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Original Citation

King, Nigel, Kirkby-Geddes, Emma and Bravington, Alison (2009) Evaluation of the impact of Paddock Pathways to health membership on beneficiaries' health, well-being and social functioning. Technical Report. University of Huddersfield.

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EVALUATION OF THE IMPACT OF PADDOCK PATHWAYS TO HEALTH MEMBERSHIP ON BENEFICIARIES' HEALTH, WELL-BEING AND SOCIAL FUNCTIONING

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Acknowledgements

The report authors would like to acknowledge the support and cooperation from:

Paddock Community Forum with special thanks to Irene Chaloner, Project Manager

The National Lottery for the funding of Paddock Pathways to Health

The Research participants

Reception and Administration staff at Paddock Pathways to Health

Liz Bates at the University of Central Lancaster, for assistance with statistical analyses

Chris Farrell-Price, Health Intelligence, Public Health Directorate, Kirklees PCT, for help with provision of PPH beneficiary data

EXECUTIVE SUMMARY

INTRODUCTION

This report is the final evaluation of the Paddock Pathways to Health programme and represents an examination of PPH activities and its impact on beneficiaries over a one year period.

The Paddock Pathways to Health (PPH) project began as a local authority SRB5 bid (under the Huddersfield Healthy Living Initiative) for which Paddock Community Forum (PCF) was the main operational lead. In 2002 an application was submitted to the New Opportunities Programme (National Lottery) to create a Healthy Living Centre in Paddock. The bid was successful. The Paddock Pathways to Health project has then, in its five years, sought to encourage improved physical and psychological health, and social functioning, amongst the local community in Paddock. It has supported a wide range of initiatives targeted at specific priority groups (e.g. older people, mothers and babies/toddlers) as well as the general population of the area.

In this context, our study sought to evaluate the impact of PPH, focusing on three main research questions:

- i) What are users' reasons for engaging in activities provided through PPH?
- ii) What is the impact of involvement in PPH activities on self-rated health and well-being?
- iii) How do participants in group activities held at Paddock Village Hall experience their involvement with PPH, in the context of their views of Paddock as a community?

METHODOLOGY

This evaluation was in two main parts:

Part 1 – A longitudinal audit questionnaire survey examining issues related to involvement in PPH activities and the impact of this on health and well-being.

Part 2 – A qualitative study (focus groups, individual interviews) of three specific activity groups supported by PPH, exploring users' experiences and perceptions of their group, the other activities and facilities associated with PPH, and the wider Paddock community.

Ethics

Approval for the study was granted by the School of Human and Health Sciences Research Ethics Panel (SREP) at the University of Huddersfield.

The Questionnaire Survey

A longitudinal postal survey was carried out between June 2007 and September 2008.

Design

The survey involved three cohorts of PPH users: those who had been beneficiaries for a year in 2007 (A), new beneficiaries in 2007 (B) and new beneficiaries in 2008 (C). For Cohorts A and B the questionnaire was administered again approximately a year later. This design facilitated both longitudinal and cross-sectional comparisons.

Part 1 of the questionnaire included demographic information, and questions related to participants' involvement in PPH activities.

Part 2 included standardised measures of health and well-being (five scales from the RAND SF-36 instrument).

Sample and recruitment

Cohort A registered between April and September 2006, Cohort B between April and September 2007, and Cohort C between April and September 2008. Across all cohorts at time 1 a total of 137 participants returned questionnaires, representing a response rate of 22%. For Cohorts A and B, 48% of those who completed questionnaires at time 1 also completed at time 2. The sample was broadly representative of PPH beneficiaries in terms of gender, ethnicity and age.

Analysis

All numerical data were entered into the statistical package SPSS for analysis. Free response items in part 1 of the questionnaire were analysed using a simple content analysis. Where appropriate, chi-square tests, t-tests, correlational analyses and ANOVAs were used. Differences according to the nature of activities were analysed, but because of the small sample sizes these were further grouped into wider categories: *health/conventional*, *alternative/complementary health*, and *interests and hobbies*.

The Focus Group Study

Design

Focus group interviews with participants from three selected activities were used. A number of individual interviews were also undertaken.

Sample and recruitment

The three activity groups were based at the Village Hall.

Shared Church Coffee Call-in:

Participants in study: 4 plus group leader; 3 male, 1 female. Age range 58–82. Ethnicity: White British.

Craft Group:

Participants in study: 10 plus group leader (includes carer and volunteer helper); 2 male, 8 female. Age range: 42–86. Ethnicity: 8 White British, 2 Asian.

PALS Exercise Group:

Participants in study: 6 plus group leader; 1 male, 5 female. Age range: 68–88. Ethnicity: White British.

Six individual interview participants were selected, two from each focus group.

Interview procedure

Focus group interviews were held in Paddock Village Hall. All but one of the individual interviews took place at the Village Hall meeting room, the other one took place in the participant's home. All interviews were audio-recorded with participants' consent.

Analysis

All the interviews were transcribed in full, and analysed using “template analysis” (King, 2004). The technique involves a systematic process of developing potential themes, applying them to a transcript, and modifying them where necessary to capture participants' meanings as fully as possible.

FINDINGS

The Questionnaire Survey

Part 1 of the questionnaire focused on participants' involvement in PPH activities, as well as collecting demographic information:

- Our sample was mostly female, white British, age range: 14–90 (skewed towards older people). Participants heard about PPH activities through health professionals, family and friends, and PPH publicity.
- Convenience of location and time were the most common reasons people joined PPH activities.
- At Time 2, participants were strongly positive about their involvement in PPH over the previous year. Most did not feel that improvements were

needed – they thought services and facilities were good or excellent as they were.

- Around half who were Paddock residents said that involvement in PPH made them feel more positive about the area generally.

Part 2 looked at the relationships between involvement in PPH activities and the RAND SF-36 instrument: General Health, Health Change, Energy/Fatigue, Emotional Well-being and Social Functioning.

Longitudinal comparisons for both cohorts (A and B) show generally improved health and well-being over time.

Specifically:

- Cohort A, who have been involved in PPH for the longest time, showed that Emotional Well-being and Energy levels improved over time.
- Cohort B respondents reported an improvement in health over time (Health Change) and a near significant improvement in General Health over time. For all other measures there was improvement over time.
- Cohort A, who took part in activities in the *health/conventional* category, showed a significant improvement in Energy/Fatigue over time. The reverse was found for those who took part in activities in the *alternative/complementary* category.
- When compared with the control condition (Cohort C), Cohort B did show a significant difference in Energy levels and the general pattern on all measures was in a positive direction.
- Correlational analysis between the attendance data (covering the six months of Time 2 data collection) and the SF-36 scales showed mostly small negative correlations.

The Focus Group Study

Three main themes (and a number of sub-themes) were identified. Two integrative themes, 'Getting older' and 'The world going down the plug-hole' pervaded all three main themes.

Us as group

Looking inward

- There is strong evidence that involvement in group activities provided an invaluable source of social support for members.

Looking outward

- The Coffee Call-in group showed strong connections to other faith-related initiatives. Craft Group members engaged in craft work outside of the group, making gifts for family and friends. PALS Group members exercised at home as well as in the classes at the Village Hall.

Perceptions of Paddock

- Participants gave mixed views on Paddock as a community. There were differences within and between groups.
- Negative perceptions reflected wider views of contemporary society rather than problems unique to Paddock.

People

- Perceptions of Paddock people were mixed: Paddock was at once seen as a good old-fashioned neighbourhood but also perceived as a place where locals just didn't care.
- Intergenerational and inter-racial issues were raised.

Physical space and facilities

- The geography of Paddock played an important part in people's perceptions of it as a physical environment. The village is strung out along

a long main road, and thus issues that affect people at one end might not affect those at the other.

- There is a sense of decline in some of the descriptions of facilities in Paddock, with participants referring to churches, shops and pubs closing. However, Paddock was compared favourably with other areas of Huddersfield in terms of opportunities to get involved in activities in the community.

Understanding and perception of PPH

Understanding of wider PPH activities

- On the whole, participants did not have a great deal of knowledge about what PPH was, or about the funding other than that it was connected to “the Lottery”.
- There was widespread knowledge of the fact that the PPH project (and the funding) was coming to an end. All three groups voiced concern about this.

Finding out about PPH activities

- Participants had quite a good knowledge of other activities and facilities available in Paddock; several had become involved in some of them.
- People tended to learn about activities through personal recommendations and through visiting the Village Hall.
- The Village Hall is viewed as a lively place that serves a crucial role in the community.

Facilities at the Village Hall

- The convenience of Paddock Village Hall as a location for services was seen as important.

DISCUSSION

Findings from part 1 of the questionnaire survey indicate quite high levels of satisfaction with the activities participants have been involved with through PPH.

The reasons users gave for engaging in PPH activities centred on the central location of activities (at the Village Hall in particular). User engagement with PPH demonstrates that the availability of locally based facilities that are easily accessible is a factor in why people take up health-related activities.

The survey showed that the project worked successfully in partnership with other health care providers, evident in the high uptake of activities based on GP/Health Visitor referral. Many users had, through visiting the Village Hall for their own activity, tried other activities too. This demonstrates that PPH has had some success in broadening the kinds of activities that people have become involved in.

Findings from part 2 of the questionnaire (the SF-36 scales) have been limited somewhat by the low response rate – especially for Cohort A. Longitudinal comparisons for both cohorts (A and B) show generally improved health and well-being over time. Of course, there could be other factors in people's lives in the community causing this effect. Analyses relating to attendance revealed some negative relationships with health and well-being measures. Looking at the other findings, such as the comparison of mean scale scores by attendance categories, the conclusion that coming to PPH activities actually impairs health and well-being seems highly implausible. It is much more likely that many of those who are very high attenders have enduring health problems which in themselves are likely to make them feel negative about their general health, levels of fatigue and emotional well-being.

Our sample was heavily biased towards those involved in health-related activities (*health/conventional* category with its strong showing for physiotherapy). Within and across cohorts, analysis shows Social Functioning is the one scale that never shows a significant positive finding. It could be that PPH activities in general do not have a strong impact on this aspect of well-being, but we suspect that the nature of the sample is the key factor here.

The data from part 2 of the questionnaire do offer some confirmation of a positive relationship between involvement in PPH activities and health and well-being.

Results from the focus group study show strong evidence that involvement in specific group activities held at the Village Hall provided an invaluable source of social support for members. We have seen in the longitudinal survey that those who had attended PPH activities for a year had higher health and well-being scores than a control group of new beneficiaries. On this evidence, PPH appears to have been successful in fostering activities that combat social isolation and improve the individual's sense of well-being.

Perceptions of Paddock as a community were mixed across and within the groups and views were often contradictory. The area was at once seen as a good old-fashioned neighbourhood by some participants but also perceived as a place where locals just didn't care. Litter and vandalism were major bugbears. Intergenerational issues were also raised, with a perceived lack of engagement from young people despite some promising projects such as the benches and landscaping at the Royds roundabout. Attitudes to the Asian community were also mixed, in that whilst a "them and us" attitude was expressed, there was also a real sense of wanting to move towards a sharing of resources and social time for communities. Negative aspects of Paddock were not seen as unique to this area, but rather as a symptom of more general decline in society. Participants' involvement in their groups at Paddock Village Hall served as something of an "antidote" to the common feeling of "the world going down the plug-hole". In addition, half of Paddock residents in the Time 2 questionnaire sample said that involvement in PPH had made them feel more positive about the area as a whole. This is particularly encouraging.

Participant awareness and understanding of PPH aims and its relationship to the Lottery was sketchy, although there was an awareness of PPH's role in capital-build projects (reception annexe). The end of PPH was perceived as threatening

to the future of the groups, and provoked anxiety about the continuation of other activities. Groups were not simply defeatist about possible future difficulties and were taking positive action to ensure their future.

PPH has been well-placed to identify projects which provide services to the community that are key to individual well-being. In this sense, PPH's legacy is that it has been very successful as a “connector” or conduit for the growth and development of community groups and in so doing has provided opportunities for enhanced individual well-being. In a practical sense too, all groups in the study have benefited from the provision of space for their group to meet as well as support from project staff.

CONCLUSIONS

There are a number of key issues which both studies address and which benefit from an integration of their findings.

The physical location of PPH

The fact that the Village Hall is located in the middle of the village helps it to play a strong role in providing a sense of community.

Paddock as a community – and PPH’s role in it

There was a strong (though by no means consensual) view that Paddock as a community suffered many of the problems of contemporary urban life. Attending activities provides social interaction, a sense of belonging and a safe environment.

The future of PPH activities

The main emphasis regarding the future was not on new developments but on maintaining and protecting what people already had.

RECOMMENDATIONS

Practice

We propose the following recommendations for those supporting, managing, and/or commissioning community-based activities in Paddock.

Supporting current groups and services

Groups and services that PPH has supported play a major role in providing meaningful social contact and activity for members, therefore we would urge the continued support of existing groups.

Addressing perceptions of “us and them”

Whilst Paddock is not a deeply divided community, there is a sense of different groups in the area living in rather different worlds that do not touch each other as much as they could.

Initiatives to encourage community cohesion (both inter-generational and inter-racial) can make a real contribution to helping people move out of their “comfort zones” and recognise common interests that can bring them together.

Diversifying involvement in activities

To build on the successes of PPH in getting people to try things they might not have otherwise considered, initiatives such as “free trial” schemes should be pursued.

Research and evaluation

There is a need for further research in the community at large, focusing on people's awareness of services and activities, and their views on what could be provided in future.

We would suggest that a variety of research methods and ways of approaching potential participants should be employed. These could include:

Individual stories of involvement in community-based activities

Research with individuals over an extended period of time exploring how involvement impacts on their wider lives would give further insight into the value of community-based activities.

User involvement in research and evaluation

We would recommend stronger user involvement in research and evaluation processes as a whole in order to access hard to reach sectors of the community. This could be by involving users in project design from the start, through consultative groups; community researchers could be trained and employed, with appropriate professional supervision.

Reference

King, N. (2004) "Using templates in the thematic analysis of text", in Cassell, C. and Symon, G. (Eds.) *Essential Guide to Qualitative Methods in Organizational Research*, London: Sage Publications.

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INTRODUCTION

In 1999 the UK government published a white paper, "Saving Lives: Our Healthier Nation". Its twin aims were to:

- improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness;
- improve the health of the worst off in society and to narrow the health gap.

(DoH, 1999).

The white paper was the government's first comprehensive plan to tackle the major health threats facing the UK population, including cancer, coronary heart disease, stroke and mental illness. It marked a reorientation of the NHS towards the local delivery of health care and for Primary Care Trusts (PCTs) to have new responsibilities for public health. It also coincided with funds becoming available from the National Lottery's New Opportunities Fund, from which the New Opportunities Programme (NOP) became the body responsible for the development and delivery of the aspects of the new health strategy.

A key initiative in the strategy was the establishment of Healthy Living Centres (HLCs). The central aims of the HLCs were to:

- promote good health in its broadest sense;
- include a range of facilities, such as health screening facilities, dietary advice, smoking cessation, employment, training and skills schemes, parenting classes, exercise classes and child care;
- involve the local community in the planning of the projects.

(DoH, 1999)

As such, there was an emphasis on the involvement of local communities in all aspects of project development and delivery. In total, 350 HLCs have been

established across the UK since 2002, of which Paddock Pathways to Health is one.

Paddock is a suburb of Huddersfield, West Yorkshire. Its growth (and demise) were linked to textile manufacturing, which was a major employer until the 1960s. It was one of the 20% most deprived wards in England (Kirklees Metropolitan Council, 2008). The Paddock Pathways to Health (PPH) project began as a local authority SRB5 bid (under the Huddersfield Healthy Living Initiative) for which Paddock Community Forum (PCF) was the main operational lead. PCF is a voluntary sector organisation run by its members which supports community projects that aim to make Paddock a better place to live and work. The proposals and ideas contained in the Stage 2 Healthy Living Initiative bid were endorsed by the local community using a community consultation tool called Planning for Real.

The Stage 2 bid was forged in partnership with the Huddersfield Healthy Living Initiative, the local PCTs and local council Social Services Department (Kirklees Metropolitan Council) and contained a raft of health initiatives under the banner of Paddock Pathways to Health. These initiatives embraced the HLC's remit to improve health in its broadest sense. Projects therefore ranged from improvements to allotments (and the establishment of a community allotment with raised beds for disabled residents), to podiatry services offered from the heart of the village in the Village Hall, to exercise classes and a craft group which has provided much needed support for isolated elderly residents. The Stage 2 bid was successful and Paddock Pathways to Health began in 2002.

The Paddock Pathways to Health project has, in its five years, sought to encourage improved physical and psychological health, and social functioning, amongst the local community in Paddock. It has supported a wide range of initiatives targeted at specific priority groups (e.g older people, mothers and babies/toddlers, ethnic minorities) as well as the general population of the area.

The Centre for Applied Psychological Research (CAPR) at the University of Huddersfield was commissioned by Paddock Pathways to Health to carry out a series of evaluations of its projects. These include a survey of participants' views of the Tai Chi group, community-based podiatry and physiotherapy services, and an in-depth study of the impact of the allotment renovations on the health and well-being of allotmenters. This report is the final evaluation of the Paddock Pathways to Health programme and represents an examination of all PPH activities and its impact on beneficiaries over a one year period.

OVERVIEW OF THE EVALUATION

This evaluation was in two main parts. The first was a longitudinal audit questionnaire survey examining issues related to involvement in PPH activities and the impact of this on health and well-being. The second was a qualitative study of three specific activity groups supported by PPH, exploring users' experiences and perceptions of their group, the other activities and facilities associated with PPH, and the wider Paddock community. This used focus groups, supplemented by individual interviews with two members from each group. We will present an account of each part separately (i.e. method, findings and discussion), followed by a conclusion section for the evaluation as a whole which will include recommendations for practice and future research.

THE QUESTIONNAIRE SURVEY

AIMS

1. To examine users' reasons for engaging in activities provided through PPH.
2. To examine the impact of involvement in PPH activities on self-rated health and well-being.

METHOD

This part of the evaluation used a longitudinal postal questionnaire, and was carried out between June 2007 and September 2008.

Design

The survey used a longitudinal design, involving three cohorts of PPH users, based on when participants first registered as beneficiaries with PPH. Cohort A registered between April and September 2006, Cohort B between April and September 2007, and Cohort C between April and September 2008. Cohorts A and B received their Time 1 (T1) questionnaires between June and September 2007, and their Time 2 (T2) questionnaires in June 2008. Cohort C only received the T1 questionnaire, between April and September 2008.

The survey was designed in this way to facilitate both longitudinal and cross-sectional comparisons, in order to effectively address Aim 2. This enabled us to look at whether people's health and well-being improved over a year after joining PPH, and also whether those who had been members for a year were doing better than those who had just joined.

Table 1: When beneficiaries joined PPH and data collection dates for each cohort.

Cohort	Date joined PPH	Time 1 (T1) questionnaire sent	Time 2 (T2) questionnaire sent
A	April – Sept 2006 ¹	October 2007	June 2008
B	April – Sept 2007	June – Sept 2007	April – Sept 2008
C	April – Sept 2008	Sept 2008	

Questionnaires

The questionnaires were in two parts. Part 1 included demographic information, and questions related to participants' involvement in PPH activities. Part 2 included standardised measures of health and well-being. The Time 2 questionnaires for Cohorts A and B differed in some of the questions used in part 1, while part 2 remained the same in both versions.

Part 1 at Time 1 (T1) included the following questions:

- What activity did you join PPH to do?

- How did you first find out about this PPH activity?

¹ Note **six** participants gave a start date on their questionnaire earlier than April 2006. We decided to take the PPH record as definitive for our purposes.

- Is there anywhere else you could have got involved with this activity? If yes, why did you choose PPH?
- Are there any other activities that you have taken part in over the last year (Cohort A)/that you plan to take part in over the coming year (Cohort B)? If yes, please list.

At T2, participants were asked to reflect on their involvement in activities over the last year and answer the following questions:

- Do you have any suggestions for how services could be improved?
- Has your involvement in PPH activities made you feel more positive about living in the area?
-

They were also asked whether they would be interested in hearing more about a range of potential activities for the future, relating to food and health, families, and the environment.

Part 2 used four scales from the Rand SF36 instrument² – a widely used set of scales measuring health and well-being. We selected the scales that were most pertinent to a wide range of PPH activities, namely:

- General health
- Health change³
- Energy/fatigue
- Social functioning
- Emotional well-being

² http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html

³ i.e. Whether and in what direction they feel their health has changed over the previous year

Copies of both T1 and T2 versions of the questionnaire are included in Appendix 1.

In addition to the questionnaire data, we were able to access information on attendance frequencies for Cohorts A and B during the six months prior to the end of T2 data collection (i.e. April to September 2008).

Sample and recruitment

In our data collection periods, we sought to sample all new members of PPH, indicated by the provision of a beneficiary number. To encourage participation, PPH offered entry to a prize draw for everyone who returned a questionnaire in each of the two data collection periods.

For Cohort A, all members who had received a beneficiary number between April 1st and September 30th 2006 were identified from PPH records by a member of their staff, and they were sent a copy of the questionnaire, an information sheet about the survey (see Appendix 2) and a pre-paid return envelope.

Questionnaires were sent out in October 2007. A reminder letter and fresh copies of the questionnaire and information sheet were sent to non-respondents.

For Cohort B, recruitment was a little more complex. We began the study in June 2007, but decided that we would include new beneficiaries from April of that year, to maximise respondent numbers; April and May 2007 joiners were therefore recruited by post in the same manner as Cohort A. For June to September joiners, our initial strategy was to ask PPH reception staff to hand questionnaire packs to all new beneficiaries in this period. However, within about a month it became apparent that for whatever reason, some new beneficiaries may not have been receiving the packs. We therefore reverted to postal recruitment for the rest of the period. Questionnaires were sent out in batches approximately at

the end of each month. Non-respondents were sent one reminder letter along with an extra copy of the questionnaire and information sheet.

Cohort C was recruited solely by post, again with questionnaires sent in approximately monthly batches between April and September 2008. Because of time constraints on the evaluation, reminder letters were not sent to Cohort C.

Respondent numbers and response rates for all three cohorts are shown in Table 2 below.

Table 2: Respondent numbers and response rates from all three cohorts.

	Number of questionnaires distributed Time 1	Number of returns Time 1 (% response rate)	Number of questionnaires distributed Time 2	Number of returns Time 2 (% response rate)
Cohort A	268	43 (16%)	43	19 (44%)
Cohort B	179	48 (27%)	48	25 (52%)
Cohort C	182	46 (25%)	n/a	n/a
Total	629	137 (22%)	91	44 (48%)

As can be seen, the response rate for Cohort A (who were recruited retrospectively at Time 1) is considerably lower than that of the other two cohorts.

Hypotheses for part 2 of the questionnaire

If involvement in PPH activities impacted positively on health and well-being, we would expect Cohort A and B participants at T2 to score more positively than they did at T1.

Hypothesis 1

Cohorts A and B will score significantly higher on the health and well-being variables at T2 than at T1.

We would also expect that those who had been with PPH for approximately a year would score higher than those who had just joined. In effect the new joiners act as a control group for the established members. Therefore we would predict that Cohort B participants at T2 (i.e. already members since the previous year) would score higher than the newly-joined Cohort C participants.

Hypothesis 2

Cohort B at T2 will score significantly higher than Cohort C on the health and well-being variables.

However, for this to be a valid comparison we would need to show that Cohort B at Time 1 did not differ significantly from Cohort C on the SF36 scales – otherwise differences with B at T2 might just reflect the fact that Cohort B had better health and well-being all along. Similarly, we would want to show that the two cohorts did not differ substantially in age, gender and ethnicity profiles, or the activities in which they took part.

Analysis

All numerical data were entered into the statistical package SPSS for analysis. The free response items in part 1 of the questionnaire were analysed using a simple content analysis to reveal the main categories of response to each. Where appropriate, chi-square statistics were calculated to examine whether comparisons of responses revealed significant differences – for instance, were older people more likely than younger people to feel that their views of Paddock had become more positive through involvement in PPH activities?

As well as the longitudinal comparisons within Cohorts A and B, and the cross-sectional comparisons between Cohorts B and C, we wanted to examine whether there were differences according to the nature of the activities people engaged in

via PPH. Because there were a large number of different activities, some with very few participants in our samples, it was necessary to group these into wider categories: *health/conventional*, *alternative/complimentary health*, and *interests and hobbies*.

Regarding the data on attendance at PPH activities and services, we did not formulate specific hypotheses as to how this might impact on the health and well-being variables. This was because it was not clear what direction of relationship we would expect to see. On the one hand, if people benefit from involvement in PPH activities, we might expect higher attendance to be positively related to health and well-being outcomes. On the other hand, where people are attending activities or services because of health-related problems, we might expect those who have more serious and persistent problems to attend more often and also to exhibit less positive health and well-being status, than those who problems are less serious and/or persistent. That would therefore lead to a negative relationship between attendance frequencies and SF36 scale scores. We therefore took an exploratory approach to examining how these variables were related (if at all),

FINDINGS

Demographics and cohort characteristics

We will examine the findings from the two parts of the questionnaire in turn. Before this, though, we present in Table 3 the demographic data (age, sex and ethnicity) for each cohort at each time period. Table 4 shows activity types and table 5 shows the place of residence (by postcode) for each cohort at each time period.

Table 3: Demographic characteristics of each cohort.

	Age		Gender		Ethnicity	Total N
	Mean	Range	Male	Female		
Cohort A Time 1	52	27-87	16	27	White-English 29 All others 7 Missing/not declared 7	43
Cohort A Time 2	62	34-87	9	10	White-English 16 All others 3	19
Cohort B Time 1	49	14-90	9	39	White-English 30 All others 9 Missing/not declared 9	48
Cohort B Time 2	56	14-90	6	19	White-British 19 All others 6	25
Cohort C	46	19-86	5	41	White-British 41 All others 3 Missing/not declared 2	46
All Time 1	49	14-90	30 (22%)	107 (78%)	White-British 100 (84% - excluding missing data) All others 19 (16% - excluding missing data) Missing/not declared 18	
Overall Paddock Beneficiary data	46	7mths – 105 yrs	2,144 (30%)	922 (70%)	White-British 2,452 (80%) All others 614 (20%)	

At both times, Cohort A has a higher mean age and a much higher proportion of male participants than the other two cohorts. Comparing all time 1 data with PPH monitoring data for all beneficiaries at 31st December 2008, our sample can be seen to be reasonable representative in terms of age, gender and ethnicity.

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