

fit *as a* fiddle

Delivering physical activity for older disabled people





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Foreword

This guide has been written by the English Federation of Disability Sport (EFDS) based on experience from its well-established Inclusive Fitness Initiative (IFI) programme.¹

The IFI programme supports the leisure industry to become accessible to disabled people and encourage more disabled people to take part in physical activity.

Recommendations and good practice are supported by learning and project outcomes of Age UK Fit as a Fiddle, which champions physical activity, healthy-eating and wellbeing programmes for older people.



1 Background and context

Active ageing is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age. It applies to both individuals and population groups.

Active Ageing: A policy framework,
World Health Organization, 2002

1.1 Introduction and aims of guide

Physical inactivity is now thought to be the leading cause of preventable deaths. Doing as little as 15 minutes of physical activity a day can add three years to your life and will improve the quality of life and independent living for longer in older populations.²

Physical activity lowers risk of heart disease, stroke and most cancers. It can prevent and treat high blood pressure, high cholesterol and diabetes. It reduces the risk of Alzheimer's, depression and improves cognitive function and memory. So why aren't we all doing it?

Encouraging and providing physical activity opportunities for older disabled populations has considerable benefits including better health, improved quality of life, independence and sense of wellbeing as well as wider social benefits.

This guide presents information, recommendations and examples of good practice to support practitioners in providing opportunities for older disabled people to participate in, and benefit from, physical activity within their local communities.

1.2 Disability and ageing

'Disability is the loss or limitation of opportunities that prevents people who have impairments from taking part in the normal life of a community on an equal level with others due to physical or social barriers.'³

Official figures suggest that there are over 10 million disabled people in the UK who represent 17 per cent of the overall population.⁴ However, it is difficult to determine the true number of disabled people due to different definitions including or excluding long-term illness and lack of willingness on the part of some individuals to confirm or perhaps consider themselves disabled. Only 44 per cent of people who had rights under the Disability Discrimination Act (DDA) in 2008 considered themselves to be disabled.⁵ Furthermore, it was estimated in 2009 that there were 15.4 million people living with a long-term health condition in England alone⁶ and estimated that there were 9 million deaf or hearing-impaired people,⁷ 1.2 million adults with a learning disability,⁸ 8.5 million with arthritis,⁹ and 10 million with a neurological condition,¹⁰ within which many older people will be included.

Thirty per cent of 50–64-year-olds have an impairment, increasing to 78 per cent of people aged 85 years and over. In addition, and as a consequence of their impairment, it is common for disabled adults to acquire multiple impairments – for example, 60 per cent of the 400,000 wheelchair users in the UK will be affected by cardiovascular diseases¹¹ due to inactivity. With an ageing population estimated to be over 15 million people by 2040 and the fact that impairment is strongly related to age (only 17 per cent of disabled people are born with an impairment),¹² it is therefore essential to ensure that older people are encouraged to be more physically active to manage their disability/condition and continue living independently for as long as possible.¹³

1.3 Legislation

The Equality Act 2010, which replaced the DDA, defines a disabled person as someone with a ‘physical or mental impairment which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities’.¹⁴ The Act encompasses legislation for non-discrimination within the provision of goods, facilities and services for disabled people along with other protected characteristics, making it unlawful for service providers to treat disabled people less favourably because of their disability. From 1 October 2012 it will also be ‘unlawful to discriminate on the basis of age unless the practice is covered by an exception from the ban, or good reason can be shown for the differential treatment (‘objective justification’)’.¹⁵

The Equality Act wholly legislates for an equal society by recognising that we do not all have the same needs: ‘An equal society recognises people’s different needs, situations and goals and removes the barriers that limit what people can do and can be.’¹⁶ Therefore it states that ‘reasonable adjustments’ must be made accordingly to allow equitable service provision and access to buildings. Regardless of duty and legislation, purely based on the statistics detailed above, it is good practice to include both the ageing and disabled populations.

In addition to the Equality Act, the Equality Delivery System and Public Sector Equality Duty also both tackle inequalities and discrimination. They include both older and disabled people in service provision within healthcare and require public bodies to consider all individuals when carrying out their day-to-day work.¹⁷

1.4 Lifestyle choices

At the beginning of 2012 the Department of Health established the Public Health Responsibility Deal,¹⁸ recognising that too many people eat and drink too much and don’t do enough physical activity. The Deal aims to encourage businesses and other influential organisations to make a significant contribution to improving public health by making collective pledges covering alcohol, food, health at work and physical activity.

The Department of Health within the Physical Activity – Inclusion strand pledge to ‘tackle the barriers to participation in physical activity faced by some of the most inactive groups in society’ of which age and disability are two. Pledges include practical solutions to tackle barriers to participation in physical activity through tailored promotion and delivery of sport and physical activity opportunities.¹⁹

The economic cost of physical inactivity documented in DCMS/Strategy Unit’s (2002) report, *Game Plan*, was estimated at £1.89 billion a year affecting the NHS, absenteeism at work and cost of premature deaths.²⁰ With increasing financial strains on the NHS, the Deal wants to create an environment that empowers and supports people into making informed, balanced lifestyle choices that will help them lead healthier lives. According to Andrew Lansley CBE MP, Secretary of State for Health: ‘Public health is everyone’s responsibility.’

It is now being readily recognised that a doctor’s role should include guiding, support, education and prescribing of exercise as an intervention for people with long-term medical conditions and as a preventative measure.²¹ Regional Health and Wellbeing Boards were set for 2012 to engage a wide variety of healthcare providers as a wider partnership approach on a local level, replacing Primary Care Trusts, to ensure that from a grassroots level the services provided are relevant for the local community, acknowledging that one size does not fit all throughout the healthcare system.

1.5 Participation levels

Scottish Research in 2006 into sport, exercise and physical activity, found that the number of people participating in physical activity was not significantly different in demographic age groups between 25 and 74 years, being within 32–38 per cent taking physical activity for 30 minutes most days. This is probably indicative of the amount of free/leisure time that retirees have over the working-age population and those bringing up families. However, there is a significant decline after 75 years of age with only 8 per cent of men and 3 per cent of women participating in physical activity at the recommended levels.²²

Based on data from Active People Survey 5,²³ 18 per cent of disabled adults participated in sport or physical activity once a week, an increase in participation from when monitoring first began in 2007. However, as disabled people get older, participation reduces, with only 7 per cent of people aged over 65 years taking part. Further statistics state that only a minority of the UK population achieve recommended levels of physical activity and that levels have declined in recent years.²⁴ If people are not motivated to take part in sport and physical activity by the time they reach older age then changing their lifestyle is going to be harder. Education, choice and inclusion are all required to affect change in older people's lifestyles.

1.6 The benefits of physical activity

Having highlighted the costs of inactivity on society, the greatest benefit of participating in physical activity is for individuals who are currently inactive. Currently only 7 per cent of disabled people participate in sufficient physical activity for disease prevention.²⁵ It could be argued that disabled people need to exercise more than non-disabled people. James Rimmer noted that when physically impaired adults move into middle and later adulthood they have additional physical and psychological barriers associated with secondary impairments, but that through physical activity health, lifespan and function increases.²⁶

As a whole, the main benefits in encouraging and providing physical activity opportunities for older disabled populations are:

- better health (condition management and/or prevention of acquiring health conditions)
- enhanced mobility and balance for falls' prevention
- improved quality of life
- continued function and independent living
- weight management
- social interaction and improved mental health and sense of wellbeing.

It is recommended that physical activity for older people includes both cardiovascular/aerobic and muscle-strengthening activities. General types of activity as part of leisure time pursuits include walking, dancing, gardening, hiking and swimming, as well as everyday living activities such as household chores, walking to the shops and activities with family and friends.

In order to improve cardiorespiratory and muscular fitness, bone and functional health, reduce the risk of non-communicable diseases (such as heart disease, stroke, cancers and diabetes), depression and cognitive decline, it is recommended that older adults (65 years and over) should do:

- at least 150 minutes of moderate-intensity aerobic physical activity throughout the week
- or
- at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week
- or
- an equivalent combination of moderate- and vigorous-intensity activity.²⁷

Moderate and vigorous intensity are defined by the Department of Health Physical Activity Guidelines as:

Moderate-intensity aerobic activity means working hard enough to raise heart rate and break a sweat. One way to tell if participants are working at a moderate intensity is if they can still talk but can't sing the words to a song.

Vigorous-intensity aerobic activity means breathing hard and fast, with an increased heart rate. When working at this level, participants won't be able to say more than a few words without pausing for a breath.

The level of working to the intensity of these definitions is subjective in terms of one's individual ability. Advocating starting slowly and acknowledging that something is better than nothing is good practice when supporting older disabled people who are new to, or anxious about, participating in physical activity. It is advisable to carry out pre-exercise screening and a health commitment statement with clients before starting any physical activity programme.

See www.fia.org.uk for further guidance.

1.7 Barriers to engagement

Despite research and statistics clearly showing that physical activity lowers the risk of acquiring impairments and medical conditions with ageing, there are still barriers to participation that need to be addressed when engaging with older disabled adults. These include transport, location, social isolation, finance, psychological issues (lack of interest/awareness, motivation or self-esteem) and lack of suitable provision in terms of venues and equipment.

Barriers to participation can be categorised into three areas: physical, logistical and psychological.



Physical barriers <ul style="list-style-type: none"> • Facility • Equipment • Health and safety 	Logistical barriers <ul style="list-style-type: none"> • Geography • Expense • Support of others • Communication • Suitability 	Psychological barriers <ul style="list-style-type: none"> • Personal perceptions • Attitudes of others
<ul style="list-style-type: none"> • Lack of choice and activities for older disabled people to participate in • Inaccessible buildings and locations • Equipment is not accessible • Service provision does not represent the community's needs 	<ul style="list-style-type: none"> • Practitioners are not disability-aware or do not instil confidence • Cost of activities is prohibitive • No older disabled role models represented • No transport to the facility nor accessible transport available • Disabled older adults may need educating about the benefits of physical activity • Reliant on carer, family or friend • Family and friends are not active either nor enthusiastic • Lack of empathy of staff and/or other participants 	<ul style="list-style-type: none"> • Lack of association with health and fitness • Perceptions that exercise is not for them • Lack of confidence • Do not identify as a disabled person • Worried about negative effects of exercise and concerned for safety • Socially isolated, loss of partner, friends • Have had previous bad experience



2 Recommendations in overcoming barriers to engagement

‘Exercise is good for you – and I try to make sure that other people know about it!’

Female participant, aged 62, IFI site, East Midlands

The following recommendations have been identified through experience from Fit as a Fiddle and Inclusive Fitness Initiative good practice and learning, focusing on overcoming/removing some of the main barriers to participation among disabled older people.

2.1 Terminology and perceptions

Everyone, whether disabled or not, forms their own identity based on many things. Psychological barriers can exist from both the practitioner and the older disabled person’s perspective in terms of their identity and how they relate to one another. An older person may not identify him/herself as a disabled person yet self-identification in the pursuit of inclusion may be the only accurate measure. It is best to work with the principle to ask rather than assume.

Health and social service provision tended to see disability as insurmountable and disabled people were limited by their medical condition. However, over the last few decades, the social model of disability has formed the foundation for disability equality and seeks to provide an environment for disabled people where barriers to participating fully in everyday life are removed. The social model of disability puts the onus of inclusion onto society rather than the impairment/ medical condition being the definition or limitation of the person.

We advocate the social model, which classifies barriers as a socially created problem. However, the bio-psychosocial model is the middle ground, integrating and considering both the extrinsic and intrinsic barriers of how disability makes people, or individuals, feel and how they are affected by society from the perspective of health encompassing biological, individual and social factors.²⁸

Recommendations and tips

When communicating with older disabled people use appropriate language (refer to section 4, ‘Further information and useful resources’ (page 22), and impairment-specific organisations for further advice), describe the activity, give instructions clearly in simple terms and demonstrate the movements.

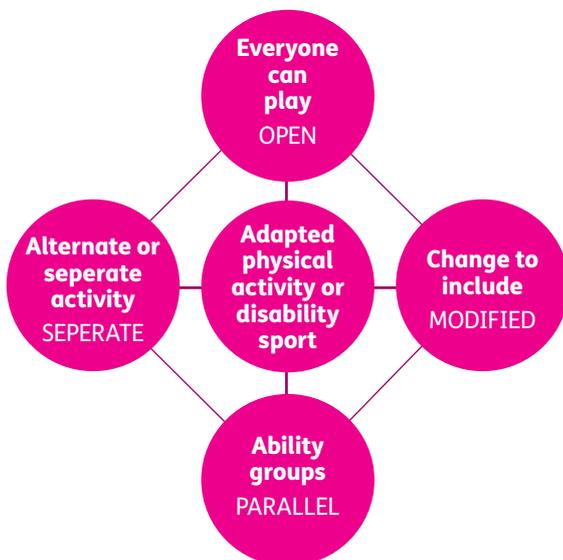
Inappropriate	Appropriate
1 The disabled, people with disabilities, invalid, handicapped 2 Stroke victim, suffers from... 3 Wheelchair-bound, confined to a wheelchair 4 The blind or the deaf 5 Mental or mentally ill	1 Disabled people 2 Living with or has (name of medical condition) 3 Wheelchair user 4 Partially sighted or partially hearing. Visually or hearing impaired, deaf, blind 5 Mental health condition the benefits of physical activity

2.2 Offering the right activities

Design and delivery of physical activity interventions need to consider inclusion and provide choice for individual older disabled people in different settings that suit them. Provision should reflect that of personalisation – person-centric planning, which consults with, and meets the needs of, the local community.

The inclusion spectrum, incorporating STEP (Space, Task, Equipment, People), can be used by practitioners to adapt and modify activities to enable the widest possible participation.

The Inclusion Spectrum Framework



STEP

Source: P. Stevenson and K. Black,
The Inclusion Spectrum Framework, 2011

Everyone can play (open) activity: naturally inclusive activities based on what everyone can do with little or no modifications:

- people find the level of participation that suits them; for example, swimming at open sessions in the local pool
- physical activity that occurs as part of daily living, such as walking to the shops.

Change to include (modified) activity:

where changes are made to the activity in order to support inclusion and are adapted to provide both support and challenge across a range of different abilities. The STEP model (space, task, equipment and people) can be used to provide a structure for adapting and modifying the activities (see the STEP examples below).

Ability group (parallel) activity: where people participate with others according to similar ability – this can be versions of the same activity, but at a level that suits the individuals in each group; for example:

- chair-based aerobics for some individuals; standing for those who are more mobile.

Alternate or separate activity: where people develop skills independently before integrating into a group setting; working temporarily on specific skills leading to more successful inclusion. Sometimes, in order to include someone more effectively, they need to practise separately first. Note: this should not be most of the time.

Adapted physical activity and disability sport activity: where aspects of adapted physical activity programmes provide a basis for participation, introducing activities designed with disabled people in mind to everyone in an activity club or group – ‘reverse integration’. For example:

- disabled people can teach their non-disabled peers an activity, such as boccia (bocce)
- participants can look at the traditional version of a sport, for example, volleyball, and play the disability sport version, in this case, sitting volleyball (on chairs or on the floor).

Note: When applying the Inclusion Spectrum model to practical situations, there will always be some individuals who will require an individualised approach.

Recommendations and tips

When planning activities, consider the participants and how you can adapt the activity to include people with all abilities using the STEP tool.

Changes in the way the activity is delivered can be made in one or more of the STEP areas (Space, Task, Equipment, People).

See the examples below for some ideas. However, use the STEP tool to structure and organise your own ideas.

Space – the way that the space is used

Examples:

- increase or decrease the size of the playing area; for example, in a target activity, such as bowls, place the target nearer or further from the bowler depending on ability
- vary the distance to be covered in activities to suit different abilities; for example, when a countryside ramble is organised, include routes of different distances to accommodate walkers who have a range of mobility.

Task – the way that the activity is performed

Examples:

- ensure that everyone has equal opportunity to participate; for example, in any game or exercise activity, make sure that everyone has the opportunity to take part:
 - enable different people to start any activity
 - have different people lead the activity
 - vary roles in a game or activity so that everyone gets to participate in a range of ways
- break down complex skills into smaller component parts to help people to develop skills more easily
- ensure that there is adequate opportunity for players to practise skills or components either individually or with a partner before including them in a group activity or game; this helps to avoid feelings of inadequacy and can help practitioners assess ability.

Equipment – varying the equipment used to suit different abilities

Examples:

- increase or decrease the size or weight of equipment to suit the ability of the participants or the kind of skill being practised; for example, some people may find it easier to throw a small ball but find a bigger ball easier to catch
- provide options that enable people to send or receive a ball in different ways; for example, in a bowls, tenpin bowling or similar game, using a chute or gutter to roll the ball down can help some participants (note that most tenpin bowling centres have these devices)
- the use of balls or other equipment that have bells or rattles can assist the inclusion of some players, for example, those who have a vision impairment
- adapt household or other available items to assist exercise or activity; for example, use small plastic water bottles as hand-weights (dumbbells); the amount of water can be varied to increase or decrease the weight.

People – ways in which the participants can be organised to promote inclusion

Examples:

- match participants of similar ability in activities to support more involvement
- where appropriate, organise people in inward-facing circles to promote social interaction
- social exercise is infectious and motivational; for example, dancing and moving to music.

For more exercise and activity ideas for older disabled people check out the THENAPA2 website www.thenapa2.org²⁹

2.3 Local community networks and partnership development

The most successful Fit as a Fiddle projects are those that have joined up with partners within the local community. These then become embedded within the community and create sustainability. Consultation can be carried out with locally relevant agencies, including local healthcare trusts, local authorities, sport development through County Sports Partnerships (CSPs), local disability and disability sport groups to develop partnership working and ensure that resources and provision work effectively. There will be overlap in provision from each and strongly forged partnerships and links will ensure that there is no duplication of effort.

Recommendations and tips

- Contact your local sports development team through the local authority website.
- Link into your local CSPs, a network of local agencies committed to working together, to increase participation in sport and physical activity. Partners include national governing bodies of sport and their clubs, school sport partnerships, local authorities, sport and leisure facilities, primary care: www.cspnetwork.org
- Find an Inclusive Fitness Initiative gym/sports facility: www.efds.co.uk/inclusive_fitness/ifi_gyms
- English Federation of Disability Sport (EFDS) signposts to numerous participation opportunities and programmes: www.efds.co.uk
- Find an inclusive sports club to participate recreationally or competitively: www.parasport.org.uk
- Find out more about Age UK Fit as a Fiddle programmes: www.ageuk.org.uk/health-wellbeing/fit-as-a-fiddle

- Find out about local healthcare provision can be found at: www.nhs.uk/Pages/HomePage.aspx
- Find out about existing activities, events and services for disabled people in your area: www.dotcommunity.co.uk

2.4 Accessibility of the activity

Access to service provision should not only cover physical access to the premises where the activity takes place but also bear in mind location and transport available to the facility. Since 2004 it has been unlawful for public-sector service providers to discriminate by having inaccessible buildings. Most new buildings will be accessible having been built to current building standards,³⁰ whereas older community and listed buildings may be exempt according to what's 'reasonable'.³¹ Consider health and safety and carry out a risk assessment according to different impairments and how disabled people will be able to evacuate the building in case of an emergency.

Recommendations and tips

- When choosing a venue to host activities, ensure that it is accessible for older disabled adults.
- Consider the whole customer journey; getting to the venue, parking, the entrance/reception, changing rooms, toilets and café area.
- To ensure the quality of the experience for your participants check ahead; phone and/or visit the facility, visit www.directenquiries.com or www.efds.co.uk/inclusive_fitness

2.5 Adapting equipment

Consideration should be given to ensuring that any equipment required for the activity is adapted to meet the needs of older disabled people with different impairments. For example, ensure there are colour-contrasted equipment, balls with bells inside for people with visual impairments, a hearing induction loop for people with a hearing impairment, and simplifying instructions for those with a learning disability. In an exercise class, for example, there should be additional chairs so that seating is readily available to anyone who may need a rest during the session.

Recommendations and tips

Adapt equipment to be colour-contrasting and tactile where possible. These changes can be completed at low cost with high-visibility tape or dots. There is already a lot of good practice within IFI Mark gyms, where equipment is accessible to many disabled people, for example, there may be hoists for access to swimming pools. Again it is best to check this availability before using the venue.

Other suggestions

(See also the STEP equipment ideas above.)

- Use household articles and other common items as exercise and activity aids. For example, after washing dishes, squeeze the dishcloth dry several times using a wringing action of the hands; or, when in the bath or shower, squeeze water out of a sponge alternately with either hand.
- In a bowls or bowling game, use a chute or gutter to roll the ball; a section of plastic gutter (available in a DIY store) can be modified for this purpose.
- Simple games can be played with little or no equipment or even just going for a walk (try to choose a circular route).

2.6 Marketing and promotion

Signposting and ensuring that marketing of the activities is inclusive and accessible to the target market is essential. Marketing is driven by customer need therefore it is essential to carry out research within the local community to establish what services older disabled people want to receive as well as existing provision among local groups that already support them. Ensure that marketing literature is relevant and accessible both visually and/or verbally to the target group. The RNIB have an excellent resource called *See it Right* about accessible communication.³²

Word of mouth is an essential marketing tool to attract people to use your service. So if your clients enjoy attending your activities then they'll spread the positive message and tell other people about them and if they don't, they'll let them know also.

Some local authority exercise programmes actively encourage older disabled people to act as advocates, for example, visiting stroke clubs and other groups to promote fitness programmes for older people.³³

Recommendations and tips

- When developing marketing material, start by getting to know your customer. Resources and other collateral should not be produced without knowing the market segment you are targeting.
- To promote your activity, ensure that it is in a large clear font (refer to *See it Right*), use inclusive imagery representing the target audience and provide contact details for email, telephone and textphone to ensure that communication is inclusive.
- Promote in your local Age UK shops or offices, and utilise your Information and Advice service to make people aware of the activities.
- Inclusive marketing is about making disabled people feel inspired that a service or product is relevant and/or accessible to them.

- You may need more persuasion to get older disabled people to use your services so try open days, taster sessions and visiting them in their environment (within a care or residential home).
- Look at ways of taking the exercise programme to potential end users in their own environment if transport or staff support initially precludes travel to a community facility.
- Use current exercisers to advocate and recruit others.

2.7 Staff training and awareness

Physical access is merely a part of being active for disabled people. The whole experience of physical activity has to be accessible – including customer service. It is therefore important for staff to receive disability awareness training so that they are confident in providing an inclusive experience to older disabled people. The value of staff training and workforce development should never be underestimated. If staff attitude and culture are not inclusive then this will prevent many users from getting much further than just an enquiry.

Recommendations and tips

- Disability equality training will give practitioners a broad understanding of disability, how to communicate terminology, etiquette, legislation, barriers and solutions to participation. EFDS currently deliver Disability Equality Training courses specifically for sport and physical activity and will be launching an online training course in the near future. See www.efds.co.uk/resources/training for further details.
- Depending on the client group it may also be necessary to take some impairment specific training and allow basic communication; deaf-blind alphabet, basic British Sign Language (see section 4, on pages 22-23, for impairment-specific organisations). Be aware that if deaf people lip-read, you should ensure that you don't stand with a light behind you and that you speak slowly and clearly.

- Policies should also be in place in relation to guide dogs so that staff are aware of what to do if a client brings one to the session.

2.8 Volunteers

Volunteers are particularly important if disabled older people have not participated in sport or physical activity before; they may be difficult to engage because they will not recognise themselves or associate themselves with physical activity and health. It is therefore vitally important within the service provision that there are role models and motivators to whom older disabled people can relate.

Attending gyms and exercising can be intimidating for anyone and this, linked with a potential lack of confidence and knowledge about physical activity, could create a greater social and psychological barrier to participation. By receiving additional support and reassurance from volunteers or 'buddies', older disabled people are more likely to feel comfortable in their surroundings and build their confidence within this unknown environment.

Recommendations and tips

- Identify an older person (or several) within the group who has an interest in sport and physical activity and may be persuaded to run the sessions or act as a buddy to less confident members of the group.
- Your Age UK volunteers may wish to support the disabled older people or you may wish to recruit for new volunteers for this service in particular through your local volunteer centre or sports college. Visit www.do-it.org.uk to register volunteering opportunities.
- Don't always assume that older people want buddies of the same age. Many older exercisers like to be around young people, so younger, responsible buddies can be recruited.



2.9 Motivations

The benefits of physical activity outlined in section 1.5 (page 5) form the basis of most people's motivations towards taking exercise. Motivational barriers for older disabled people are generally greater because of inaccessibility, poor health or pain when exercising, rather than the usual lack of time that exists for the working-age population. There are many excuses for not participating and more persuasion may be required. Health can in itself be a barrier to being healthy whether this is perceived or a reality.

June Isaacson Kailes asks the question in her research 'Can disability, chronic conditions, health and wellness coexist?',³⁴ and concludes that most disabled people are not sick. Personal health for older disabled adults is often seen as something that they have little or no control over, which creates a 'learned helplessness'. She goes on to say the following:

'Providers who understand that disabled people can be healthy, active, and assertive participants and co-managers of their health and health care, can be of tremendous assistance in helping people select and practice tailored health promotion behaviors and activities directed at increasing a person's level of wellbeing. Physical exercise, good nutrition, stress-management and social support are important for everyone, but they are actually more critical for disabled people.'

However, motivations for exercise will differ. Reasons such as losing weight, stress relief and staying toned become less important and older disabled adults are more likely to take part in physical activity to enjoy the social aspects of group activities, to improve their general health and because it helps their impairment.³⁵

In a study of older disabled users of IFI sites in the East Midlands in 2006, Ken Black found that the number one factor that motivated older people to begin, and then sustain, exercise, was health, followed by enjoyment of exercise and social aspects.³⁶

If older disabled people are currently inactive and have been sedentary for a length of time, or perhaps physical activity has never been part of their routine, then behaviour change needs to be instilled to overcome psychological barriers and create a habit of exercise as an important part of their lifestyle. An attitudinal change will be required to create a positive experience, making physical activity accessible, enjoyable and part of everyday life.

Recommendations and tips

- Research and consider motivations within the local community and target group and tailor the activity to ensure that the audience's reasons to exercise are met.
- Consider attitudinal barriers – for those that are sedentary it is essential to make activity part of daily life activity and routine.
- Make sure that the activity is varied, fun and enjoyable!



3 Good practice case studies

'People don't believe I'm 83!'

Walter, user, Pioneer Health Club, Bacup

This section of the resource focuses on good practice highlighted through Fit as a Fiddle programmes and Inclusive Fitness Initiative case studies where internal and external barriers to engagement have been addressed to create inclusive environments for older disabled people to participate in physical activity.

Walter

Walter, 83, was prescribed exercise by his doctor as part of a local GP referral scheme years ago to manage his osteoarthritis and general health. Since his referral Walter now visits his local IFI Mark gym three times a week.

This independent privately owned gym acquired the IFI Mark in 2010 by designing a fully accessible facility, which included, among other adaptations, accessible parking bays and changing facilities, automatic doors and doors wide enough to comfortably accommodate wheelchair users. They purchased IFI accredited fitness equipment accessible to disabled people, which was positioned to allow enough room for people to transfer easily, with a separate smaller gym for new members who feel intimidated training in the main gym. Frontline staff were trained in disability equality, personal trainers at YMCA fit Level 3 Exercise and Disability and market the service to older adults within the local community.

Walter is the oldest gym member at the health club and thoroughly enjoys his gym training sessions. All the staff know Walter and make him feel welcome at the facility. The gym instructors take an interest in Walter's wellbeing and progress at the gym and review his exercise programme on a regular basis.

The rewards for Walter are that he feels healthier and lighter and is able to participate in ballroom dancing, which is another activity he enjoys. His joints are more flexible and less painful. Walter uses physical activity not only to manage his condition but to enjoy a very active social life, provided by the broad choice of inclusive activity within the local community – gym, bowls and ballroom dancing.

This health and fitness club recognised the demographics of their local community and the potential to provide a service to older people. When moving premises they designed the gym with accessibility in mind and promoted their facility at the local GP surgeries, care homes, opticians and mobility shops.



Harry

Harry attends the Chronic Obstructive Pulmonary Disease (COPD) sessions that are delivered at his local community centre. The project was designed and delivered through Fit as a Fiddle funding. When developing the activities, the Fit as a Fiddle project officer visited three COPD rehabilitation clinics in the local areas to assess and plan suitable provision for COPD patients. Group sessions for COPD patients were developed to be progressive from seated exercise, standing and the more cardiovascular sessions, and a local community venue chosen that was central among the catchment area of the three clinics with good transport links.

‘Some of our referrals had never been physically active before so we wanted to reassure them. We started off slowly and did a bit at a time. We developed different levels of classes to suit and progressed at the group’s speed.’

The project officer initially provided demonstrations at the clinics to support new referrals to motivate them and make them feel at ease with attending the sessions. The project now sits on the Older People’s Physical Activity and Sports Strategy steering group developing a five-year vision creating sustainability of delivery.

Sheila

Sheila has been registered blind for 20 years and felt that she couldn’t take part in physical activity because of her disability. Sheila received information about a five week Fit as a Fiddle activity session in large print through the RNIB and decided to attend. Sheila immediately showed a keen interest in New Age Kurling and with the extra support of volunteers who provided one-to-one support to participants through additional verbal instruction and demonstrations she was able to participate fully. Because of her positive experience Sheila talked about and introduced the activity to her friends.

Sheila found out about the Fit as a Fiddle sessions through accessible communication and with the support of volunteers at the activities the sessions were inclusive and enabled Sheila to participate fully. The organisers had contacted the RNIB and Deafblind UK for advice and material to support both visually and hearing impaired people attending the sessions.

‘We encourage everyone to take part and adapt the game accordingly to ensure that it’s inclusive and everyone gets a fair go.’

George

George attends a new bowls activity session run in partnership with the local bowling club and the association for blind and partially sighted. The partnership was set up as a social activity to help reduce social isolation for blind and partially sighted members of the association. Some of the members had participated in bowls before they acquired their visual impairment so it was an obvious choice.

Volunteers were recruited from the blind and partially sighted association to provide one-to-one support to meet the individual and varied needs of the participants; describe the rules clearly, describe where the bowls are and support anyone unable to bend down or balance. Fit as a Fiddle initially provided transport for the group and the bowls club provided the instructors and adapted bowling equipment.

‘The club is very successful and the group wanted to carry on taking part so they now pay subs towards transport, hiring the equipment and the instructor – it’s value for money for the fresh air!’



Veronica

Veronica has a learning disability and lives in supported housing with three other older women who also have a learning disability. The local leisure centre hosts free swim sessions for disabled people one day a week. After a few weeks one of the house mates no longer wanted to attend the session and the sole carer couldn’t leave her in the house alone.

When the women didn’t turn up to the sessions the membership advisor at the leisure centre phoned them to see why they hadn’t been attending. On hearing the problem she suggested a local volunteer transport scheme, which, for the cost of mileage, would provide a regular driver to transport them to and from the sessions.

‘Veronica gets a taxi each week to and from the leisure centre to come to our disabled swim session and she now also uses the gym independently with our support. We know to expect her’.

Veronica has a concessionary membership to the facility and she now uses the gym to support her weight-loss goals. Her induction and exercise programme have been adapted to include photographs of the exercises she has to do rather than written instructions that Veronica can’t read. This allows Veronica to do the exercises independently, although there is always a member of gym staff available.

The leisure centre has circulated leaflets and visited the local day care centre to promote their inclusivity and are on www.disabledgo.com, a website for the disabled community to find access to all kinds of services.

Felicity

Felicity, 64, has an impressive sporting background having represented England many times as a cross country runner. After raising children, she started working at the local leisure centre as a receptionist. She soon progressed to the gym, shadowing at first and then becoming qualified as a personal training instructor.

Felicity became integral in leading and planning the expansions of new ideas to develop different exercise classes for the community based at the local authority IFI Mark gym. She instigated partnerships with local health practitioners for Phase 4 cardiac rehabilitation patients against British Association for Cardiac Rehabilitation (BACR) guidelines and a GP Referral Scheme in 2000, which started with one surgery and now receives referrals from five other surgeries and others outside of the local authority.

Felicity soon gained the confidence of the local GPs and progressed to working with two local hospitals who invited the instructors to bespoke courses in cardiac rehabilitation. Felicity gained qualifications in BACR Phase 4 cardiac and stroke rehabilitation. The leisure facility is committed to continuing professional development of its instructors in both exercise prescription and customer service and it has become a centre of excellence. Felicity has experience of prescribing exercise to older disabled adults with many conditions and impairments and quality checks that clients are not being prescribed any exercises that are contraindicative of their conditions.

‘The training we have received as practitioners gave us confidence to develop partnerships with local GP surgeries and hospitals and meant that the classes we provide for older disabled people have gone from strength to strength’.

The leisure centre is committed to being inclusive within its service provision and has ensured that staff who provide exercise prescription and run classes are confident in their own ability through adequate training. All other customer-facing staff throughout the facility have received disability equality training. Subsequently, the centre has been able to develop and deliver a strong GP referral scheme, Strokeability, health walks and chair-based exercise classes for older disabled people depending on their ability or medical condition. The groups meet twice a week for an aerobic-based class session in the studio and aerobic and strength training in the gym.

Clients share experiences with each other about managing their conditions and keeping a healthy lifestyle. The social aspects of the group sessions support quality of life and wellbeing and Felicity has proved to be a great role model.

4 Further information and useful resources

4.1 Disability sport and physical activity organisations

English Federation of Disability Sport:
www.efds.co.uk

Inclusive Fitness Initiative:
www.efds.co.uk/inclusive_fitness

Disability Sport Wales:
www.fds.org.uk

Scottish Disability Sport:
www.scottishdisabilitysport.com

Disability Sport Northern Ireland:
www.dsni.co.uk

Interactive (London):
www.interactive.uk.net

Federation Disability Sports Organisations:
www.fds.org.uk

British Amputee & Les Autres Sports Association:
www.sites.google.com/a/balasa.org.uk/main/Home

Cerebral Palsy Sport: www.cpsport.org

Dwarf Sports Association UK:
www.dsauk.org

Mencap Sport: www.mencap.org.uk/what-we-do/our-services/leisure-and-sport/mencap-sport

Special Olympics GB:
www.specialolympics.org

UK Deaf Sport: www.ukdeafsport.org.uk

WheelPower: www.wheelpower.org.uk

Parasport: www.parasport.org.uk

4.2 Health conditions and physical activity resources

Arthritis Care, *Exercise and Arthritis* – pdf available at:
www.arthritiscare.org.uk

British Heart Foundation, *Physical Activity and Your Heart* – pdf available at: www.bhf.org.uk

Diabetes UK, *Keeping Active* – hardcopy booklet available at: www.diabetes.org.uk

National Osteoporosis Society, *Exercise and Osteoporosis* – pdf available at: www.nos.org.uk

Stroke Association, *Stroke and Exercise* – pdf available at: www.stroke.org.uk

4.3 Older people and physical activity resources

Department of Health, Factsheet 5, *Physical Activity Guidelines for Older Adults (65+ Years)*: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128146.pdf

THENAPA Active Ageing activity cards:
www.thenapa2.org/publications/products/Cards/index.htm

Age Concern, Northern Ireland, *Promoting Physical Activity with Older People, A Resource for Sports Development Teams and Leisure Centres*:
www.sportni.net

National Institute for Health and Clinical Excellence, *Active for Life: Promoting physical activity with older people (guidelines)*: www.nice.org.uk/about/nice/whoweare/aboutthehda/hdapublications/active_for_life_promoting_physical_activity_with_older_people_guidelines.jsp

Bupa, *Exercise for Older People*: Resources: www.bupa.co.uk/individuals/health-information/directory/e/exercise-older-people?intcmp=fitness-exercise%3aexercise-older-people

Age Concern, 2008, *Working with Older People with Learning Disabilities*: www.ageuk.org.uk/documents/en-gb/for-professionals/equality-and-human-rights/16_0208_working_with_older_people_with_learning_disabilities_lessons_from_an_age_concern_pilot_programme_2008_pro.pdf?dtrk=true

Age UK Knowledge Hub: www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true

Age UK Expert Series, *Equalities Guide*: www.ageuk.org.uk/Documents/EN-GB/For-professionals/Equality-and-human-rights/Expert_Guide_Equalities_In_Services_pro.pdf?dtrk=true

British Heart Foundation National Centre for physical activity & health, for information on Active Ageing events, see: www.bhfactive.org.uk/sites/Active-Ageing-Events

British Heart Foundation,
Interpreting Physical Activity Guidelines:

www.bhfactive.org.uk/olderadultsguidelines/index

THENAPA 2 ageing and disability programme, downloadable resources available at: www.thenapa2.org/publications/products/index.htm

4.4 Motivation and behaviour change resources

British Heart Foundation, *How to Engage Inactive Communities in Physical Activity: Top Tips from the BHFNC 8th Annual Conference*: http://archive.oxha.org/knowledge/publications/UK_Inactive_Communities_BHFNC_Top_tips_booklet_final.pdf

Move it or Lose it! – Exercise for life resources: www.moveitorloseit.co.uk

K. Black (2006) 'Motivational Aspects Affecting the Exercise Status of Older Disabled People Participating in the Inclusive Fitness Initiative Programme', in proceedings, 2nd EU Workshop Adapted Physical Activity – A EU workshop, 'The State Art of Assessment of Physical Activity in Elderly People', Oslo University College, 25–26 September 2006

M. Morris and A. Schoo (2004) *Optimizing Exercise and Physical Activity in Older People*, Edinburgh: Butterworth Heinemann

Notes

- 1 The Inclusive Fitness Initiative, established in 2001 by EFDS, is a programme that supports the fitness industry to become more inclusive, catering for the needs of disabled and non-disabled people alike. Through a range of projects and products the initiative has supported facilities across England to create an inclusive service, increasing participation by disabled people. See www.inclusivefitness.org/gettingpeopleactive
- 2 Brian B. Parr (2012) *Exercise Is Medicine*, Aiken Standard: <http://www.aikenstandard.com/story/050712-exercise-is-medicine-parr--3979057#ixzz1v7UueEQV>
- 3 V. Finkelstein and S. French (1993) 'Toward a Psychology of Disability', in J. Swain et al. (eds), *Disabling Barriers – Enabling Environments*, London: Sage, pp. 26, 34
- 4 ODI (2011) 'Disability Prevalence Factsheet' available at: <http://odi.dwp.gov.uk/docs/res/factsheets/disability-prevalence.pdf>
- 5 B. Williams et al. (2008) *Experiences and Expectations of Disabled People*, ODI, prepared by GfK NOP Social Research, Office for Public Management, ppre, Icarus Collective and University of Nottingham
- 6 Department of Health (2009) *Your Health, Your Way – A guide to long term conditions and self care*, London: The Stationery Office
- 7 A. Davis (1995) *Hearing in Adults*, London: Whurr
- 8 Department of Health (2001) *Valuing People: A new strategy for learning disability for the 21st century (White Paper)*, London: Crown Copyright
- 9 YouGov (May 2012) *OANation 2012 Survey*, commissioned by Arthritis Care
- 10 Brain and Spine Foundation: www.brainandspine.org.uk/about_us/neurological.html
- 11 British Association of Cardiac Rehabilitation (2000) *Phase IV Exercise Instructor Training Module*, revised edition
- 12 Labour Market Trends report, April 2005
- 13 www.papworth.org.uk/page.php?s=6687c18bee5293eee5a580f747000190&urlid=summary_statistics
- 14 Equality Act (2010) <http://homeoffice.gov.uk/equalities/equality-act>
- 15 Home Office (2010) Equality Act www.homeoffice.gov.uk/equalities/equality-act/age-discrimination
- 16 Home Office (2007), Equalities Review www.justice.org.uk/pages/equalities-review.html
- 17 Home Office (2010), Equality Act www.homeoffice.gov.uk/equalities/equality-act/equality-duty
- 18 Department of Health (2012) Responsibility Deal: <http://responsibilitydeal.dh.gov.uk>
- 19 Department of Health (2012) Responsibility Deal: <http://responsibilitydeal.dh.gov.uk/2012/02/08/p5-factsheet>
- 20 Sport England (2004) *Driving Up Participation: The challenge for sport*
- 21 Brian B. Parr (2012) *Exercise Is Medicine*, Aiken Standard: www.aikenstandard.com/story/050712-exercise-is-medicine-parr--3979057#ixzz1v7UueEQV

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- 22 Education Department Research Findings No. 20/2006, *Sport, Exercise and Physical Activity: Public Participation, Barriers and Attitudes*, Lorraine Murray, Ipsos MORI Scotland
- 23 Sport England (2011) Active People Survey 5
- 24 Parliamentary Office of Science and Technology (2001) *Health Benefits of Physical Activity*: www.parliament.uk/briefing-papers/POST-PN-162.pdf
- 25 S. Wicebloom (2007) *Training for Disabled People*, London: A. & C. Black
- 26 J. H. Rimmer (2004) *Exercise and Physical Activity in Persons Aging with a Physical Disability*, *Physical Medicine and Rehabilitation Clinics of North America* 03/2005; 16(1): 41–56. DOI:10.1016/j.pmr.2004.06.013
- 27 Department of Health (2011) *UK Physical Activity Guidelines*, London: Crown Copyright
- 28 World Health Organization (2002) *Towards a Common Language for Functioning, Disability and Health*, The International Classification of Functioning, Disability and Health
- 29 THENAPA 2 was a European-wide adapted physical activity programme running from 2005 to 2010 to develop a curriculum and resources on adapted physical activity for older people. Activity cards can be downloaded from: www.thenapa2.org/publications/products/Cards/index.htm
- 30 The Building Regulations (2010) *Access to and Use of Buildings*, Approved Document M. 2004 edition incorporating 2010 amendments
- 31 Equality and Human Rights Commission (2010) *Making Reasonable Adjustments*: www.equalityhumanrights.com/advice-and-guidance/before-the-equality-act/guidance-for-service-users-pre-october-2010/health-and-social-care/access-to-services-treatment-and-support/making-reasonable-adjustments
- 32 RNIB (2006) *See it Right, Making information accessible for people with sight problems*, CD-ROM
- 33 K. Black (2006) 'Motivational Aspects Affecting the Exercise Status of Older Disabled People Participating in the Inclusive Fitness Initiative Programme', in proceedings, 2nd EU Workshop Adapted Physical Activity – A EU workshop, 'The State Art of Assessment of Physical Activity in Elderly People', Oslo University College, 25–26 September 2006
- 34 J. I. Kailes (2005) *Can Disability, Chronic Conditions, Health and Wellness Coexist?* National Center on Physical Activity and Disability
- 35 L. Murray (2006) *Sport, Exercise and Physical Activity: Public participation, barriers and attitudes*, The Scottish Government, Ipsos MORI
- 36 K. Black (2006) 'Motivational Aspects Affecting the Exercise Status of Older Disabled People Participating in the Inclusive Fitness Initiative Programme', in proceedings, 2nd EU Workshop Adapted Physical Activity – An EU workshop, 'The State Art of Assessment of Physical Activity in Elderly People', Oslo University College, 25–26 September 2006
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