Sporting Equals Policy Paper – The *fit as a fiddle* Programme: Older People Faith and Community Strand

Introduction

Sporting Equals is an independent body developed to promote ethnic diversity in the area of sport and physical activity. Set up in 1998 by Sport England and the former Commission for Racial Equality, Sporting Equals aims to raise awareness of the needs of Black and Minority Ethnic (BME) communities and to promote inclusion and diversity across the sport and health sectors. Sporting Equals expertise and its access to a network of over 5,000 groups has helped deliver a successful model with consistent messaging. Links to and knowledge of disadvantaged communities and experience of faith and cultural sensitivities has engaged groups who are otherwise disconnected from mainstream services.

This paper aims to demonstrate the business case for working with BME older people to help reduce health inequalities. It outlines Sporting Equals' role in delivering the faith and community strand of Age UK's **fit as a fiddle** programme. This has made a significant impact on the lives of BME older people through supported interventions. Through the project Sporting Equals worked with local organisations to deliver a bespoke training programme for volunteers and a package of activities aimed at those aged over 55. The three key objectives of the project were to:

- Improve and develop levels of physical activity
- Encourage healthy eating
- To help stimulate mental wellbeing.

The business case for reducing health inequality

The **business case** for working with BME older people to help reduce health inequalities has been demonstrated in a number of research studies, highlighting the need for faith and community focused interventions. Key findings are summarised below:

- The numbers and proportions of older people from black and minority ethnic communities have risen rapidly over the past decades and are projected to continue to rise[1]. Black and minority ethnic groups make up over 16% of the population of England, but 8% of people in England aged 60 and over[2].

- The impact of ageing (in terms of health and support needs) happens at a comparatively younger age among many minority communities.[3] Statistics show black and minority ethnic groups suffer disproportionately higher rates of certain health conditions:

[1] Black and minority ethnic older people's views on research findings, Joseph Rowntree Foundation, 2004
[2] Estimated resident population by ethnic group, age and sex, mid-2007, (experimental statistics)
[3] Black and minority ethnic older people's views on research findings, Joseph Rowntree Foundation, 2004

- The levels of heart disease, diabetes and strokes are significantly higher within BME groups[4]. This is one effect of rising obesity levels and is a common feature across most ethnic groups.
- South Asians are up to 6 times more likely and Black African Caribbean are 5 times more likely to develop diabetes than their White British counterparts.[5]
- African Caribbeans have a higher risk of stroke, hypertension and diabetes than the general population[6].
- South Asian Women are less likely to do the recommended levels of exercise (3x30 minutes per week)[7].

- There are specific mental health concerns for older BME adults. For example, there is a higher percentage of dementia and depression within BME communities[8]. Many cultural groups fail to recognise dementia as an illness and tend to attribute dementia to growing old.

- The level of physical activity undertaken varies across different ethnic groups. For many older people with a strong religious allegiance, participation in sport and activity may be problematic because of the requirements of their faith, particularly with regard to single-sex provision and the appropriateness of clothing.

    - Pakistani and Bangladeshi Communities have the lowest levels of sports participation rates, leading to greater health inequalities[9] and over half of people in the BME demographic do little or no sport.
    - Research shows that the inactivity gap between BME communities and the White population is widening.[10]

- There is enormous diversity of culture, traditions and dietary habits both between and within different minority ethnic groups. Western influences on diet have affected traditional eating patterns to a considerable extent but many older people still retain their traditional eating practices. For example, Bangladeshi men and women are more likely to eat both red meat and fatty foods and are less likely to eat fruit than any other minority ethnic group[11].

Research findings have also demonstrated the **failure of current mainstream services to engage** with BME older people. Research has shown that people from deprived or ethnic communities are less likely to interact with mainstream health services and are "less likely to have their body mass index or smoking status recorded. They are also less likely to have records for HbA1c[12], retinal screening, blood pressure, and neuropathy or flu vaccination"[13]. Furthermore, a number of studies report that older BME people state they feel that mainstream health services often do not meet the needs of culture and religious beliefs that are important to different minority communities.[14] This might range from the lack

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[4] Race Equality Foundation
[5] Diabetes UK
[6] Dr Veena S. Raleigh Glowinna Mario Polato, Health Commission, Evidence in health inequalities
[7] Sport England, Active People 2
[8] Mental Health Foundation
[9] Sporting Equals Business plan
[10] Active People Survey (2008)
[11] Erens B, Primatesta P, Prior G. 2001. *Health Survey for England. The Health of Minority Ethnic Groups '99.* London: The Stationery Office. Accessed from: www.archive.official-documents.co.uk/document/doh/survey99/hse99-09
[12] HbA1c is the short form for Glycated Haemoglobin, which serves as a marker for average blood glucose levels in monitoring for diabetes.
[13] http://www.diabetes.org.uk/Documents/Reports/diabetes_disadvantaged_06_execsum.pdf
[14] Duval L, et al (2004)

of understanding around cultural diets or a lack of knowledge and respect for religious beliefs and practices.

Different communities often have a different view of health and wellbeing.[15] Older people felt that community based voluntary organisations were more likely to reflect their needs.[16] Two further key barriers to participation identified were language issues[17], and lack of awareness of what is on offer. Health service literature is often not translated into BME languages and little use made of BME publications, radio stations or organisations which are a major information source for BME networks[18]. Alongside this little effort is made to engage those who are further disengaged from service as they are unable to read or write and therefore information is only accessible through 'word of mouth'.

Reach

Feedback from **fit as a fiddle** partner organisations shows that **older BME groups are particularly disadvantaged**, with social structures that are often limited to family or religious gatherings. As a result, it has been important for Sporting Equals to work with partner organisations who are well networked within local communities. Sporting Equals has engaged with at least two organisations in each geographic region, enabling 289 volunteers to participate in specialist training across 39 local, community-based organisations.

By working with these organisations the **fit as a fiddle** project has been embedded in communities which statutory providers might otherwise struggle to reach. **fit as a fiddle** monitoring data has shown a high level of success in engaging with older people from BME groups. The projects' participant information shows engagement with a wide range of minority communities, and the profile of **fit as a fiddle** participants by religion demonstrates engagement with all major faiths in England.

Through **fit as a fiddle**, Sporting Equals has empowered over 1,200 older people from disadvantaged communities, providing them with support, through the volunteer networks, to live healthier, fitter, more informed and less isolated ways of life. A further 4,000 beneficiaries were engaged through 'roadshows', a extension of the **fit as a fiddle** model that brought the healthy lifestyle message to a wider audience still.

Impact of fit as a fiddle

The evaluation report of Sporting Equals' **fit as a fiddle** project found **positive impacts for a range of different stakeholder groups** which include project participants, volunteers and partner organisations. The most significant impacts were experienced by the older people who took part in **fit as a fiddle**. Participants found benefits including improved self-esteem, self-confidence, physical health and mental wellbeing. A number of older people (and volunteers) reported changes in diet and a greater understanding of healthy eating, and some reported immediate benefits from their physical activity sessions. A further impact was a reported behaviour change outside the project sessions, resulting in greater health awareness and enhanced health prospects. Evaluators reported that the impacts of participation were felt by participants within a relatively short period of time.

[15] Black and minority ethnic older people's views on research findings, Joseph Rowntree Foundation, 2004
[16] Black and minority ethnic older people's views on research findings, Joseph Rowntree Foundation, 2004
[17] ibid
[18] Ploszajski Lynch Consulting Ltd (2005)

Volunteers trained through the programme also reported significant impacts, noting that they had been able to meet new people, build skills and gain positive experience for their CVs, as well as developing softer skills such as self-confidence and self-esteem. Volunteers also went on to provide benefits for their wider communities and for the host organisations they worked with. Their commitment to delivering the project and to developing their skills and knowledge base has meant that these organisations now have a pool of volunteers to draw from, and in some cases this has meant an element of sustained delivery beyond the end of the **fit as a fiddle** funding.

A further impact was made with South Asian women, as research has found that 92% of South Asian women do not undertake the recommended level of physical activity (3x30 minutes a week)[19]. The project managed to make a significant impact with this group with just over 41% of South Asian Women being supported through this intervention.

Impacts for projects included enhanced capacity support through a trained pool of volunteers. A noticeable change in behaviour has resulted in light of the way older people were managed moving away from a sedentary approach to a more proactive approach with projects encouraging older people to get involved in activities through volunteer support. Alongside this links have been developed with key partners such as NHS trusts to help provide long term support.

Policy and Economic Benefits

The success of **fit as a fiddle** demonstrates a strong resonance with policy developments around the Big Society objectives. The Cabinet Office recognises that *"active local people can be better than state services at finding innovative and more efficient solutions to local problems"*[20]. Participating organisations have been equipped with specialist knowledge to work with the hardest to reach and have successfully engaged with these groups in relation to improved health awareness. In this vein, the project has achieved enhanced health outcomes for participants, bringing with it an **economic value**. For example, in the Third Report on Health Inequalities of the House of Commons Health Select Committee, evidence given to the committee found that it costs five times as many resources to deliver targeted interventions *"to a hard-to-reach family, as opposed to an ordinary disadvantaged family"*[21]. As **fit as a fiddle** partner organisations have been supported to engage the hardest to reach, the related costs in this area should be reduced.

The **fit as fiddle** model should also contribute to reducing direct costs of healthcare for common issues affecting BME groups. For example, rising levels of obesity have a significant financial cost to both the NHS and the wider economy through increased incidence of related diseases. A report published by the Government Office for Science estimates that with all other conditions held constant other than Body Mass Index, the cost of diabetes to the NHS will increase from £2bn in 2007 to £3.5bn in 2050, and the cost of coronary heart disease will increase from £3.9bn to £6.10bn in the same period. The 'Tackling Obesities: Future Choices' research predicts that by 2050 the cost to the NHS of

[19] Sport England, Active People 2

[20] http://www.cabinetoffice.gov.uk/content/big-society-frequently-asked-questions-faqs

[21] http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/286/28609.htm

dealing with incidences of high weight and obesity could rise to £9.7 billion with a wider cost to society of £49.9 billion. Although White British groups are experiencing the most significant increase in obesity levels, some BME groups are also disproportionately affected. Estimates show that Black African and Pakistani people will experience significant increases in obesity, with the levels amongst Pakistani men growing from 16% in 2006 to 50% in 2050[22].

The economic benefits are therefore clear in terms of cost of preventative strategy against cost of long-term health care. In another example, BME older individuals are often the most isolated and a study by the Sainsbury Centre for Mental Health[23] hypothesised that better mental health services for BME communities could yield a double benefit of improved individual outcomes and reduced financial costs. This is because mental health intervention for BME groups often comes at a time of crisis, requiring a higher level of intervention and thus greater costs. The study, which looked at provision of hospital-based and community-based services across four London NHS Trusts, found that the total average annual cost per Black service user was £6,539 compared with £4,132 per White service user.

Key interventions can play a significant part in aiding long-term health benefits. The **fit as a fiddle** model also supports the governments' agenda of encouraging older people to take part in 150 minutes of moderate intensity activity a week.[24] The programme developed by Sporting Equals demonstrates how behaviour change can be aided and through support to encourage increased physical activity levels alongside ensuring a balance is maintained with healthy eating and mental wellbeing.

Review and Conclusion

The need then for preventative health care initiatives is more important than ever, particularly for the target groups engaged in **fit as a fiddle**. The costs of delivering Sporting Equals' model have been low, with the provision of the road shows costing as little as £5.04 per participant and projects costing £47.09 per person. Sporting Equals evaluation research shows that even one incidence of contact with a beneficiary could influence behaviour change. From the studies assessed in a Cochrane Foundation review on the provision of dietary information, it was found that advice led to improvements in cardiovascular risk factors such as blood pressure and cholesterol levels[25].

The success of the **fit as a fiddle** project in engaging with over 5,200 older people from disadvantaged communities across a wide geographical spread **demonstrates the need for community based supported interventions**. Project feedback consistently reported the popularity of the activities and the demand for health projects that can reach different communities. Sporting Equals developed a bespoke model based on extensive preparatory and development work which was designed to partner with a wide range of faith and community organisations. This 'cascade' approach meant that the organisations engaged as partners were able to reach some of the most isolated groups who would be unlikely to engage with mainstream provision. The focus on religious and cultural issues in the training

[22] Government Office for Science, Tackling Obesities: Future Choices - http://www.bis.gov.uk/assets/bispartners/foresight/docs/obesity/17.pdf

[23] Sainsbury Centre for Mental Health, 2006, Policy Paper 6: The costs of race inequality

[24] Factsheet 5, Physical Activity Guidelines for Older People, Department of Health, July 2011

[25] Brunner EJ, Rees K, Ward K, Burke M, Thorogood M. Dietary advice for reducing cardiovascular risk. *Cochrane Database of Systematic Reviews* 2007, Issue 4. Art. No.: CD002128. DOI: 10.1002/14651858.CD002128.pub3.

package meant that participants reported that their preferences in these areas were respected.

The **fit as a fiddle** model could be used as best practice to help guide future interventions for older BME people. Project learning highlights that an initial regional mapping led to success in identifying appropriate partner community groups who could access disengaged communities but could also support a number of volunteers to undertake training and deliver activities. Sporting Equals was then able to support these community groups and build the capacity of their staff and volunteers through the provision of training, resources and one to one support.

The legacy of this work is a pool of skilled and culturally sensitive personnel who can continue to engage and support older BME people after the **fit as a fiddle** project has come to an end. The national approach delivered through local community partners allowed for targeted provision to take into account the diversity and complexity of the BME sector, and this could be successfully replicated in other funded initiatives.

Sporting Equals role in light of reaching out across regions, links through its regional networks, providing key knowledge and support in light of working with people from different faith backgrounds and cultures has all made this project a success and well placed for delivering similar interventions in the future.

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