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January 2020

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## Evaluation of Redbridge Active Together: final report

Commissioned by the London Borough of Redbridge

**Institute for Health and Human Development (University of East London)**

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The views expressed in this report are those of the authors and do not necessarily represent those of the London Borough of Redbridge and Vision Culture and Leisure.

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## 2 Introduction

The London borough of Redbridge commissioned the Institute for Health and Human Development, based at University of East London to conduct an evaluation of the Redbridge Active Together programme. This is the final report for this evaluation and describes the background and aims of the project, methodology, main findings and recommendations from both the quantitative cohort study alongside the process evaluation and qualitative results.

### 2.1 Background

Physical inactivity is a major public health problem. Along with unhealthy diet, smoking, and excessive alcohol consumption, physical inactivity is one of the major risk factors for non-communicable diseases such as coronary heart disease, diabetes, colon cancer and breast cancer (Newton et al. 2013). Approximately 3.2 million deaths each year are attributable to insufficient physical activity (WHO 2017).

In the London Borough of Redbridge, the importance of physical activity has been highlighted in key documents including the Health and Well-being strategy, the joint Strategic Needs Assessment and the Obesity Strategy (Redbridge council, 2015).

About 27.5% of people in Redbridge are considered inactive (do not currently achieve 30 minutes of moderate physical activity per week). This has health as well as financial implications as the cost of physical inactivity in Redbridge is £19.4m per year (UK Active, 2014).

In this context, 'high risk' areas were identified where physical activity levels were lower than other areas. Four Redbridge estates were chosen on the basis of their deprivation (Index of Multiple Deprivation) and reported antisocial behaviours including drug dealing; and low levels of physical activity in comparison to levels nationally and in London. (Orchard: 47.6%, Tiptree: 41.6%, Hermitage: 49.2% and Buttsbury:39.1%).

### 2.2 The Active Together Programme

The ACTIVE TOGETHER programme was a three year physical activity programme targeting four disadvantaged estates in Redbridge namely Tiptree, Buttsbury, Orchard and Hermitage with the following aims:

- improving participation in physical activity
- improving physical activity levels. (Target outcomes for this included (i) increasing the number of adults walking at least 10 minutes per day; (ii) Increase the number of adults reaching the recommended guidelines of 150 minutes.)
- increasing knowledge of physical activity opportunities within Redbridge
- training 50 people in Redbridge per year to promote and run physical activities amongst residents.

The programme is managed by the Vision Redbridge Culture and Leisure Limited (Vision RC&L) who employed a Physical Activity Officer (PAO) responsible for the following:

- conducting a consultation with residents in the target estates to understand the current levels of physical activity and the best strategies for engaging residents into physical activity as well as the barriers to physical activity.
- Recruiting and training volunteers to become physical activity champions (PAC). PACs were intended to support the development of activities in the programme, help identify and overcome barriers to participation, and be supported by the Sport and Health team to ensure the programme became embedded in the four estates, increasing its sustainability.
- Supporting and encouraging resident led initiatives, where feasible. The PAO led the coordination of activities (e.g. walking groups, yoga), but aimed to encourage residents to become engaged in various ways including spreading the word to other residents, running activities or some other involvement.

### 3 Methodology

Redbridge council asked the Institute for Health and Human Development (IHHD) at University of East London (UEL) to conduct the evaluation of the programme. This methodological section outlines the main aims and objectives of the evaluation as a whole. Ethical approval was obtained from the University of East London Research Ethics Committee (UREC) (ref. no: 171806).

#### 3.1 Aims and Objectives of the evaluation

The business case for the Active Together programme included a number of outcomes that should be achieved by this project, including the role IHHD plays in evidencing the outcomes. In order to meet the programme outcomes, the overall aims of the evaluation were as follows:

- To assess the impact of the Redbridge Active Together programme on physical inactivity in four of the most deprived estates in Redbridge.
- To explore the process of implementation of the programme including assessing its acceptability, adoption, appropriateness, feasibility, fidelity, dose, and sustainability.
- To highlight the key enablers and barriers or strengths and weaknesses of the programme to know what worked well, what didn't work well, and what needs to change.
- To explore key improvement factors from a process evaluation and provide recommendations for the future.

The objectives of the evaluation were to collect and analyse a range of data on the following:

- Analyse monitoring information on the Redbridge Active Together programme including: routine registration of participants attending organised activities collected by Vision RC&L for the three-year programme. It includes information about the profile of users, their level of participation, drop outs etc.

- Vision RC&L to collect baseline and follow up data with support from IHHD at UEL in relation to the provision of students who could volunteer and support Vision RC&L in data collection alongside Vision RC&L recruited volunteers from the local community.
- IHHD to analyse population level changes using a cohort survey of a representative sample of participants to measure baseline physical activity levels along with relevant factors that will be adjusted for in the analysis.
- Perceptions of key personnel from the delivery team and users of the programme using semi-structured interviews to understand in-depth what worked and what did not work in the implementation of the project to date.

### 3.2 Methodological design

In order to achieve the overall aims of the evaluation, both an outcome and process evaluation were proposed which led to the adoption of a mixed method study design including a cohort study and a range of qualitative interviews.

Outcome evaluation: In order to assess whether the programme achieved the outcomes set in Table 1 (p.6), we designed a cohort study of a representative sample of participants living in the four estates of Buttsbury, Orchard, Tiptree and Hermitage. A range of individual outcome changes were measured at baseline and 12 months follow up by paper-based questionnaire administered face to face at baseline and again either face to face or by telephone collection at follow-up from baseline respondents. The collection of baseline data started in March 2017 and finished in May 2018. Follow up commenced in July 2018 and ended in October 2019. In order to collect data, IHHD (UEL) researchers trained Physical Activity Champions and Vision Culture Leisure Centre employees on survey and door-knocking strategies. The target of 260 completed baseline questionnaires was met by the end of May 2018. However, the original target number of 130 was not met, and a final number of 73 questionnaires were collected at follow up. The data collection was carried out by Vision RC&L with support from UEL in relation to provision of volunteers for data collection. UEL provided several volunteers and trained them in research methods. However, during follow up data collection, Vision RC&L undertook a number of staff changes which prevented the achievement of the initially stated follow up target.

The data has now been assessed and population level impact extrapolated by comparing those who engaged in physical activity made available by the programme with the overall population of respondents at follow up.

Table 1: Original project outcomes and methods for data collection

	Themes	Design and methods of data collection
Outcome evaluation	Aim: to capture changes in individual and population level outcomes	
	<p>Changes in the following:</p> <ul style="list-style-type: none"> <li>- individual physical activity levels: (i) the number of adults walking at least 10 minutes per day; (ii) Increase the number of adults reaching the recommended guidelines of 150 minutes</li> <li>- Population level physical activity outcomes</li> <li>- community cohesion in the four estates</li> <li>- health and mental well-being status of residents</li> <li>- use of alcohol and smoking</li> <li>- Barriers to engagement in physical activity</li> </ul>	<p>Design; Cohort study</p> <p>Method: baseline and 12 months follow up of participants from the four estates. Baseline survey of 260 residents of the four estates (June 2017- May 2018). 12 months follow up of 130 participants to baseline and collected via email, phone or face to face interviews (June 2018 – July 2019)</p> <p>Vision RC&amp;L responsible for data collection. IHHD to provide help with volunteer recruitment, research training, data inputting and statistical analysis of both baseline and follow up data</p> <p>Tools: International Physical Activity Questionnaire (IPAQ) to assess mild, moderate and vigorous physical activity Community cohesion questions from the Social Capital Harmonised Questionnaire Set. Validated health and mental wellbeing questions</p>
Process evaluation	Aim: to examine how the programme was implemented: Fidelity, Dosage, Access, Equipment	
	<ul style="list-style-type: none"> <li>- <u>Fidelity</u>: Was actual programme performance met original goals for implementation? Which elements worked and which didn't and how these have affected, altered or amended the original plan and aims of the programme?</li> <li>- <u>Dosage</u>: the intended outcomes of the programme activities such as number of sessions delivered, number of PAC trained, number of participants engaging in each aspect of the programme.</li> <li>- <u>Access</u>: were the intended participants able to access the programme effectively? Who did and why did not have access?; what were the barriers?; and how did this affect participation in the programme? Were the locations for delivery of the programme conducive to achieving its goals? Were PAO, PAC and PAI able to access participants and was the relationship between participants and the programme implementation team effective?</li> </ul>	<p>Qualitative interviews with participants and other stakeholders:</p> <ul style="list-style-type: none"> <li>- Semi-structured interviews will be conducted with five key personnel from the delivery team and eight users in the period Jul-Sep 2018. Data will be analysed using thematic analysis and will feed into the development of the programme in subsequent years.</li> </ul>

	<p>- <u>Equipment</u>: Were the facilities and any information (leaflets etc.) related to the programme accessible to participants?</p> <p><u>Sustainability</u>: was the programme sustainable? To what extent has the programme been embedded in the four estates?</p>	
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Process evaluation: The process evaluation explores the planning and delivery of the programme and assesses a core set of ‘implementation’ outcomes that determine whether the programme was successfully executed or not. In-depth interviewees included were carried out with three local residents; two consecutive project managers, a council lead, an activity organiser and a resident engagement officer. It is worth noting that we were expecting to interview more local residents. Staff at Vision RC&L were responsible to contact potential interviewees and pass on the information to UEL researchers so that interviews could be arranged. However, despite several requests from UEL to a number of Vision RC&L staff, it was not possible to recruit the necessary sample. The main implementation outcomes measured included fidelity, access, dosage, and sustainability (see Table 1, for more details).

## 4 Results

### 4.1 Results from outcome evaluation

This section provides an analysis of baseline and follow-up survey data collected from a total sample of 261 baseline and 73 follow up respondents as detailed in the previous section. The results from the outcome evaluation are split between participants to the programme (n=22) and the overall population of follow up respondents (n=73).

#### 4.1.1 Descriptive analyses of participant demographic characteristics

The population of respondents is predominantly female and ethnically diverse (Table 2; p.6). The mean age of respondents is 46 years old and two out of three respondents are female (66.3%) which may reflect the time of day in which the population was surveyed, including more women at home with young children. While the largest ethnic group at baseline self-defined as being white (40.1%), this group decreases to 29.6% at follow up with a corresponding rise in the unspecified/other category (28.0%).

Table 2: Demographic details of SP users at baseline and 12 months follow up

Profile	Baseline		Follow up	
	n	%	n	%
Age groups (years)				
18-24	18	10.5	2	3.8
25-44	65	37.8	22	42.3
45-64	63	36.6	20	38.5
>=65	26	15.1	8	15.4
Unspecified				
Gender				
Male	81	33.3	21	28.8
Female	161	66.3	49	67.1
Unspecified/Other	1	0.4	1	1.4
Ethnicity				
White	95	40.1	21	29.6
Black or Black British	55	23.2	18	25.4
Asian or Asian British	60	25.3	21	29.6
Chinese	1	0.4	0	0
Mixed	19	8.1	9	12.7
Unspecified/Other	7	3.0	2	28.0
Length of residence in neighbourhood				
Less than 1 year	10	4.0	5	6.8
Between 1 and 10 years	106	42.8	30	41.1
Between 11 and 20 years	72	29.1	20	27.4
Over 20 years	60	24.3	18	24.7
Long-standing health problem or disability	82	36.0	28	40.0

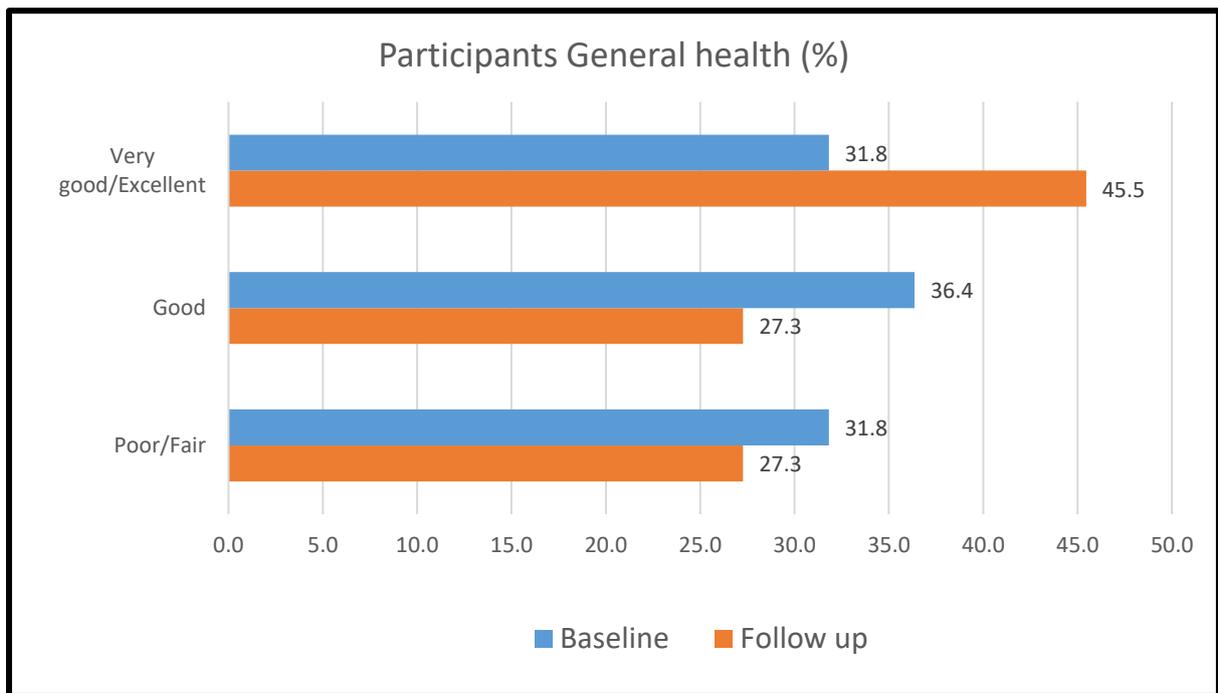
#### 4.1.2 Results from participants to the programme

In order to directly assess the impact of the Redbridge Active programme, this section examines baseline and follow up results for respondents who have attended physical activity classes on offer through the Redbridge Active programme. Out of the 73 follow up responses, only 22 have attended physical activity classes so analysis of statistical significance was not possible. However, we felt it is still important to describe changes for the population of participants to the programme and examined changes in general, mental health, and physical activity levels.

#### 4.1.2.1 General health of participants

Respondents who participated to physical activity classes on offer through the programme were asked one question about their general health. Overall, Figure 1 shows a considerable positive change in health status between baseline and follow up.

Figure 1: General health of participants (%)

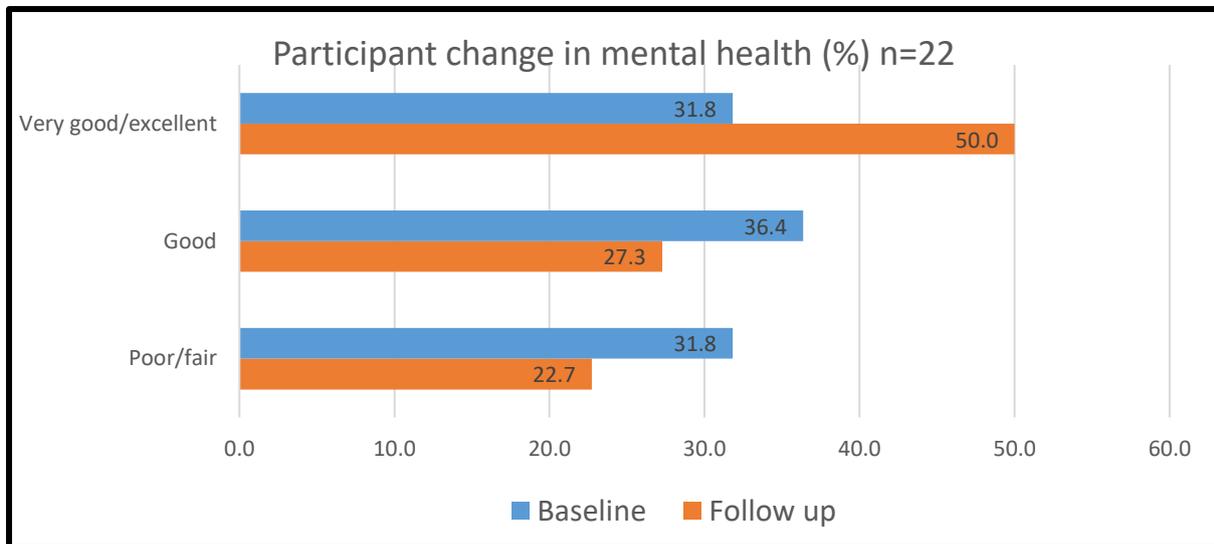


However, the same does not apply in relation to alcohol consumption and smoking. Amongst the participants to physical activities, none consumed alcohol at baseline, but 5.3% consumed alcohol at follow up. In the remaining sample there was a small decline in alcohol consumption (26.9% to 23.1%). Smoking was 11% higher at follow up (31.8% to 42.8%), whilst for the rest of the sample was only marginally higher at follow up (22.6% to 23.5%).

#### 4.1.2.2 Mental health of participants

Participants to physical activity classes on offer through the programme were asked one question about their mental health ('In general, would you say your mental health is..') at baseline and follow up (Figure 2; p.10). Responses were arranged on a Likert Scale from 'Poor' to 'Excellent'. Respondents showed a clearly marked improvement in self-reported mental health, particularly in the category 'very good/excellent'.

Figure 2: Participants change in reported mental health



#### 4.1.2.3 Physical activity levels of participants to the programme

One of the key expected aims of the Redbridge Active Together programme was the assessment of physical activity changes in the four estates for the people attending the activities on offer and also for the wider resident population. We have baseline data from 242 people and 22 at follow up.

There are different ways to calculate physical activity levels. One of the most commonly used is the level of physical activity as defined by the Chief Medical Officer (CMO) (CMO, 2019) which defines as 'active', a person who either achieves 'at least 150 minutes of moderate intensity physical activity (MPA) per week' or achieves 'at least 75 minutes of vigorous physical activity (VPA) per week'. Moderate intensity is physical activity that requires an increased breathing rate, but the person is still able to talk (e.g. swim, brisk walk, cycle). Vigorous physical activity is defined as breathing much harder than normal (e.g. running).

One of the first questions that can be addressed by this evaluation is whether the Redbridge Active Together programme has led to a statistically significant change in physical activity levels for the people who have attended physical activity classes on offer through the programme. These represent 30% of follow up respondents (n=22). Of these, 13.6% were defined as 'active' at baseline and 26.7% at follow up. Thus, if it is assumed that the programme is responsible for these changes, it could be concluded that the Redbridge Active Together programme led to a reduction of inactivity by 13.1%.

However, when these changes are measured through statistical analysis, they did not show any statistically significant change. Chi-Square test for independence showed no statistically significant association (alpha value less than 0.05) between 'being active' and participation

to physical activity classes as part of the programme. Moreover, the statistical analysis shows that one of the key assumptions is violated as the sample size is too small. Thus, it can be concluded that the sample size at follow up is too small to make any reasonable conclusions as the impact of the programme on the level of physical activity in the four estates.

Although the sample sizes are very small and there may also be systematic differences between groups, it is also possible to compare those who have attended physical activity classes with those who did not. Among the group of respondents who did not attend physical activity classes on offer through the programme, 14.3% were defined as active at baseline, whilst 21.4% at follow up. This is a positive change of 7.1% but is smaller than the change recorded by individuals who attended physical activity classes (i.e. 13.1%).

#### 4.1.2.4 Community cohesion of participants to the programme

Participants in physical activity classes were asked a number of questions about community cohesion in their neighbourhood. Overall, community cohesion for participants in physical activity classes was mixed. In Table 4, respondents reported positive changes in relation to the number of people they can count on (1.68-2.17) and they felt that neighbours showed more concern in what they were doing (2.00-2.16). However, in Table 3, trust in the neighbourhood and diversity (i.e. living with people from different background) recorded a negative score. Please note, that lower scores in Table 3 denote positive changes.

Table 3: Participants neighbourhood cohesion (Part A)<sup>1</sup>

Please indicate how much you agree or disagree with the statement below:	Description	Baseline mean and sample size	Follow-up mean and sample size
<b>How easy is it for you to get help from neighbours if you should need it?</b>	1=very easy 2=easy 3=possible 4=difficult 5=very difficult	2.59 (n=22)	2.53 (n=17)
<b>My neighbourhood is a place where people from different backgrounds get on well together</b>	1= Definitely agree 2=Tend to agree 3=tend to disagree 4=Definitely disagree	1.71 (n=17)	2.00 (n=16)

<sup>1</sup> Lower scores in Table 3 denote positive change

<b>People in my neighbourhood pull together to improve the place</b>	1= Definitely agree 2=Tend to agree 3=tend to disagree 4=Definitely disagree	2.44 (n=16)	2.50 (n=16)
<b>In my neighbourhood:</b>	1=many people can be trusted 2=some people can be trusted 3=a few people can be trusted 4=none of the people can be trusted	2.22 (n=18)	2.43 (n=14)

Table 4: Participants neighbourhood cohesion (Part A)<sup>2</sup>

<b>Please indicate how much you agree or disagree with the statement below:</b>	<b>Description</b>	<b>Baseline mean</b>	<b>Follow-up mean</b>
<b>Number of people I can count on for help in times of difficulty</b>	0=None 1=1 person 2=2-5 people 3=6-10 people 4=More than 10 people	1.68 (n=22)	2.17 (n=18)
<b>Concern people show in what you are doing</b>	0=No concern 1=A little concern 2=Not sure/uncertain 3=Some concern 4=A lot of concern	2.00 (n=22)	2.16 (n=19)
<b>Neighbourhood is a place you enjoy living in?</b>	0=no 1=yes, to some extent 2=yes, definitely	1.14 (n=21)	1.20 (n=20)

#### 4.1.2.5 Engagement in programme activities

Although we could not access data about the total number of participants in programme activities, we can report on attendance from the 22 respondents we have data for. A total number of 49 sessions were attended by participants who completed the follow up questionnaire. On average, these participants attended 3 sessions each. More than half of

<sup>2</sup> Higher scores in Table 4 denote more positive change

the participants (54.5%) attended because they had received a leaflet through the post, whilst 14% knew Mark Healy (one of the programme coordinators). Buttsbury and Orchard received the most participants (8 and 7 respectively), whilst Hermitage only 2.

Almost half of this sample (44.4%) also attended other activities that are not offered by the programme which means that this group is use to engaging to physical activities. However, the other half are not, so the programme may have played an important role in engaging these.

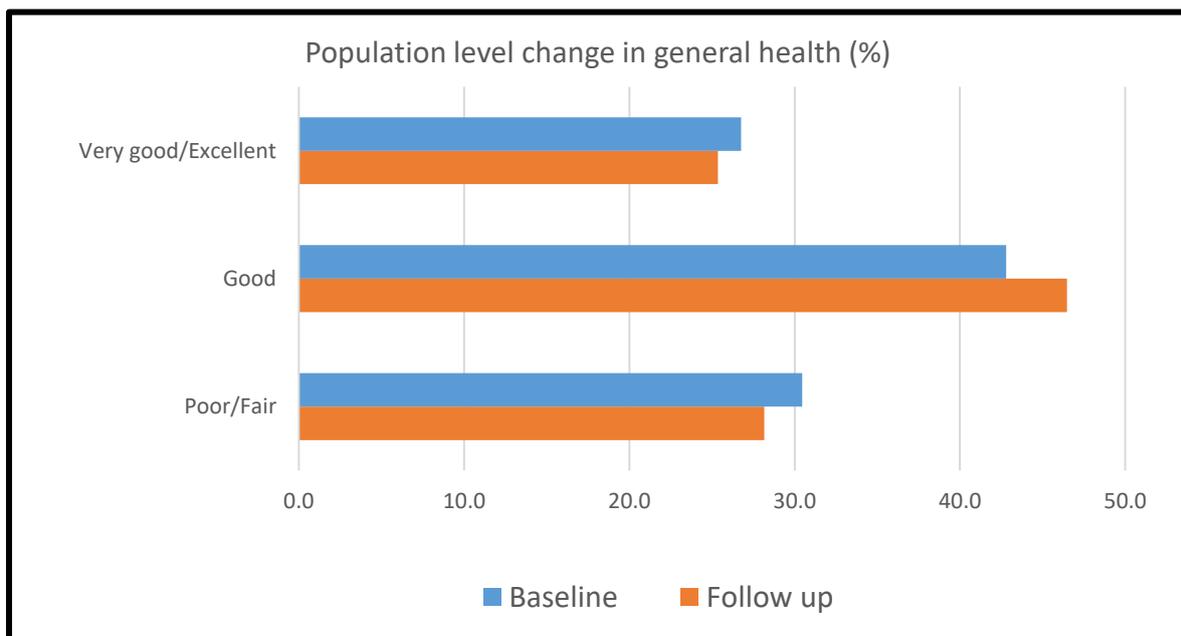
#### 4.1.3 Results from the overall population

IHHD was asked to assess outcome changes at the population level. This section examines such changes in general health, mental health, physical activity and inactivity, community cohesion of the overall population of 73 follow up respondents. These include participants (analysed above) and non-participants to the activities on offer through the programme and examines potential population level changes. With this sample size it is very difficult to assess any population changes. However, we felt that it is important to describe and produce some statistical analysis to assess a potential population level change.

##### 4.1.3.1 General health of the overall population

Respondents to baseline (n=243) and follow up (n=71) were asked one question about their health status (*Figure 3*). Overall, responses show a slight positive change in the general health of respondents as those who reported 'good' at follow up increased. The other two options essentially cancel each other out.

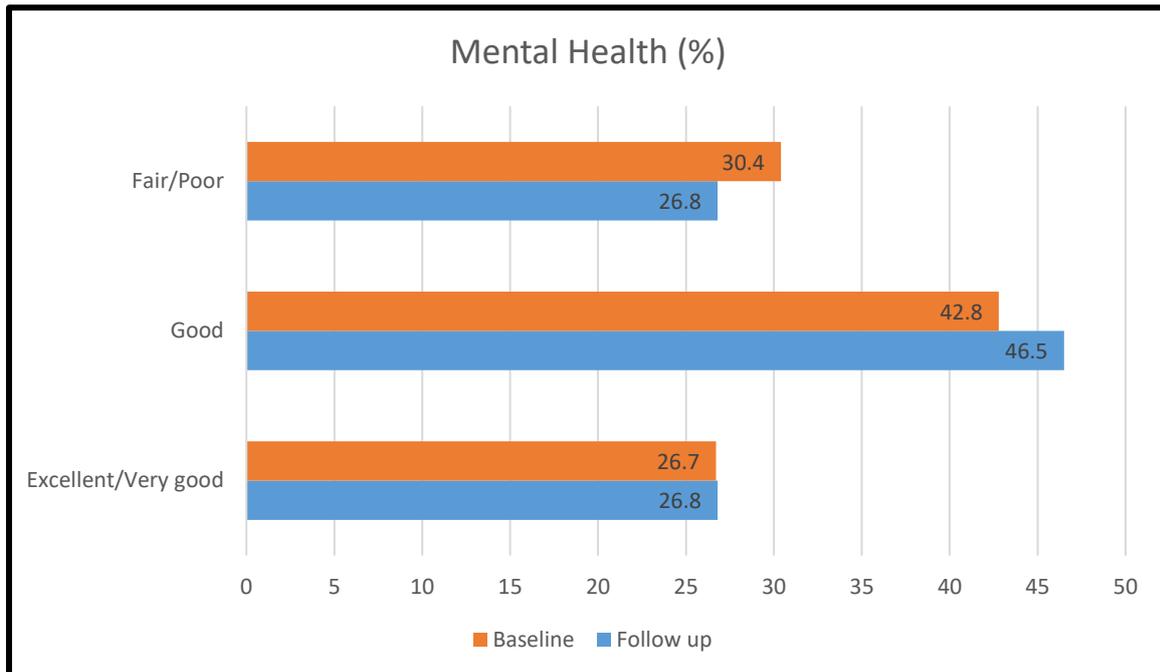
*Figure 3: Population change in general health (%)*



#### 4.1.3.2 Mental health of the overall population

Figure 4 shows changes in self-reported mental health between baseline (n=243) and follow up (n=71). One question about mental health was asked 'In general, would you say your mental health is..' and possible responses were arranged on a Likert Scale from 'Poor' to 'Excellent'. Overall, a positive change in mental health between baseline and follow up can be seen across the overall population. However, as noted elsewhere, this cannot necessarily be attributed to the impact of the Redbridge Active programme.

Figure 4: Overall population mental health score changes



#### 4.1.3.3 Physical activity and inactivity of the overall population of respondents

The evaluation also looked at the whether levels of 'inactivity' changed between baseline and follow up as an indication of the impact of the programme on potentially reducing levels of inactivity at the population level rather than just for individuals who have attended Redbridge Active Together activities between baseline and follow up. As noted above, the comparison includes people who completed both baseline and follow up questionnaires but did not necessarily attend physical activity classed offered as part of the programme.

We tested the level of inactivity by using two different definitions. This is because in the time between baseline and follow up new guidelines were published by the Chief Medical Officer (DHSC, 2019). The old guidelines (CMO1) are still useful as they enable a comparison with the levels of physical activity in Redbridge and nationally (Table 5).

Thus, when using the old CMO definition of physical inactivity<sup>3</sup>, we found an overall increase in physical inactivity across the four estates. However, this is due mainly to data from Orchard estate which showed a marked increase in inactivity (Table 6). The remaining three estates showed a decline in physical inactivity from baseline to follow up.

*Table 5: Physical inactivity in the Redbridge Active Together sample, London, Newham and England (CMO1\*)*

<b>CMO1 - &lt;30 min mod intensity equivalent minutes per week (physical inactivity)</b>				
<b>Four estates baseline (n=242)</b>	<b>Four estates follow up (n=43)</b>	<b>Redbridge</b>	<b>London</b>	<b>England</b>
39.3 (*)	51.2	27.5	22.9	22.2

(\*) This value is different from the first year report because this analysis includes the total baseline sample which was not available when Year one report was submitted

*Table 6: population level changes in inactivity in the four estates (CMO1\*)*

<b>CMO1 by estate (% inactivity)</b>	<b>baseline (n=241)</b>	<b>follow up (n=43)</b>
Orchard	14.9	45.5
Tiptree	39.4	31.8
Hermitage	16.0	9.1
Buttsbury	29.8	13.6

*Table 7 below show the level of physical inactivity according to the more recent (2019) Chief Medical Officer definition of physical activity. We have calculated physical activity according to the definition and assumed that all people who do not meet that definition are physically inactive. Overall, the analysis showed a small reduction in inactivity from baseline to follow up (2.2%). As for estate level change in inactivity (*

Table 8; p.16), Orchard has shown a marked increase in physical inactivity (18.5%) confirming the trend of the first CMO definition of physical inactivity.

*Table 7: Overall population changes in inactivity (CMO2)*

<b>CMO2 - less than 150 min mod activity per week or less than 75 min of vigorous activity per week (% inactivity)</b>			
	<b>baseline (n=242)</b>	<b>follow up (n=43)</b>	<b>Difference</b>
Population overall	78.9	76.7	-2.2

<sup>3</sup> This is based on the old Chief Medical Officer definition which is defined as the percentage of adults (aged 19+) that are physically inactive (<30 moderate intensity equivalent minutes per week). We analysed vigorous and moderate physical activity and adjusted the sample; missing cases were removed; total minutes of physical activity above 960 minutes were also removed from analysis as unrealistic (IPAQ guidelines); Newham, London and England data are for

Table 8: Overall population changes in inactivity by estate (CMO2)

CMO2 by estate (% inactivity)	baseline (n=241)	follow up (n=43)	Difference
Orchard	17.9	36.4	18.5
Tiptree	28.9	36.4	7.5
Hermitage	20	12.1	-7.9
Buttsbury	33.2	15.2	-18

Data was also collected on the barriers experienced by participants in accessing activities (Figure 5; p. 19). Given that Orchard showed an increase in inactivity for both CMO definitions used, we examined the top reported barriers to physical activity in Orchard to assess whether there is any specific barrier that may explain levels of inactivity. The three most important barriers recorded in Orchard were 'no time' (15.1%), 'just can't be bothered' (10.5%) and 'no nearby facilities' (9.3%), broadly consistent with the picture for all the estates.

Paired sample t-test for two continuous variables MET minutes of vigorous, moderate, walking and sitting activities at baseline and follow up was conducted. Overall, the data shows a decline in moderate and vigorous physical activity between baseline and follow up, mitigated by an increase in walking and decline in sitting. However, it is important to note that none of the variables examined in Table 9 are statistically significant ( $p \leq 0.05$ ).

Table 9: Population level changes in physical activity

Measure	Population level change		
	N	Net change <sup>6</sup> Coef. (95%CI)	Significance P value (*)
MET minutes per week of moderate activity	43	-9.49 (-745.82; 764.80)	0.98
MET minutes per week of vigorous activity	46	-170.43 (-611.44; 952.31)	0.66
MET minutes per week walking	54	1319.67 (-92.96; 2732.29)	0.07
Minutes per week sitting	54	-2.22 (-5.73; 1.28)	0.21

<sup>6</sup> Net change refers to the difference in the average score between baseline and follow-up; (\*) significance is when  $p \leq 0.05$

#### 4.1.3.4 Community cohesion at the population level

Community cohesion is important in order to guarantee a good, healthy, and safe living environment. It is based on people sharing a sense of belonging within their neighbourhood, a set of values and purpose. The evaluation was specifically interested in understanding

whether the programme may have led to population benefits that go beyond physical activity, such as increased trust, joined up action, and relationships between neighbours. Although it would be incorrect to attribute all the changes in community cohesion to the programme as these may be due to a wide variety of other reasons, it is possible to compare the mean values at baseline and follow up and describe what overall changes have taken place in relation to the state of community cohesion on the four estates.

Participants were asked a number of questions relating to experiences of their own neighbourhood (Table 10 and Table 11 below). In all but one of the questions, the follow up mean score showed a positive improvement in perception of neighbourhood<sup>4</sup>. Scores for the question ‘Do neighbours show concern in what you are doing?’ remained almost the same with 2.15 at baseline and 2.14 at follow-up.

*Table 10: Overall population neighbourhood cohesion (Part A)*

Please indicate how much you agree or disagree with the statement below:	<b>Description</b> (lower scores denote more positive change)	<b>Baseline</b> mean and sample size	<b>Follow-up</b> mean and sample size
<b>How easy is it for you to get help from neighbours if you should need it?</b>	1=very easy 2=easy 3=possible 4=difficult 5=very difficult	2.55 (n=244)	2.30 (n=67)
<b>My neighbourhood is a place where people from different backgrounds get on well together</b>	1= Definitely agree 2=Tend to agree 3=tend to disagree 4=Definitely disagree	1.88 (n=215)	1.76 (n=58)
<b>People in my neighbourhood pull together to improve the place</b>	1= Definitely agree 2=Tend to agree 3=tend to disagree 4=Definitely disagree	2.60 (n=193)	2.39 (n=51)
<b>In my neighbourhood:</b>	1=many people can be trusted 2=some people can be trusted 3=a few people can be trusted	2.33 (n=196)	2.37 (n=41)

<sup>4</sup> Please note that lower scores for questions in Table 10 are more positive, whereas higher scores for questions in Table 11 are more positive.

	4=none of the people can be trusted		
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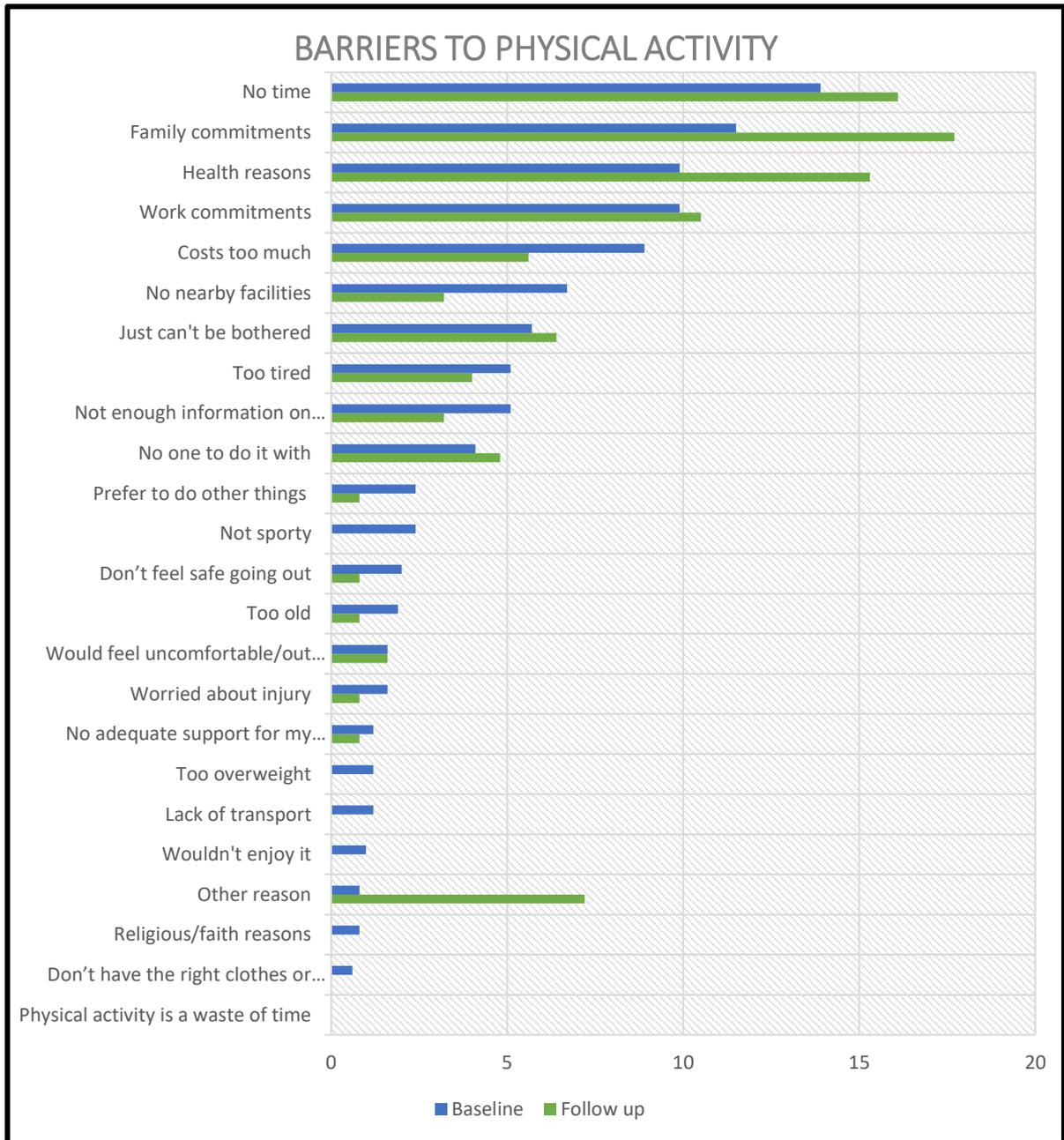
Table 11: Overall population neighbourhood cohesion (Part B)

Please indicate how much you agree or disagree with the statement below:	Description (higher scores denote more positive change)	Baseline mean	Follow-up mean
<b>Number of people I can count on for help in times of difficulty</b>	0=None 1=1 person 2=2-5 people 3=6-10 people 4=More than 10 people	1.71 (n=244)	1.83 (n=64)
<b>Concern people show in what you are doing</b>	0=No concern 1=A little concern 2=Not sure/uncertain 3=Some concern 4=A lot of concern	2.15 (n=242)	2.14 (n=65)
<b>Neighbourhood is a place you enjoy living in?</b>	0=no 1=yes, to some extent 2=yes, definitely	1.34 (n=231)	1.40 (n=67)

#### 4.1.4 Barriers to physical activity

The barriers to physical activity question was created in order to improve the programme and highlight any differences between the four estates. The top three barriers experienced to taking part in physical activity remained the same at baseline and follow up (Figure 5; p.19 ). They included ‘lack of time’, ‘family commitments’ and ‘health reasons’. This is important as it confirms that respondents feel these are key barriers over time and do not seem to change. In contrast some of the less frequently cited barriers at baseline such as: ‘not sporty’, ‘too overweight’, ‘lack of transport’ and ‘wouldn’t enjoy it’, are not represented at all at follow up. However, qualitative interviews provided a different interpretation of reported barriers to physical activity (see 4.2.1.5; p. 22).

Figure 5: Overall population changes in reported barriers to physical activity



## 4.2 Results from the process evaluation

As part of the overall evaluation of the intervention, in-depth qualitative interviews were carried out with local residents and stakeholders who were asked about their experiences of implementing and/or participating in the Redbridge Active Together programme. The aim of the process evaluation was to assess key aspects of the implementation around fidelity, dosage, access and equipment. Interviewees included: three local residents; two consecutive project managers, a council lead, an activity organiser and a resident engagement officer.

Engagement in little or no physical activity is well-understood to be a risk factor for serious secondary health problems and is high on the agenda of public health concerns nationally. In the London Borough of Redbridge, participation in physical exercise is below the national average and in some of the more deprived parts of the borough it is of particular concern. Four estates in these areas were identified by the Redbridge Active Together program and chosen to receive an intensive, targeted intervention which aimed to increase levels of engagement with physical activity among local residents.

While there was plenty of provision for physical activity in the borough, residents from the four targeted estates in particular were not engaging in it. The main aim of the Redbridge Active Together programme was to try to understand what the barriers to participation were as well as encouraging people to become more physically active by just 'moving more'.

*'the idea of this project was to find out what those reasons are, what the barriers are, what would encourage people to take part in organised maybe activities, what would encourage them just to move more.'* (Council lead)

Table 12: Aims of the process evaluation

- Fidelity: Was actual programme performance met original goals for implementation? Which elements worked and which didn't and how these have affected, altered or amended the original plan and aims of the programme?
- Dosage: the intended outcomes of the programme activities such as number of sessions delivered, number of PAC trained, number of participants engaging in each aspect of the programme.
- Access: were the intended participants able to access the programme effectively? Who did and why did not have access?; what were the barriers?; and how did this affect participation in the programme? Were the locations for delivery of the programme conducive to achieving its goals? Were PAO, PAC and PAI able to access participants and was the relationship between participants and the programme implementation team effective?
- Equipment: Were the facilities and any information (leaflets etc.) related to the programme accessible to participants?
- Sustainability: was the programme sustainable? To what extent has the programme been embedded in the four estates?

Time constraints, family and work commitments were cited as the most important barrier to physical activity. Other aims of the project were to increase local knowledge and accessibility of existing provision as well as empowering and training local people to take ownership of activities themselves and become 'physical activity champions'. It was also hoped that community cohesion would improve as a result of the intervention. Previous public engagement initiatives had identified factors such as cost, distance and lack of time as barriers to participation and as a response to these findings, outdoor gyms were installed in green spaces across the borough.

*'we commissioned Vision to install those outdoor gyms and put them in various parts of the borough like parks and open spaces and recreation grounds and things like that. But I think the feeling was that even those facilities are not being used by certain erm, members of the community' (Council lead)*

A period of extensive consultation and engagement with local residents was carried out in order to determine what the residents themselves wanted rather than just imposing new activities upon them. This involved the project manager knocking on doors and distributing leaflets and becoming a well-known and approachable 'face' of the project.

#### 4.2.1 Access

##### 4.2.1.1 Engagement process and working at a local level

The initial engagement process with local residents was widely agreed to be a major success of the project. This work extended beyond the initial consultation and feedback was sought from local residents on how the activities were going, making changes where necessary. Rather than imposing the intervention on the four estates, this resulted in the development of a portfolio of activities that were very much resident led.

*'As long as all the resources were focussed on the resident, that one resident to say 'Well this is what needs to be done.' And then we wrapped resources around it and we'd just facilitate it really, so it's, it's initiating a relationship and being resident led.'* (Project manager 1)

##### 4.2.1.2 Key person as activator

The success of the engagement process was mainly attributed to the work of an enthusiastic and committed 'Activator' who persistently knocked on doors and introduced himself personally to local residents, resulting in him becoming a familiar, approachable and trusted figure with whom residents felt comfortable expressing their views.

*'Everyone on the estates knew who he was and erm, he was the person to go and speak to if they wanted to do.'* (Project manager 2)

*'...just being there constantly. So at any kind of gathering he was there. Whether it was a physical activity erm, an event or not just being there, and so people started knowing...it just personalised it, I think that was a really good, good way of erm, yeah personalising the project and creating those links.'* (Project manager 2)

#### 4.2.1.3 Trust and word of mouth

Building face-to-face trust relationships with residents had an impact beyond what would have been achieved by more usual marketing methods. Leaders within the local community would then take up the message and pass it onto neighbours, encouraging them to participate.

*'So quite a chaotic...lifestyle but this one resident was able to, to guide me in to what activities would take off in the local estate, how they would get people there. She would often say to me, "Well I'll get you five people there if you do it at this time and that time and if my children can come." So that's how we designed the family yoga. And her social network grew and grew.'* (Project manager 1)

*'You only need like one or two leaders and there was one or two of the older ladies that were really, really happy to sort of go and, "Oh I'll knock on so and so's door to come down." "Let me see if they're in." Or they'd find out why somebody didn't go, so they'd go the next day and say, "Oh I went to so and so's house and she didn't come to the walk because of this that and the other." They'd find out.'* (Activity organiser)

#### 4.2.1.4 Taster fitness sessions

As the target population were physically inactive and many of the respondents were women, it was decided to put the emphasis on fitness sessions rather than sport. Social events were planned within the estates where people could meet and chat and try out 10 minute 'try before you buy' sessions of the available activities.

*'We had people who came down and did erm, massage, head massage and erm, beauty treatments and we had teas and coffees and things. And then little tiny, tiny sort of 10 minute 5 minute 10 minute bursts of activity for people to see what the classes were going to be like. So that when the first week came, they'd already met the coach, they'd already had a little go themselves and sorted of actually, 'It doesn't matter if you're erm, you haven't done exercise for ages because it's really not about that.'* (Project manager 2)

More women responded to the consultation process than men, and in their requests for activities, the emphasis was on fitness rather than sport, as well as sessions for children. The intervention team responded to this by trying to include sessions for adults alongside, or straight after those for children where possible.

#### 4.2.1.5 It's not for me/I don't belong

There was a general sense that the most common barrier to residents engaging was that they couldn't see themselves as part of it. This may have been due to lack of confidence and being uncomfortable arriving for the first time alone, or that it was just not a priority to attend. Men were harder to engage than women and more work needs to be done around pinpointing the reasons for this.

*'It's far more than, we kind of use the time and the cost and er, it's too far away and all that.'*

*And some of them are genuine barriers but we often use them as an excuse but actually I just don't feel it's for me.'* (Project manager 2)

*'Right I'm going to drop everything and I'm going to go to my Zumba class.'* You have to be really really, quite you know determined to do that and I don't think that makes a difference who you are, what your education level is, or what your physical activity level is or anything else, it's just down to that individual.' (Council lead)

#### 4.2.2 Equipment

##### 4.2.2.1 Local facilities

Location was a major determinant of attendance for the residents of the estates. Having a community hall available for use on two of the estates worked well despite occasional problems booking slots for activities. In Buttsbury, a local youth centre 10mins walk away was used but did not seem to have the same community feel to it and in Hermitage there was no such facility available.

*'Just having something next, right next, literally next door to where they live in their community just made it so much easier...there was no erm, there's no kind of barrier of having to get childcare, things. So I think that's always a big, the distance and particularly in the kind of communities that we're working, people don't travel as far. So there's always been a tendency, "Oh there's an activity it's only a mile away." But for a lot of people that's a very, very long way.'* (project manager 2)

Getting 'buy in' from the local facilities at the outset of the project was also mentioned, due to the importance of having an available space within the boundaries of each estate. One of the halls also became too hot for comfort during the summer and the exercise class was held outside which made one resident uncomfortable (Resident 1).

#### 4.2.3 Fidelity

##### 4.2.3.1 Community champions

An original aim of the project was to train local people to become 'community champions' of physical activity on their estate and to qualify them as RSPH activators. However, the chaotic nature of many of the lives of those living on the estates made this approach inappropriate and instead individuals were recognised for their engagement and contribution to the programme in a more natural way for them.

*'We'll sit in a room and decide that we want 10 people qualified as RSPH, activators because we know that that approach will work in terms of getting people from the community to talk to, but we forget the quite important part is whether the people that we're targeting actually want to do that... those residents who were encouraging their neighbours to come to events, were offering ideas suggestions to scheduling, suggestions for new activities.'*

*That's how I quantified what a community champion was rather than your traditional job description person spec involved.' (Project manager 2)*

However, some participants did receive and appreciate more formal training:

*'It (walk leader training) involves everything you know like the safety things, encourages the people, and explain all the benefits and everything of walking...it was very good, it was really, really, very good.'* (Resident 2)

#### 4.2.4 Dosage

Although there was no specific target for participation in the activities and numbers varied depending on the activity and the estate, project leaders felt generally happy with overall numbers.

Participants generally appreciated the activities and reported positive health outcomes. They would have liked more activities at different times of day and were also prepared to pay a little towards them if necessary.

*'I think it was beneficial for me and the friends that I was coming with. Everyone really looked forward to it. So, people would be there waiting for the teacher to come and she was bang on time. It was fun, I think that was one of the good things about it. And people felt a lot better, people lost weight, amazing amount of weight.'* (Resident 3)

One participant wanted more information around staying healthy, for example dietary advice. One participant noted that while there were activities for young children, there was little available for teenagers.

*'Sometimes you need somebody to motivate you, yeah. I wanted my daughter to go with me, but she was like, 'No no no mummy. I'm sure it's all older women.'* (Resident 1)

One of the core aims of the project was to have a 'Community Activator' who fronted the project and became part of the communities by building relationships with local people. This ambition was realised very successfully for this project and should be shared as an example of best practice within other similar public health initiatives.

*'He encourage actually, and he was very good, even when I saw first time, even when he phoned me first time, when he dropped the leaflet and when I phone him, he was very like er, er, you know cooperative, helpful on the phone. I could tell you that he's very good, the way he answered me on the phone.'* (Resident 2)

##### 4.2.4.1 Community cohesion and connectedness

Improving community cohesion was another core aim of the intervention. The estates were initially identified on the basis of deprivation, bringing with it challenges with anti-social

behaviour and safety. However, this was an area where the project did appear to have a positive impact.

*'There is many incidences of anti-social behaviour, there was low level crime across the estate, but we scheduled the activities to take place on the estate and er, the before, during and after these activities, there was a positive vibe, energy going through the estate... They felt safe, there is, there was communication going on between residents who would, previously just walk and not acknowledge one another.... so in that sense erm, there was a real impact on, positive impact on community cohesion and also around anti-social behaviour.'* (Project manager 1)

Another positive outcome was the creation of opportunities to get to know and understand other cultures and experiences. During a walking group a dog continually kept coming up to the group, causing two Muslim members of the group to back away.

*'We kept saying to them, "Oh the dogs not going touch you, dogs not going to, don't worry about the dog, walk along, don't worry about the dog, don't worry about it." Anyway in the end the lady said, "No no we can't touch the dog." So we were all like, "Well why?" And when they explained to us, that obviously in their religion its seen as, you know, you shouldn't touch a dog and they told us all the reasons why they're not supposed to. And we would never have known that, so we've learned something new now.'* (Activity organiser)

Participants also appreciated the opportunity to meet people and form new connections.

*'I don't know even all my neighbours we don't know each other. So this type of activities, when I join I thought, 'That's great.' Because er, I like to meet to see other people.'* (Resident 2)

With a new, more flexible definition of a 'community champion' as someone who was involved in promoting the activities either by word of mouth or in other ways, the project lead estimated that around 25 community champions have been identified. Similar adaptations to training were also being tried out.

*'In terms of the training element it's the part that we're still trying to, we're doing a lot of it verbally how we can kind of formalise that. One way we've looked at is doing short videos that people watch and then answer questions...they're encouraged to then go and promote what they've learnt, so if they've learnt, one of the short videos is about where you can get active in the local community.'* (Project manager 2)

#### 4.2.4.2 Estate Demographics

Hermitage estate had the lowest engagement rates from local residents and there was a sense that this may be because the estate had a more mixed demographic who had less of a community identity.

*'When you go around you don't see people out during the day, but if you go round after*

*work everyone's coming back from the tube station...you've got two communities there. So you might have people who are living in social housing and might be looking for more activity, and then a lot of people, one of the most common things that I heard when I was speaking to people is that they already have a gym membership or they already go to a running group.'* (Project manager 2)

On Orchard estate the population appeared to be quite transitory with people moving on continually and often not being able to speak English, which may have contributed to lower level of engagement in community activities.

#### 4.2.5 Sustainability

While it wasn't clear how sustainable the project as a whole would be in the long term, the success of individual groups (for example, the walking groups) suggests that local residents themselves now have the confidence to continue the sessions themselves, having developed the use of communication tools like WhatsApp which were initially set up for them by the project manager.

*'We had a Health Walk WhatsApp group and the group grew to maybe 20 in number. And although it was imitated, the thread of conversation were initiated by the project leads around, "Great energy last night. Really nice to see so many of you." That opened up the conversation for others to join that so they all brought their own energy to that. And in the end those social networks began to knit and to thread between one another, and that was a huge, and I believe actually that is still going now.'* (Project manager 1)

## 5 Summary of the main findings

### 5.1 Outcome evaluation

- A cohort study of residents in the four estates of Buttsbury, Orchard, Tiptree and Hermitage was conducted. Baseline data from 260 and follow up data from 73 residents were collected between March 2017 and October 2019.
- More women than men participated in the evaluation of the Redbridge Active Together programme. A third of the respondent reported long-standing health problems or a disability.
- The right group of residents was targeted. The level of inactivity of the Redbridge Active Together sample was substantially higher (39.3%) than the borough of Redbridge (27.5%), London (22.9%) and England (22.2%) at baseline (*Table 5*).
- Participants to the programme: for the 22 respondents who actively participated in the programme activities, there was an increase (13.1%) among those defining themselves as 'active' following the implementation of the intervention. This increase was double of the remaining follow up sample of respondents who did not

attend physical activity classes on offer through the programme. However, statistical tests showed no significant difference, primarily because of the small sample size. Both general and mental health improved but this was mitigated by reported increases in alcohol consumption and smoking for this population of participants to programme activities. Community cohesion in this group of respondents remained essentially the same, with contradictory results. These group attended on average three sessions each, primarily on offer at Buttsbury and Orchard.

- Overall population analysis: while there appears to be reductions in mental health in the sample population of respondents, it is not possible to tell whether this is due to the Redbridge Active Together programme as the sample of follow up participants was too small to measure the statistical significance of any intervention effect. It is interesting to note that the level of physical inactivity increased between baseline and follow up. However, this increase was mainly due to the negative impact of the Orchard estate rather than an overall increase in inactivity. A modest increase in general health and more substantial increase in mental health were recorded. Statistical tests on level of physical activity did not show any statistically significant change in moderate, vigorous, walking physical activities or sedentary behaviour.
- Overall, levels of community cohesion from the population level analysis showed a positive improvement but, again, the sample size of actively participating respondents was too small to say whether this is as a result of the Redbridge Active Together programme.
- Barriers to physical activity were broadly consistent between baseline and follow up (in order of priority: No time; family commitments, health reasons and work commitments) reinforcing the conclusion that these represent an important barriers to accessing physical activity.

## 5.2 Process evaluation

The findings from the process evaluation suggest that a number of residents have participated in physical activities that they were not involved with before the intervention and certainly have an increased knowledge of the opportunities available to them to participate in physical activity on their estate. The initial engagement of local residents was a major success of the programme and can be attributed to the committed project lead who made himself a trusted and accessible presence around the estates. As a result of this detailed on the ground knowledge, adaptations were made to the development of the program most notably in the way that Physical Activity Champions were identified and trained.

*'There wasn't much of what did not work well. It was the proximity to the house and the fact that er, the timing was very suitable, and er, the instructor that they had was very good, she's very, very cheerful, she's very, very motivating, it's just fun.'* (Resident 3)

A significant barrier to engagement seemed to be residents not being able to visualise themselves attending events and this was addressed in the taster sessions which were run at community events on each estate. While this may have helped to bring in women, particularly those with young children, the men on the estates proved harder to engage. Lack of availability of facilities for hosting activities within the estates was also found to be a problem in one of the locations.

## 6 Recommendations for the future

- Initial engagement consultation with local residents to get their views on what is needed in terms of types of activity, for whom and at what times. Ideally, this should be designed as a co-production exercise, where residents have the space and time to provide their views.
- Recruitment of a dedicated project manager who can engage residents directly and become the trusted 'face' of the project. The engagement of local residents needs to be a consistent feature of the programme as it was in the case of this programme.
- Interviews revealed that identifying and support community 'leaders' who know groups of residents and can cascade information and engage others is key as it enables a spread by 'word of mouth' via a trusted figure in the community.
- Identify available resources in the local vicinity, for example, community halls.
- There needs to be flexibility in the recruitment and training provision of 'community champions'.
- Although face to face interaction may lead to greater engagement, follow up data show that leafleting has led to engaging a substantial number of the respondents, so perhaps different promotional approaches need to be pursued in parallel.
- There are fewer men in the sample than women. This may reflect the time of day that residents were approached to complete the survey, with more women present, or it could reflect a bias in the overall make-up of the estates where women with young children are often a dominant population. Either way a recommendation for the future could be to find a way of engaging men in particular.
- While participants cited similar barriers to engaging in physical activities at both baseline and follow up, a theme that came out of the process evaluation suggests that actually, participants may have a tendency to cite practical barriers such as 'no time' when actually just find it hard to visualise themselves attending an unfamiliar situation. The initial engagement process for the Redbridge Active Together programme did recognise this and try to ameliorate the problem by introducing taster sessions where instructors could meet the residents.
- Building on the previous point, a flexible and responsive approach to the development of the initiative is needed. For instance, providing guidelines to carry out in-flat physical activity may be a good way to start engaging residents. Once residents feel more confidence in their own physical abilities, they may be more likely to take positive action and attend physical activity classes outside their own home environment.

## 7 Conclusions

The findings of this report show that there were clearly many positive aspects to the development and implementation of the Redbridge Active Together programme, most notably the enthusiastic and committed project leaders and managers who were effective in their initial engagement of local residents. However, the evaluation component of the programme suffered from high staff turnover among project management at Vision RC&L which in turn had an adverse impact on the evaluation's original targets in terms of follow up data collection and recruiting participants for interview. As a result, there was not a large enough sample of participants to be able to conclusively assess the effectiveness of the Redbridge Active Together intervention.

## 8 References

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