information will increase clients' knowledge	For which clients and in what context: - does information increase knowledge? - does information not increase knowledge (eg is it meaningful and coherent in the context of pre-existing knowledge/experience)?
That increased knowledge will engender a sense of empowerment and control	For which clients and in what context: - does knowledge lead to empowerment? - does knowledge not lead to empowerment (eg might knowledge lead to a sense of disempowerment as a result of contextual constraints)?
That a sense of empowerment and control will enable people to take action to look after/improve their health and wellbeing	Which clients, in what context and why: do/do not take action/change behaviour etc.?

Theory of change

Question

Social activity

That providing opportunities for clients to engage socially with others of a similar age will improve their health/wellbeing directly (eg walking groups) and/or indirectly (eg enhancing quality of life)

Which clients, in what context and why:
welcome the opportunities provided and find them beneficial?
would prefer alternative activities/activities with others from different age groups?
do not take up the opportunities provided?

Partnership

That partnership working will facilitate clients' access to a wider range of services

In what contexts and why:
do projects and partner agencies signpost clients to each other?
do they not do so?
do project clients follow/not follow the signpost?

That partner agencies are a valuable source of advice for projects

In what contexts and why:
do partners provide advice?
do projects follow/not follow it?

That engaging partners will convince them of the project's benefits/of the need to offer a new service themselves

In what contexts and why:
are partners convinced/unconvinced of project benefits?
do partners take on the provision of services seen as appropriate for them by projects?

That building partnerships takes time

In what contexts and why:
is partnership building time consuming?
can it be achieved more quickly?
How feasible is it to build effective partnerships within the time and resources available?

That providing feedback to partners will keep them engaged

In what contexts, how and why:
does feedback encourage/not encourage engagement?

Appendix 3 Approaches to the local evaluations

Pilot	Resources allocated as £ and % of budget*	Evaluation design: methodology/ conceptual framework	Methods	Stakeholder involvement	Types of data collected	Types of measure used
North Staffs	£10,000 4%	Descriptive, action research to inform development of project Baseline, midpoint and endpoint data with different stakeholders	Questionnaires Project monitoring through activity-logging system Semi-structured interviews Focus groups Observations Workshop	Local organisations Project coordinator Host agency staff Lay members of communities Advisory group Trainer Volunteer advisers	Activity data – numbers of: - advisory sessions - clients - events - meetings with other agencies Age and gender Health beliefs	Clients' satisfaction and their views on effectiveness of advisory services
East Devon	Info. not available	Process evaluation of ongoing learning Objectives-based	Evaluation form for sessions (Incorporated national evaluation findings)	Users	Activity data – numbers of: - sessions - attendees - people using each service at sessions - businesses involved - venues in which sessions took place Age, gender, social class and ethnicity Distance travelled to attend Time since last health check	Impact on attitudes to health and retirement Satisfaction Self-reported changes in health behaviour

Dorset	£13,000 11%	Pre-post health check assessment	Survey with 3-month follow up	Patients	Activity data – numbers of: - health checks - workshops - ‘did not attend’ Number and class of cardiac medication Number identified as low, moderate or high risk for osteoporosis Number on bone active treatment and medication Number experiencing fracture after minor bump or fall Number with diabetes Number of smokers, mean duration of smoking	Satisfaction Impact on health behaviour Impact on breast screening uptake Impact on numbers started on cardiac medication by GP as consequence of health check Impact on referrals for bone scan since check Impact on self-reported consumption of fruit, vegetables and cereal, and on exercise
Hackney	£5,000 5%	Participatory approach focusing on learning and collaboration	Interviews Attendance at meetings Lifestyle questionnaire	Partners Participants Non-participants Steering committee	Activity data – numbers of: - participants - health checks - lifestyle questionnaires - health plans - follow-up checks - focus groups - attendees at open day Age, gender and ethnicity	User satisfaction Self-reported behaviour change Self-reported improved health
Hull and East Riding	£2,500 1%	Action research Objectives-based Underpinned by EQFM	Evaluation form in resource pack Interviews with partners (incorporated national evaluation) Training and workshop evaluation forms Review panel on draft pack	Users Partners Staff	Activity data – numbers of: - copies of pack - workshop attendees - people trained to use pack - organisations receiving pack Age attending training Contexts in which pack used Some (incomplete) data on age and ethnicity	Satisfaction with workshop and pack

Sandwell	£5,000 3%	Used EQFM Excellence Model Logical framework to set goals, purpose and outcome objectives	Self assessment survey Focus groups Surveys Stakeholder conference	Staff Users Employers Employees	Self-assessment data Age, gender, ethnicity, length of residence in area Needs assessment Activity data: number taking up leisure pass number attending for health checks	Self-reported impact on physical activity Satisfaction
North Notts	£7,000 8%	Pre- and post-course assessments	Pre-/post-survey Observations Feedback reported on flipcharts	Users	Number of attendees Age and gender (incomplete)	Attitudes concerning health and retirement User satisfaction Impact on initial preparation for retirement
Southwark	£10,000 10%	Narrative approach to identify processes of implementation and perceived impacts Underpinned by programme logic approach	Interviews Documentary analysis Meetings with staff User transcripts from national evaluation Project coordinator's diary Usability evaluation	Project staff Board Users in usability evaluation	Coordinator's time sheet Activity data – numbers of: - attendees at launch - community groups targeted - mailshots to agencies - website hits - members recruited - those receiving computer training	Process measures (set- up and use of website, training) User perception and self- reported lifestyle change

* In some cases additional assistance was provided at no cost.

Appendix 4 Sample of pilot participants interviewed in phase 3

Pilot participants interviewed in phase 3

Pilot project	Total respondents	Male	Female	Ethnic group	Age range
East Devon	11	4	7	White (11)	50–62
Hull and East Riding	9	3	6	White (9)	51–67
Dorset	12	N/A	12	White (12)	51–66
Hackney	8	0	8	White (7) Black (1)	52–61
North Nottinghamshire Sandwell	11	5	6	No data	50–60
Industrial estate health check	13	9	4	No data	51–60+
Textile company health check	16	0	16	Asian	>49 = 9
Engineering company health check	41	No data	No data	No data	>49 = 14
Extend	*15	0	15	Asian	>49 = 9
Leisure pass	11	7	4	No data	>49 = 3
Southwark	3	1	2	White (3)	57–62
North Staffordshire (lay advisers)	8	1	7	White (8)	>49–60+
Total on basis of available data	143	30	72	White (50) Black (1) Asian (16)	>49–66+

*These 15 women also took part in the textile company health check and are therefore not included in the totals.

Appendix 5 Partners involved in pilot projects

Partners involved in pilot projects

Pilot project	Project partners	Partner representatives interviewed
East Devon	Voluntary sector (4) NHS (2)	0
Hull and East Riding	Voluntary sector (3) NHS (1) Local authority (1) Education (1)	Voluntary sector (3) Local authority (1)
Dorset	NHS (3) Education (1) NHS (1) Private sector (1)	NHS (2)
Hackney	Voluntary sector (3) NHS (2) Local authority (1) Education (2)	NHS (1) Voluntary sector (1)
North Notts	Voluntary sector (3) Local authority (2) Education (1) Private sector (1) Statutory sector (1)	Voluntary sector (1) Local authority (1) Education (1) Private sector (2)
Sandwell	Voluntary sector (6) NHS (1) Private sector (2)	Voluntary sector (2) NHS (1) Private sector (1)
Southwark	Voluntary sector (3) Local authority (2)	Voluntary sector (2)
North Staffs	Voluntary sector (4) NHS (1) Local authority (1) Private sector (1)	Voluntary sector (3) NHS (1) Private sector (1)