Natural England Commissioned Report NECR118

An evaluation of the Walking for Wellness project and the befriender role

First published 16 July 2013

www.naturalengland.org.uk

Foreword

Natural England commission a range of reports from external contractors to provide evidence and advice to assist us in delivering our duties. The views in this report are those of the authors and do not necessarily represent those of Natural England.

Background

When Walking for Health was launched in 2000 walking was not considered a serious form of exercise. Now the health benefits of short, regular, brisk walks are widely understood. The Department of Health considers that health walks can be a way of increasing people's levels of physical activity and improving their health.

In 2007, Department of Health and Natural England working in partnership with local statutory and voluntary organisations took the decision to invest in an expansion of Walking for Health as part of the package of public health initiatives aimed at getting people more active.

As part of the Walking for Health expansion a programme of evaluation was established. The aims of the programme were to evaluate, quantitatively and qualitatively, both health and environmental outcomes from the Walking for Health intervention. To deliver the breadth and depth of evaluation Natural England has worked with research and academic partners.

This report by Leeds Metropolitan University was supported by a small grant from Natural England. Walking for Health is a physical activity intervention with the primary purpose of making a positive difference to people's physical health. However, it is also recognised that group nature of the activity can also benefit people's mental health and wellbeing.

This report presents research findings from a pilot project in Northumbria that sought to extend access to Walking for Health to people with mental health needs through the concept of the befriender role.

The results of this work highlight the value in proactive recruitment of people with a wide range of health needs and the importance of the social dynamic of walking groups in supporting and encouraging individual participants. It highlights the potential for Walking for Health as a mechanism to assist people with mental health needs.

This report should be cited as:

SOUTH, J., GUINTOLI, G. & KINSELLA, K. 2012. *An evaluation of the Walking for Wellness project and the befriender role*. Natural England Commissioned Reports, Number 118.

Natural England Project Manager - Dave Stone, Deputy Chief Scientist, Natural England, Suite D, UNEX House, Bourges Boulevard, Peterborough, PE1 1NG **dave.stone@naturalengland.org.uk**

Contractor - Jane South, Centre for Health Promotion Research, Leeds Metropolitan University

Keywords - Walking, walking for health (wfh), mental health, wellbeing, theory of change

Further information
This report can be downloaded from the Natural England website: **www.naturalengland.org.uk**. For information on Natural England publications contact the Natural England Enquiry Service on 0845 600 3078 or e-mail **enquiries@naturalengland.org.uk**.

ISBN 978-1-78354-025-9

An evaluation of the Walking for Wellness project and the befriender role

Jane South
Gianfranco Giuntoli
Karina Kinsella

July 2011

Centre for Health Promotion Research

Leeds Metropolitan University

E-mail: j.south@leedsmet.ac.uk

leeds metropolitan university

Contents

Acknowledgements

This evaluation was funded through a small grant from Natural England. The authors would like to thank the following individuals for their contribution to the study.

- Dave Stone, Natural England, for his encouragement and interest in the initial idea of exploring mental wellbeing and social capital.
- Tim Fitches, Natural England, for sharing his expertise on the Walking for Health database.
- Coral Hanson, Blyth Valley Arts & Leisure and North Country Leisure, for her commitment to the evaluation and for providing practical support throughout the research process.
- The Leeds Metropolitan University steering group - Professor Jonathan Long, Professor Jim McKenna, Dr. David Carless – for their helpful suggestions and advice in the design of the study.
- Sue Rooke, Faculty Research Support Unit, Leeds Metropolitan University, for administrative support and help with data collection.
- All the participants for giving up their time to take part in the evaluation, including the walk coordinators, walk leaders and walkers who allowed us to join their health walks and share their experiences.

Executive Summary

Introduction

Walking for Health is a national programme of volunteer-led health walks, coordinated through Natural England and endorsed by the NHS as a means of promoting physical activity in the sedentary population. Walking for Wellness is a pilot project that has sought to widen access to Walking for Health in Northumberland and to pilot a new befriender role supporting the engagement of people with mental health needs in health walks. The pilot project, which started in April 2010, has been delivered by North Country Leisure and Blyth Valley Arts and Leisure, in partnership with Natural England. Northumberland County Council provided funding through the Communities for Health programme. The report presents findings from an evaluation of the Walking for Wellness project, conducted by Centre for Health Promotion Research, Leeds Metropolitan University. It presents evidence about engagement in walking groups and the social and health outcomes that can result from participation.

Background

There is a solid body of evidence demonstrating the health benefits of physical activity, but more needs to be known about the effectiveness and sustainability of lay-led walking programmes. Environmental and social conditions are known to be influencing factors for physical activity behaviour. Research shows that elements of social capital, such as trust and social participation, can affect the promotion of physical activity over and beyond physical characteristics of the environment. More evidence is needed on the links between engagement in lay-led walking programmes, social capital and wellbeing outcomes.

Evaluation aims and objectives

The primary aim was to undertake an evaluation of the Walking for Wellness project. Specific objectives were to:

- examine whether and how befriender and walk leader roles help people with mental health needs engage with health walks.
- identify effective referral and recruitment methods to support the engagement of people in health walks.
- explore the links between engagement in health walks, wellbeing outcomes and social capital.
- scope options for future evaluation studies, including gathering stakeholder views on acceptability of evaluation methods.

Evaluation methods

The evaluation was based on Theory of Change methodology and used a mixed methods design. Qualitative data were gathered through: individual semi

structured interviews with stakeholders involved in project delivery: focus groups with walkers from six health walks; and a focus group and telephone interviews with befrienders. In total 92 people were interviewed, including 77 walkers. Participation trends 2009-11 were examined through secondary statistical analysis of monitoring data from the Walking for Health database.

Key findings – interviews and focus groups

There are a range of motivations for joining a health walk including wanting to improve physical health, prevent loneliness and get to know the local area. The main reported barriers were fear of not being able to complete the walk and anxiety about joining a social group for the first time. Overall walking groups are experienced as friendly, welcoming groups, and have a mix of people taking part, including some individuals with physical or mental difficulties.

There were difficulties in establishing the befriender role; however, the process of befriending within walking groups was seen as important. Walkers reported a reluctance to talk about other people's mental health issues and the introduction of the Rosenberg self-esteem scale in the registration questionnaire had been an additional barrier.

Reported benefits of health walks included:

- Increased physical fitness
- Regular exercise
- Improved mental health e.g. more relaxed, increased confidence
- Local knowledge
- Reduction of social isolation
- Improved social networks
- Links to other community activities.

The social aspects were an integral part of the experience and provided a motivation for engaging in the physical activity. There was evidence that the health walks in Northumberland form part of the infrastructure of community life and lead to increased social capital.

Findings – analysis of monitoring data

Demographic characteristics of Northumberland walkers are similar to national figures but with significantly less younger walkers (16-54 years) and walkers from Black and Minority Ethnic groups.

Just under a third of walkers (31.3 %) have diagnosed health conditions and around 7.8% have a disability.

The total number of registered walkers attending Northumberland's walk groups steadily increased from 2009-2011, although the number of new (first time registered) walkers declined.

The six sampled walking groups showed similar demographics patterns to Northumberland, however, some of the groups have significantly higher or lower uptake from people with disabilities or health conditions.

Issues for consideration

- Options for further widening access include increasing referrals from health professionals and making both short and long walks available.
- Targeted information for potential recruits could provide reassurance about the experience of joining a new group and expectations about pace.
- Befriending is an important function of walking groups but formalising roles may not be needed.
- The project has uncovered a deep rooted stigma around mental health issues and wider strategies are required to address this.
- Further research is needed to explore barriers to recruitment and why people drop out.

Conclusions and recommendations

Walking for Wellness has developed strategies to widen access to health walks. Although there has been an overall increase in the attendance numbers of registered walkers, it is not clear whether this is linked to the introduction of the project. The evaluation found that walking groups accommodate and support the participation of individuals with mental health needs or physical difficulties, within appropriate limits. Walking groups are friendly and members offer peer support to each other but the formalisation of the natural befriending role did not chime with walkers. Engaging in a health walk is as much about the social aspects as the physical activity and there was good evidence that participation can increase wellbeing, reinforce coping strategies, and enhance social networks.

Key recommendations from the evaluation include:

- Increasing the number of schemes that have more than one walk option available.
- Production of targeted information suitable for people interested in becoming involved and/or health professionals.
- Consideration as to how the befriending role develops, focusing on enhancing informal roles rather than formal training.
- Further evaluation is needed to assess the long term impact of the project, as referral routes and roles develop.

The Report

1 Introduction

Walking for Health is a national programme of volunteer-led health walks coordinated through Natural England and endorsed by the NHS as a means of promoting physical activity (Department of Health, 2009). As a public health intervention, the national Walking for Health initiative has achieved considerable success in terms of volunteer involvement to support wider participation in health (The Countryside Agency, 2005).

This report examines engagement in health walks and the benefits that can result from that engagement. It presents findings from the evaluation of the Walking for Wellness project, Northumberland, which is an innovative project that has sought to widen access to the Walking for Health initiative. The project has piloted a befriender role to support the engagement of people with mild to moderate mental health needs in health walks and related outdoor activities.

1.1 Walking for Health

Walking is undisputedly beneficial for health, and has been described as the "easiest, most accessible, cost effective, and enjoyable way for most people to increase their physical activity" (Heron and Bradshaw: 3). In 2000, the British Heart Foundation and the Countryside Agency (now Natural England) established the Walking the Way to Health initiative as a means of increasing physical activity in the sedentary population. Volunteer walk leaders who organise regular short health walks in their communities are the backbone of the initiative. Volunteers receive a standard one day training covering practical advice on how to lead a health walk. Once trained, walk leaders plan routes in their local areas and support participants on the walk, ensuring everyone returns safely.

As part of the Walking for health initiative, participating walkers complete the Outdoor Health Questionnaire, allowing Natural England to collect attendance data[1]. In 2010, there were over 11,000 active walk leaders and more than 63,000 people regularly taking part in health walks, three quarters of these are aged over 55 years. There is a recognised need to develop a robust evidence base for volunteer-led walking programmes and potential to explore the wider social impacts.

[1] A copy of the Outdoor Health Questionnaire and key statistics can be found at http://www.wfh.naturalengland.org.uk/our-work/evaluation

1.2 Walking for Wellness project - Northumberland

Walking for Wellness is a pilot project that has sought to widen access to the Walking for Health initiative in Northumberland. One of the project aims has been to establish a network of befrienders who can support the engagement of people with mental health needs in health walks. The pilot project, which started in April 2010, has been initially funded by Northumberland County Council through the Communities for Health programme and is being delivered by North Country Leisure and Blyth Valley Arts and Leisure, two voluntary sector organisations who are working in partnership with Walking for Health, Natural England. Project targets include the establishment of five new walking groups, and the recruitment of 80 volunteer befrienders, 50 additional walk leaders and 700 new walkers. Four new walk coordinator posts (15-20 hours per week) were created to support the expansion; two co-ordinators based the south east (the more urban area of the county), one in the west and one in the north of Northumberland. Key project activities to date include[2]:

- Coordinators and staff associated with the project undertook the Mental Health North East two day course 'Mental Health and Physical Activity Trainers Training'.
- Information sharing sessions were held with all active volunteer walk leaders.
- Development and delivery of a Befriender Volunteer Training package covering basic information on mental health issues.
- Identification of individuals willing and able to take on a befriending role in health walks.
- Promotion of Walking for Health and the befriender element to GP surgeries.

Given the innovative nature of the Walking for Wellness project and the need to further develop the evidence base on the wider benefits of health walks, it was agreed that the Centre for Health Promotion Research, Leeds Metropolitan University would carry out a qualitative evaluation of the project. The evaluation was supported through a small grant from Natural England.

[2] Walking for Wellness Interim Report – November 2010.

1.3 Evaluation aims and objectives

The primary aim of the pilot study was to undertake an evaluation of the Walking for Wellness project, with a focus on the befriender role as a mechanism for engagement in health promoting activity. Specific objectives were:

- To examine whether and how befriender and walk leader roles help people with mental health needs to successfully engage with health walks and other outdoor activities.
- To identify effective referral and recruitment methods (both formal and informal) to support the engagement of people in Walking for Wellness health walks.
- Using qualitative methods, to explore the links between processes of engagement in health walks, wellbeing outcomes and social capital.
- To scope options for future evaluation studies, including gathering stakeholder views on appropriateness and acceptability of evaluation methods and measures.

1.4 Structure of the report

The report presents the findings from the evaluation of the Walking for Wellness project. It provides an assessment of whether the project has been successful in its aims to widen access to health walks and identifies points of learning from implementation of the befriender role. More generally, it presents evidence of links between engagement in walking groups, mental health outcomes and social capital. The report starts with a short section summarising the background literature on walking and health, the existing evidence base on lay-led walking programmes and the socio-environmental factors that impact on engagement. The evaluation approach and methods are described in full in Section 3. In the following section, the findings from qualitative interviews and focus groups with walking groups, befrienders and professional stakeholders are presented, followed by results from the analysis of the monitoring data. In Section 5, evidence is synthesised and considered in relation to the evaluation objectives. There is also discussion of significant issues emerging from the evaluation. The final section contains a short conclusion and recommendations for the future development of the project.

2 Background

The evaluation has provided an opportunity to build on the evidence base for the Walking for Health initiative and similar volunteer-led walking programmes. This section briefly reviews the research literature on walking groups as a public health intervention and the socio-environmental determinants that have been found to impact on engagement.

2.1 Walking and health

There is a substantial body of evidence that shows that physical activity is positively associated with improved health and well-being outcomes in adults and older people (e.g. Kelley *et al.*, 2009; Paluska & Schwenk, 2000; Sjosten & Kivela, 2006; Department of Health, 2009; Natural England, 2010). In particular, research has shown that vigorous and moderate-intensity physical activity contribute to a lower risk of cardiovascular disease, some cancers, Type 2 diabetes, osteoarthritis, and osteoporosis (Eyler *et al.*, 2003). Walking has been described as a near perfect exercise (Morris & Hardman, 1997), as even walking at a moderate pace of 3 miles/hour (5 km/hour) expends sufficient energy to meet the definition of moderate intensity physical activity (Ogilvie *et al.*, 2007; Siegel, Brackbill, & Heath, 1995). Brisk walking can generate positive health outcomes such as long-term maintenance of weight loss, increasing high-density lipoprotein, reducing blood pressure, and decreasing the risk of death from cardiovascular disease and cancer, while incurring a comparatively lower risk of injury (Lee & Buchner, 2008; Eyler *et al.*, 2003; Morris & Hardman, 1997).

Systematic reviews of the literature have examined the effectiveness of interventions to promote physical activity in general and, more specifically, walking. In 2006, NICE Public Health Interventions Advisory Committee determined that there was insufficient evidence to recommend the use of pedometers and walking and cycling schemes to promote physical activity (NICE, 2006). Insufficient evidence was also found to recommend the use of exercise referral schemes to promote physical activity, however, sufficient evidence was found to recommend the use of brief interventions in primary care to increase physical activity (NICE, 2006). Brief interventions vary from basic advice to more extended, individually focused attempts to identify and change factors that influence physical activity levels.

In a systematic review of research on interventions to promote walking, Ogilvie et al. (2007) found that the most successful interventions could increase walking among targeted participants by up to 30-60 minutes a week on average, at least in the short term. Successful interventions were considered to be those tailored to people's needs, those targeted at the most sedentary or at those most motivated

to change, and those delivered either at the level of the individual (e.g. brief advice, supported use of pedometers, telecommunications) or household (e.g. individualised marketing) or through groups. However, Ogilvie et al. (2007) concluded that the reviewed studies provided evidence of the efficacy of the mentioned interventions rather than of their effectiveness, because they did not find that the reported benefits were sustained over time.

Lay-led walking programmes

The Walking for Health initiative, led by Natural England, enables local groups and organisations to develop and run volunteer-led health walk schemes. A longitudinal study of 4500 people undertaken to evaluate the effectiveness of this programme (IPSOS Mori, 2011), showed that it may not achieve the target of increasing the proportion of physically active participants on three or more days per week. However, the results suggested that Walking for Health can help to improve the levels of physical activity for some of the most sedentary in society (IPSOS Mori, 2011).

Research points to the social benefits of lay-led walking programmes. A review of local evaluations of Walking for Health schemes found that a wide range of health and social benefits were reported and the volunteer model was sustainable with support (The Countryside Agency, 2005). An evaluation of the Walk and Talk scheme for older people in Australia found that 55% of respondents were motivated to take part by the chance to meet people (Jones and Owen, 1998). Social support from peers is a facilitating factor in walking programmes. In a Lay Health Advisor programme based in North Carolina that included neighbourhood walking groups, the ability of the lay health advisors to form strong relationships with other stakeholders was identified as a factor in the programme's success (Plescia *et al.*, 2006). The 'Walkable Neighbourhoods for Seniors' initiative involved both older people's active involvement in assessing walking routes, and the recruitment of a cohort of peer leaders who then went onto become 'walking advocates' (Hooker *et al.*, 2007). Walking groups were successfully formed, however, the evaluation pointed to the need for professional support for the volunteers.

2.2 Social and environmental determinants

Physical activity behaviour can be seen to be influenced by the interaction between individual factors and social and environmental conditions. Studies that have investigated the relationships between environmental factors and physical activity have focused both on aspects of the physical environment, such as urban design factors (e.g. Jackson, 2003; Renalds, Smith, & Hale, 2011), and social factors, for example social capital (Ball *et al.*, 2011; McNeill, Kreuter, & Subramanian, 2006). Understanding the role of key modifiable aspects of both the physical and social environment to promote physical activity is important because physical activity

often takes place in a community or neighbourhood context, for example walking programmes offered through local community organisations (Ball *et al.*, 2011). Consequently, an exclusive focus on psychological and behavioural factors without also considering social norms for activity, resources and opportunities for engaging in physical activity, and environmental constraints such as crime, traffic or unpleasant surroundings, is unlikely to produce behaviour changes (McNeill *et al*., 2006).

Mc Neill et al. (2006) identified three broad overarching categories that represent five most commonly studied social factors cited in the research literature on correlates of physical activity:

- *Interpersonal relationships.* Social support consistently predicts physical activity behaviour (McNeill *et al.*, 2006; Trost *et al.*, 2002). In particular, 'buddy systems', walking groups, and exercise contracts with another person can increase time spent engaging in physical activity and frequency of exercise (Kahn *et al.*, 2002). Other individual factors positively associated with increased physical activity are having a spouse and/or supportive family and friends (McNeill *et al.*, 2006).

- *Social inequality*. The research literature consistently suggests that health status is positively associated with people's socio-economic status (Marmot, 2010). McNeill et al. (2006) mention that individuals with lower socio-economic positions are more likely to report engaging in job-related physical activity and walking compared to individuals with higher socio-economic positions who are more likely to report engaging in leisure-time physical activity and sport related activity.

- *Social capital and neighbourhood factors*. Studies of the relationships between social capital and physical activity in Sweden found a significant negative association between social participation (a dimension of social capital) and low leisure-time physical activity (Lindstrom, Hanson & Ostergren, 2001a; Lindstrom *et al.*, 2001b). In an Australian study that involved 1405 women recruited from 45 Melbourne neighbourhoods of varying socioeconomic disadvantage, Ball et al. (2011) found that women who participated in local groups or events and women living in neighbourhoods where residents trusted one another were more likely to participate in leisure-time physical

activity. Renalds et al. (2011) found that neighbourhoods that were characterised as more walkable, either leisure-oriented or destination-driven, were associated with increased physical activity, increased social capital, lower overweight, lower reports of depression, and less reported alcohol abuse.

Overall, walking may be influenced by interventions targeted at the individual at community level, especially if tailored to individuals' and communities' needs, as well as by environmental and societal conditions. In particular, research shows that elements of social capital such as trust, social participation, and social interactions can be crucial factors affecting the promotion of physical activity over and beyond any physical characteristics of the environment.

3 Methods

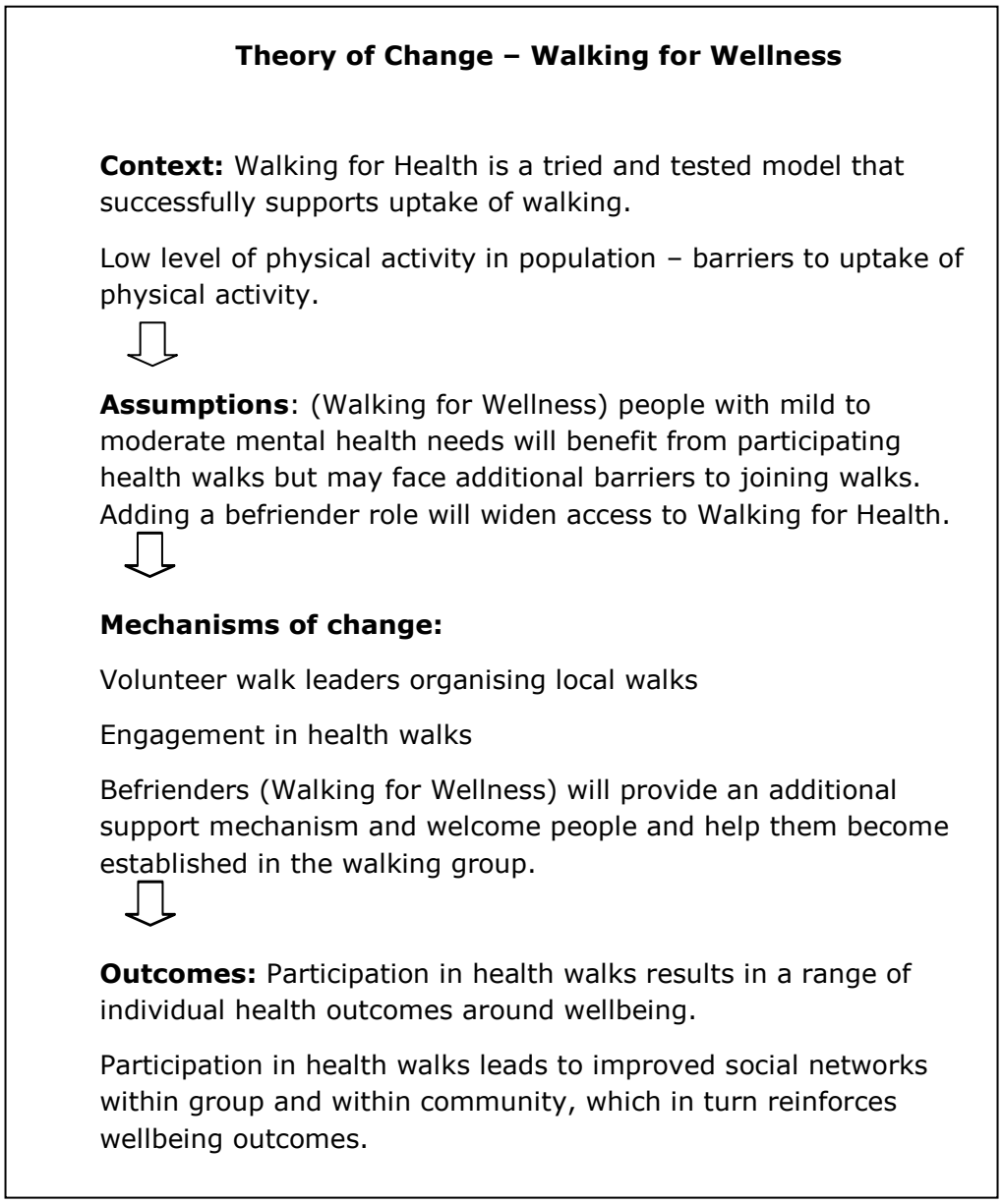
The evaluation of Walking for Wellness had a dual purpose: as a pilot study to explore the links between walking groups, wellbeing outcomes and social capital, and as a formative evaluation of a new approach to widening access to walking groups through the introduction of a befriender role. Additionally, as part of the pilot, some public involvement was undertaken to inform future research which involved gathering stakeholder views on appropriate evaluation methods (which will be reported elsewhere).

3.1 Evaluation approach

The evaluation approach was guided by the principles for evaluation of community-based public health projects by facilitating stakeholder involvement in design and ensuring the methods fitted with the ethos of the project (Green & South, 2006). Due the small scale of the study, a focused and pragmatic approach to data collection was required, but at the same time it was important to use a realist approach to unpack the relationships between context, mechanisms and outcomes (Pawson & Tilley, 1997). The evaluation was based on Theory of Change methodology to articulate the links between purposeful activities, underlying assumptions, mechanisms of change and outcomes (Connell & Kubisch, 1988). An initial Theory of Change for Walking for Wellness was developed (Figure 1). There were two strands in that Theory of Change that the evaluation aimed to explore:

- Whether and how the processes of engagement in Walking for Health lead to mental health outcomes and increased social capital.
- Whether the befriender role provides a mechanism to increase access, particularly for people with mental health needs.

Figure 1. Theory of Change – Walking for Wellness



3.2 Methods

The evaluation used a mixed methods design, drawing on qualitative data to explore perspectives on processes and outcomes, and quantitative data to examine the patterns of engagement. Use of mixed methods allowed some triangulation of data and identification of areas of consistency/inconsistency between the two data sets (Patton, 2002). The main methods were:

- Individual semi structured interviews with stakeholders involved in the delivery and management of the walking schemes and the Walking for

Wellness project, including the project manager, walk co-ordinators and representatives from commissioning and other partner organisations.

- Focus groups with walkers taking part in a sample of six health walks. The focus groups included both new and established walkers and volunteer walk leaders.
- A focus group with individuals who were acting as befrienders or had received training to be a befriender. In addition, two semi structured telephone interviews were conducted with befrienders not able to attend a focus group.
- Secondary analysis of the monitoring data collected by Natural England through the Outdoor Health Questionnaire (OHQ).

Short semi structured telephone interviews with people with mental health needs who had been referred to the Walking for Wellness project were planned but this element did not take place due to the delayed implementation of referral routes.

3.3 Interviews and focus groups

Interview and focus group schedules were prepared to address the key objectives of the evaluation, using open ended questions to cover topics such as recruitment processes, perceived benefits of participation, links to social networks, and the befriender role. In the focus groups, questions were carefully chosen to stimulate discussion on matters of access and wellbeing and to allow participants to identify issues they deemed significant. All interview schedules were refined with the assistance of the steering group and the final versions can be found in Appendices 1-3.

Sample

A purposive sampling strategy was adopted to gather the views of individuals who were information-rich cases because of their involvement in the project and to ensure that there was some heterogeneity in the sample (Patton, 2002), thereby reflecting the different communities and areas within the Walking for Health schemes in Northumberland, the type of walk, and typical size of attendance. The research team worked closely with the Walking for Wellness project manager to select the potential stakeholders and health walks. A sample of six health walk groups (Table 1) was selected, four of these groups were part of the befriender project, whereas the other two health walks were selected as a point of comparison because they had not identified any befrienders.

Table 1. Sample of health walks

Health walk group	*Area of Northumberland*	*Urban/ Rural*	*Walk*	*Befrienders in group*[3]	*Average Attendance*
Alnwick	North Northumberland	Semi-Rural	Intermediate walk	5	8
Blyth Bootbenders	South East Northumberland	Urban	Flat coastal walks - 4 miles	4	40
Cramlington - Concordia Crew	South East Northumberland	Urban	Flatish walks with 2 mile, 4 mile and 6 mile options	3	53
Morpeth	South East Northumberland	Urban	Longer walk although short walks also available	None	23
Rothbury	North Northumberland	Rural	Short starter walk	None	12
Stocksfield	West Northumberland	Rural	(Short walk)	1	15

Recruitment and data collection

The project manager and walk coordinators distributed a letter of invitation and information sheet from the research team to walking groups and individual stakeholders (Appendix 4). The research team followed this up to arrange individual interviews or to attend walks. For the focus groups with walkers, two researchers joined the walks; the focus groups were organised to take place after the walks and these were held in the community settings where the walking group normally met. It was made clear that walkers were free to decide whether to stay for the focus groups, and due to the numbers opting to participate extra focus groups were run in three of the health walks. In total, 92 individuals participated in the study (see Table 2). Ten focus groups were conducted; nine with walkers attending health walks and one with befrienders. Ten individual interviews were conducted; eight with stakeholders (3 telephone interviews and 5 face-to face) and two telephone interviews with befrienders.

[3] Figures on befrienders and average attendance at time of data collection were provided by the Walking for Wellness project coordinator from the project monitoring data.

Table 2. Participant numbers

Group/role	Focus group/ interview	Females	Males	All participants
Health walks				
Alnwick	1 focus group	2	1	3
Blyth Bootbenders	2 focus groups	15	8	23
Cramlington	2 focus groups	9	5	14
Morpeth	2 focus groups	7	11	18
Rothbury	1 focus group	5	2	7
Stocksfield	1 focus group	9	3	12
Sub total	**9 focus groups**	**47**	**30**	**77**
Other roles				
Befrienders	1 focus group 2 interviews	6	1	7
Stakeholders	8 interviews	5	3	8
Total Participants		**58**	**34**	**92**

Analysis

The interviews and focus groups were recorded on digital recorders with the permission of participants. These recordings were later transcribed verbatim. Thematic analysis was undertaken to organise and code the data, with the support of NIVIO qualitative software. In line with the guidelines suggested by Braun & Clarke (2006), data were coded with the three authors independently coding selected transcripts to improve inter-rater reliability. Codes were then organised into major categories and a narrative summary was produced.

3.4 Monitoring data

The statistical analysis was undertaken on the Walking for Health database, which was introduced by Natural England in June 2008. The database offers a reliable and accurate sample of approximately half of the entire population of walkers belonging to Natural England walk schemes (Fitches, 2011). Information is available at the walk scheme level, collected through the Outdoor Health Questionnaire (OHQ). Walk schemes promote and organise health walks, which usually differ on the basis of their level of difficulty, from starter (i.e. shorter walks) to the advanced (i.e. longer walks).

The aim of the secondary analysis was to explore the demographic and health characteristics of walkers as well as the participation trends in Northumberland from 1st April 2009 to 30th June 2011, with a particular focus on the six walk groups recruited for this study. April 2009 is a relevant date because in that period Natural England – in partnership with the Department of Health – started a three-year expansion programme of the Walking for Health initiative with the aim to increase participation fourfold.

The specific objectives of the secondary analysis of monitoring data were to:

- report descriptive statistics on the walk schemes active in Northumberland, with a specific focus on:
  - how the recruitment of new walkers has changed over time
  - the age distribution of the registered walkers
  - the percentage of individuals with health problems and their main demographic and social characteristics.

- explore demographic and health characteristics of the six sampled walk groups, including comparing the four sampled walk groups with befrienders with the two sampled walk groups without befrienders.

- compare the number of new walkers joining the four sampled walk groups with befrienders with the numbers of new walkers joining the two sampled walk groups without befrienders, before and after April 2010, the start of the Walking for Wellness project.

Analysis

Univariate and bivariate statistics, for example chi-square tests of independence, were used for the analysis. For cross tabulations, adjusted standardised residuals were calculated to determine what factors specifically contributed to group differences (Agresti, 1996). Where relevant, the strength of the chi-square relationships was assessed through the Cramer's V measure.

Rates of change in the recruitment of new participants were calculated using the formula Year 2-Year 1/Year 1, where 'year 1' is the total of registered walkers attending from April 2009 to March 2010 and 'year 2' is the total of registered walkers attending from April 2010 to March 2011. Data at the Northumberland, North East and national level were compared by converting percentages in proportions and, where appropriate, comparing them using the normal approximation.

3.5 Ethical issues

The evaluation received ethical approval from the Faculty of Health & Social Sciences Research Ethics Committee. The evaluation conformed to recognised ethical practice by ensuring:

- informed consent
- confidentiality
- secure information management
- attention to risk reduction
- the right to withdraw from the research.

Particular care has been taken to ensure that when reporting qualitative results, all names and identifying details have been removed from quotations and examples.

The data received from Natural England was in the form of an anonymised data set. The research team did not have access to individual participant details.

4 Results

The quantitative and qualitative results are presented in separate sections. In the first section, themes from the interviews and focus groups are presented that cover recruitment processes and participation in walking groups, access for people with physical or mental health needs, reported benefits and the new befriender role. In the second section, the results from analysis of the monitoring data are presented.

4.1 Findings - interviews and focus groups

Nine focus groups were held across six walking groups, and in total 77 walkers participated. Of these 47 were female and 30 were male. There was a spread in terms of length of involvement from those who had been involved for years, in some cases six or seven years, to those who were relatively new to the groups. Some participants were walk leaders. A focus group was held with 7 individuals identified as befrienders, six were female and one was male. There were a further two individual phone interviews with befrienders. Eight professional stakeholders participated in individual interviews, including walk coordinators, commissioners and the scheme coordinator. The results are presented in major thematic categories with anonymised quotations used to illustrate themes.

4.1.1 Pathways to involvement

The evaluation aimed to explore how and why people became involved in health walks and how that engagement could best be supported. In the focus groups, walkers described a range of motivations for joining their walking group and how they first became involved. Motivations included:

- Being invited by a friend or family member
- Health related – both to improve fitness or because changes in health prevented more active sports
- Combatting loneliness and having the opportunity to meet new people
- Having more time with the transition to retirement
- Getting to know the local area
- Seeing the opportunity and having a go.

Being invited by a friend or family member was the most common reason given for joining a health walk. Something to 'fill my time in' in retirement was another prominent theme. Several participants explained how they already knew about the

existence of walking groups through friends and had taken up the opportunity to meet new people now they had more spare time through retirement.

> *When I retired I just asked around and I knew Margaret and Sue[4] and that was a good way to meet new people because when you leave work you leave everything behind social. So I thought it's a good way to get exercise and a bit of social life so that's what I did.*
> *(Focus group, health walk)*

Of those who described the onset of physical health problems, such as a heart attack, as being a motivation, some had joined a walking group via Health Start (an exercise referral scheme) or through other fitness classes at the leisure centre. One woman explained that her husband had been referred via the GP and whereas he had dropped out, she had continued.

> *My husband has numerous health problems and was recommended to come on the walks by the doctor and he is not keen on walking so I started to come with him to give him support. I've been going for about three to four years, he lasted about six weeks I think.*
> *(Focus group, health walk)*

Life changes, such as bereavement, retirement or moving to a new area, could act as a stimulus to join a local walking group. Some participants articulated making a positive choice to join a health walk because of the social networks offered and the chance to combat loneliness. Others described a more accidental involvement, finding out via a leaflet or advertisement and giving the walking group a try. Several walk leaders described becoming involved when they first heard about the scheme starting up and in some cases had been approached to become involved.

> *I mean we moved to [town] from elsewhere and didn't know anyone here anyway and in your seventies meeting people is not awfully easy, so it was a good way of meeting people. (Focus group, health walk)*

Recruitment routes were various. As described above, a number of participants found out through leaflets in the doctor's, through leisure centres or through tourist information/heritage activities. Being part of an existing group, for example in a class at the leisure centre, meant that the walking group was a natural progression for some people. Word of mouth, particularly recommendation from family or friends was an important factor. Partners sometimes instigated the process, although not everybody stayed. Witnessing the walking group out and about could also act as a stimulus.

[4] Names have been changed to protect anonymity

4.1.2 Involving new people

The focus groups and interviews explored the routine processes of engagement in order to understand the addition of a befriender role. Groups were described as having a core group of walkers, however new people regularly joined, with the exception of one of the smaller groups (Alnwick). In two of the groups, it was reported that visitors to the area occasionally joined the walks.

Factors that hinder involvement

The two most prominent issues were apprehension about the extent of physical activity involved, with the fear of not being able to complete the walk, and the problem of joining an existing group and not knowing people. The act of joining a group for the first time could be perceived as daunting. This was mentioned as a barrier in one of the larger groups (Cramlington), where some participants identified the issue of walkers forming smaller groups or cliques.

> *And I think if people come along and they don't get into one of these small groups, maybe they feel – I think you can't walk around for two hours without talking to anybody. And if they're not the type of person that can push themselves into one of the groups, they can feel left out. (Focus group, health walk)*

> *Well it's always hard for people that new coming to break into a group so we're quite open in welcoming strangers because we know that's a difficulty for people. (Focus group, health walk)*

> *P7. I think (new people) they're most apprehensive as to how far you walk and what the terrain's like, a bit nervous that way.*
> *P3. They're worried in case they can't manage the pace and the length. (Focus group, health walk)*

Other issues concerned how health walks were perceived. Two individuals mentioned seeing walking groups as being "a bunch of women" and needing reassurance that men would be involved. In another focus group, the issue that new recruits might be conscious of walks being visible as groups of "old people snaking the way around the streets" was raised.

Factors that facilitate involvement

Factors that facilitated involvement related directly to the perceived barriers. Having a range of walks including, and most importantly, a short walk, was seen as reassuring for those new starters. It was pointed out that people could always move up to other walks as they became more confident.

> *It's like a stepping stone, isn't it? You get people's confidence up and ability up to then go onto longer walks with other groups. (Focus group, health walk)*

Some people coped with their first attendance by coming with a friend or family member, which helped get over the initial meeting, however, walking group members welcomed new people when they came on their own. Walk coordinators could also play a role in introducing new people. The sociability of the walking group and having people who would happily approach new recruits and talk to them during the walk were important factors and were seen in both befriending and non–befriending groups.

> *[…]because if we see somebody strange we just introduce them to other people in the group so that gets them broken into the group and they make certain friends within the group. It's amazing how it happens. And a lot of people have said to me they came on their own and they've met people and now they're good friends with the people outside the group. So it keeps the friendship going. A lot of these people are on their own. (Focus group, health walk)*

Friendship and having a place to meet people were motivating factors, as discussed above, and the experience of joining a friendly group provided positive reinforcement to continue. One individual made the comment that walking groups were in fact less daunting than other forms of social activity because it did not require walking into a room full of people.

Most new recruits stayed but some dropped off after a few weeks. Perceived reasons were that individuals realised that walks were "not for them", that the health walks were too slow - "some people would like to walk further or faster"- or that family commitments made it difficult.

4.1.3 Widening access

In light of the focus of the Walking for Wellness project, we wanted to explore whether access was facilitated for people with mental health needs. Due to the stigma of mental health, participants in the focus groups were also asked to discuss how people with physical limitations were involved in order to stimulate discussion on access issues. There was strong evidence that walking groups can and do support the involvement of people with both physical and mental health problems.

Access for people with physical limitations

In all the focus groups, participants described examples of how people with physical difficulties had been able to join the walks. Examples given included people recovering from joint replacements or other operations, people with heart conditions or past strokes, and people with long term limiting conditions such as blindness, epilepsy and cerebral palsy. Although wheelchairs were raised as a

practical barrier on walks, there were examples given of people using Zimmer frames or being supported by a carer to take part in the walk.

> *We've had one guy joined us with palsy. He used to come with a carer and he quite enjoyed the few walks he did but I think his carer stopped coming. He managed the walks ok we just had to keep an eye on him. But we have had one or two people with quite severe handicaps. That guy was quite severely handicapped and he did enjoy the walk but I don't know whether his carer stopped coming or he stopped coming. (Focus group, health walk)*

The walk coordinators or walk leaders routinely took information from new walkers at registration through the Outdoor Health Questionnaire and one walk coordinator explained how he would gently alert the walk leader if anyone had specific health problems. The general sense from the focus groups was that walking groups were accessible to people with physical limitations and the group naturally included people whatever their ability. One adaptive response was just to take the walk slowly and make sure the back marker stayed with the person, something that was also observed by the research team on the walks attended. Several participants stressed the inclusivity of the group when faced with people having difficulties. Although participants also discussed how people self-selected out when it got too difficult.

> *And you can't walk too slowly – there's no such thing as walking too slowly. The walks are for people of all abilities. And as you get fitter, you're able to walk faster. You get your heart beating. There's absolutely nothing at all wrong with walking very slowly at the back. And if somebody needs to stop and go back that's fine. (Focus group, health walk)*

> *People struggle for different reasons, don't they. I mean some people have a job going uphill, going downhill, getting over a fence – so I mean it all balances out and people are prepared to help. (Focus group, health walk)*

Another strategy was having a range of walks. The offer of a short walk, often no more than two miles, was seen as an enabling factor for individuals who were less fit. Some of the groups deliberately planned walks with minimal or no stiles as these were seen as a physical barrier for some.

> *This only other thing that might put someone off is that the walks are five miles. That could put some people off. I know [the walk coordinator] started a shorter walk.... I think the numbers are going up there. There are some people that go on a walk on a Tuesday and a mile or two is enough for them. (Focus group, health walk)*

While the dominant theme was of inclusion, it was reported that some people stopped coming either because they self-selected out due to worsening infirmity or because their doctor advised them.

With physical disabilities I suppose it's the extent to which you're physically debilitated. Because obviously if you're into having to push wheelchairs then you can't access some of the places we go to. Plus the fact I think again depending what people are able to do, some people won't be able to climb over stiles. So you would need to look at an individual I think and find out what their particular needs are and that really I don't think is our brief. (Focus group, health walk)

Widening access for people with mental health needs

Discussion on involving people with mental health needs raised a different set of issues to the physical limitations, but the theme around the inclusivity of the health walk was still apparent. In terms of mild to moderate mental health needs, participation on a health walk was not seen as major problem. Indeed a number of examples were given of where walks included people whose condition was perceived to affect their communication or social skills but other walkers adapted, in much the same way as they might have done with a slow walker.

The benefits of walking for mental health were emphasised by walk members, as well as by professional stakeholders. Several participants spoke of having past or current mental health issues, like stress or anxiety, and a walking group was seen as an appropriate way of improving health.

I: What if someone with mild mental health issues, anxiety or depression wanted to join the group?
P1. I don't think it would be a problem I think the best thing that they could do is to get out and socialise in the fresh air. I've had stress and anxiety myself. In fact I think the medical profession would say that if anyone suffers from that then they should go and join a walking group. (Focus group, health walk)

Examples were also given of people who had joined to deal with factors negatively impacting on mental health, such as bereavement. In addition, there were examples of people with dementia, or experiencing memory problems, participating in health walks. One walk coordinator was in the process of setting up a group for dementia sufferers.

Notwithstanding the inclusive ethos of walking groups, there was seen to be a limit in terms of the severity of any condition. A strong theme was that mental health needs were not visible so the group did not necessarily know. In one focus group there was discussion about the worry about taking responsibility for people with mental health problems and participants recounted a recent incident where someone had collapsed.

With depression yes but any stronger mental issues I don't think we're capable of really looking after the people. It depends how you define the word 'mental' I think. (Focus group, health walk)

I think the helpers, there are several helpers, would be aware and would give them support and I think the rest of us probably would. I mean mental illness is not something that sticks out like horns, quite a lot of people with mental illness you wouldn't actually notice. (Focus group, health walk)

In general mental health issues were seen as something hidden and there was no expressed desire to be more open, although paradoxically, some individual walkers disclosed experience of mental health conditions in the focus groups.

If you know that somebody has got specific problems, you might get so worried about their specific problems that you're going to make them feel different. I think there's a limit to how much you should know about somebody. (Focus group, health walk)

The 'hidden' nature of mental health, fitted with a strong theme in the stakeholder interviews around the stigma of mental health. Those implementing the project had encountered issues of stigma and the unwillingness of participants in walking groups to recognise these issues. This was seen to be one of the barriers to implementation encountered in the project.

I think, one thing is, we realise is how much it's a stigma that people have been frightened of, and I think we've managed to break down some of those. In the early days, I think we found it very hard, you know, we'd lost a walk leader or two. It was kind of like I'm not taking mental people on a walk. But now people are - even myself and my colleagues around me, I think it's made us realise what people we have on there who already would be classified in that category, but will just be on health walks anyway. (Interview, professional stakeholder)

4.1.4 Befriender role

One of the primary aims of the evaluation was to examine the effectiveness of the new befriender role as a mechanism to increase access, particularly for those with mental health problems. The Walking for Wellness project involved the identification of potential befrienders in the walking group and the offer of bespoke training. The training consisted of a short 2-3 hour course that aimed to increase awareness of mental health issues through an overview of mild mental health conditions such as depression and anxiety, and to prepare the befrienders to undertake their role in welcoming new walkers. Where befrienders were identified, the role was seen to extend to all groups not just those with mental health needs.

The evaluation found that there was incomplete implementation of this element of the project for a number of reasons; these included time lag with implementation, initial focus on other elements of the project, such as developing new walks, difficulties in recruiting people to come on the befriender training and reluctance to engage with the role because of the stigma of mental health.

> *A lot of it really was that I suppose there's quite a stigma attached to people with mental health problems. I think that's why we're having trouble getting people onto the courses at the moment. We maybe need to sort of change the way that it's been advertised and put across. You know, cause if you say 'mental health' to someone they think of, automatically think of the extreme cases as opposed to people who maybe just suffer from a bit of you know anxiety and depression… (Interview, professional stakeholder)*

A further issue was the use of the Rosenberg self-esteem measure which for some groups had been a major barrier with engaging with the project, and in some cases had led to some walk leaders resigning.

> *I think when we did the original training with the walk leaders to explain what the scheme was, you know, what it was about, and the big thing that caused a real problem was the Rosenberg self-esteem thing and that was actually - when I just said somebody stopped before - that was the sort of thing that people couldn't get around, saying "I'm not going to do - I don't feel comfortable with this. I'm not going to do this?" (Interview, professional stakeholder)*

The difficulties with implementation meant that it was challenging to carry out interviews as planned with befrienders. One focus group was held with people identified as befrienders but they were unaware of undertaking training, although did discuss the role at length. One interview was completed with an individual who had agreed to take on the role but had not done training, and one with an individual who had completed the training but had decided not to take up the role because they wished to focus on being a walk leader. A question was also asked about the befriender role in the focus groups, but even in walking groups where there were befrienders, there was little discussion, except to agree when the role was explained that the befriending function was done in the groups informally as part of the normal way the group functioned.

More in depth discussion of the befriender role and role attributes took place in the stakeholder and befriender interviews. Befrienders were seen as performing a role in the group that was distinct from the walk leader role. The walk leader planned walks and had responsibilities for leading the walk and ensuring the safety of participants, therefore it was not easy for them to concentrate on talking to new people. Whereas the befriender or buddy role was about welcoming new people, showing empathy and making contact on the walk and introducing them to other group members. Befrienders did not see their role as extending to meeting people at their house or recruiting new people.

It involved looking out for people who look as if they're on their own, they look lonely, they're not looking comfortable. On the short walks we've had a few who I think are probably mentally ill or who have been mentally ill and they look very uncomfortable indeed and they are very relieved when somebody goes up and talks to them. So I think really my role as a befriender is to keep a sharp eye out for people but do it surreptitiously and talk to people or just smile and say hello and walk alongside. (Interview, befriender)

Key attributes of befrienders were:

- Being sympathetic and patient,
- Having an ability to talk to people – people skills
- Good listeners
- Naturally sociable.

I think they need to be, they'd need to have empathy, need to be a good listener, need to be a friendly person, and understanding and kind really. I don't think it'd be a suitable role for somebody who's really opinionated, because you want the person who comes in, who's not maybe feeling that confident to you know feel welcome and feel that they've had a good experience. (Interview, professional stakeholder)

There was little evidence of a formal befriending role being taken up in the health walks, and this role did not appear to chime with participants. One exception was where a coordinator of one health walk reported identifying befrienders who were active in their roles. Despite the lack of resonance around a formal befriender role, nevertheless the concept of befriending was seen as essential in terms of integrating new members. One of the strongest themes occurring across all participant groups, including in groups without any befrienders, was that walk participants regularly provided peer support to participants. Participants, including those identified as befrienders, were emphatic that the befriending role occurred naturally in groups, and the wider group could and did ensure people were welcomed.

I think it happens naturally here. People don't leave people on their own. (Focus group, health walk)

I suppose you could class everyone as a befriender within your group. All our people in our group you could say are befrienders really because they wouldn't let people walk on their own anyway. Focus group, befrienders)

Everybody greets everybody I don't think you need a specific person. It's just a group it happens. (Focus group, health walk)

4.1.5 Benefits from participation in health walks

Participants were asked to identify any gains from involvement in health walks and any drawbacks. The research team were keen to explore perceptions about the social benefits and mental health outcomes linked to walking. The responses were universally positive about the benefits of being involved in a health walk and it was possible to identify a number of individual-level outcomes. Even though a question was asked about drawbacks, the only drawbacks that were identified were bureaucracy with registration, the weather and the occasional difficult personality.

Increased physical fitness

A number of participants talked about feeling fitter often giving examples of increased capacity for exercise, for example being able to walk further or less reliance on asthma medication. Some of these individuals had graduated to longer walks where there were short and long walks on offer. There were also individuals who benefited from walking as part of their rehabilitation from injury or surgery. There was some evidence of the place of regular health walks in supporting more frequent moderate exercise, but this was not as prominent in discussions in comparison to the theme of feeling fitter and having improved physical function.

> *And I do find that it keeps me fit. If I haven't been walking, and we go on a lot of walks up hills here, and if we haven't been walking regularly I'm really struggling, but I do find the health benefits suddenly creeps up on you. The more you limber up the fitter I seem to get (Focus group, health walk)*

The health benefits were frequently talked about alongside the social benefits. One strong theme was that the social aspects, that is the companionship of other walkers and the 'chat', helped facilitate regular physical activity. One individual described: "*The jaw gets exercised, the body gets exercised*".

> *We wanted to walk, so you've got the exercise, you've got the fresh air and you've got the friends that you make, all the chat and it's just something we carried on doing. We find it very beneficial. (Focus group, health walk)*

Improving mental health

As indicated above, the walks were being accessed by people with various mental health needs, and participation was perceived to help address social isolation, depression or anxiety. This could be about primary prevention, for example, feeling more relaxed, or it could related to coping with life's stresses. One participant spoke about another walker who came while a close family member was dying and how the walk had provided "a necessary release".

> *Generally though, walking lifts you. I mean if you are feeling down or you're worried about things, just physical getting out there and walking, particularly with a group cause you're talking to people all the time, you know just gives you a lift and you feel so much better at the end. (Focus group, health walk)*

Walking was seen to promote positive wellbeing through the combination of being in fresh air, companionship and exercise. In the stakeholder interviews, walk coordinators and others were clear about the mental health benefits resulting from having the opportunity to meet people and form social links.

> *One [individual] was medically retired from work due to stress and anxiety couldn't cope with it anymore and joined the walk group on the back of that to get out and get some fresh air, because she believed it was going to improve her wellbeing and sense of, you know how she felt about herself, and just coping really. And she said it's been brilliant. Because when she first left work she said she felt very stressed, very low, very unsure about her confidence to do anything. And that includes just going out for a walk. (Interview, professional stakeholder)*

Participation could promote positive health for people who were vulnerable or experiencing social problems. Some people described gaining confidence or observing others opening up in the social setting of the walk.

> *But I've seen it where there've been issues from mature adults whereby they've been in a shell, perhaps a mental health issue it isn't, but, you know, it's opened them up. I've seen people opened up and laughing and talking. They didn't, they wouldn't say boo when the first come. (Interview, professional stakeholder)*

Providing incentives to go out

Participants identified the value of participation in a regular organised walking group in relation both to facilitating regular physical activity and reducing social isolation. Many commented that without the incentive of the organised walk they might just sit at home. A further theme was the importance of feeling safe walking as a group, especially as a female.

> *You have to make the effort to come out. I could quite happily sit in the house, sit there every day but I'd weigh twenty stone by Christmas. At least I get to see people. (Focus group, health walk)*

> *I think it's safer to walk in a group especially for females. I know some people are quite happy to walk alone. Personally, I don't walk through the countryside alone. (Focus group, health walk)*

Local knowledge

Health walks were seen as a way of gaining valuable local knowledge, especially if new to an area. Participants described learning about local history, pathways and places to go.

> *And I think when you're used to going round in cars, if you're in this area and you go to walk and come back in a car and now people are stopping and walking and seeing things that they haven't seen. They've lived here forty*

years and they're still finding new places from coming on this walk. (Focus group, health walk)

Improved social networks

One the strongest themes was that participation in health walks brought social benefits from meeting people and friendships were often formed. These outcomes were highly valued and seen as integral to the experience of being part of the walk.

> *Health benefit, then the social benefit, we meet and finish at a fixed place and there's a café there where we all have a cup of tea and that is an integral part of the Walking for Health programme. We have to try and involve somewhere where people can socialise so people don't just do the walk and go home, they socialise. A lot of them are single people who perhaps don't see people from day to day and it's a good chance to meet other people and a mixed bunch from different walks of life as well. (Interview, befriender)*

In addition to the links formed within groups, being a member of the health walk could lead to better awareness and the opportunity to participate in local activities. Examples included:

- Sports activities – e.g. badminton or swimming
- Other walking groups, both longer health walks or walks organised by other voluntary organisations
- Social groups – e.g. craft or history groups

4.1.6 Strengthening communities

One of the objectives of the evaluation was to investigate the extent to which there was a link between processes of engagement in health walks and social capital, that is the bonds people form within communities and the links to wider social networks. The nature of the walking group as a social group and the links to other activities were strong themes.

The nature of the walking group

In the focus groups, participants took the opportunity to describe at length the experience of being in their group and its characteristics. They were asked to indicate if health walks were mainly about walking or socialising. People saw the health walks as being about walking **and** socialising – the two aspects being inextricably linked together. One individual argued that *"the social interaction helps you with your health".* This finding was also reflected in interviews with other stakeholders who recognised the social benefits as being a core feature of the health walks.

When asked to describe their walking group, the friendly and open nature of groups was emphasised (see Box 1). Having a place to stop for refreshments –'tea and scones' - after the walk was also regarded as an important element. Some groups organised additional social activities such as Christmas parties, trips out and even the occasional weekend away. The nurturing ethos of the group was seen as significant. Participants described people looking after each other and being helpful. The mix of people was another feature that some participants highlighted. Although participants did describe their role in mutual support, it was the walk leaders who planned and organised the walks and group members reported that they were not routinely involved.

Box 1 How would you describe your group?

Just a happy bunch I would say! People come and go. (Alnwick)

Helpful as well. If you see somebody struggling we look after each other. (Blyth)

A couple of hours well spent in the morning. (Blyth)

It's a mixture of people as well and everybody has a history, a different history. (Blyth)

Friendly, everybody talks to everybody. (Cramlington)

We're a big group of friends, social people who happen to walk on a Monday morning. Again it's like secondary really, the walking. (Cramlington)

Old and friendly. (Morpeth)

A nice bunch of people. A mixture of people from different places and not all from Morpeth. (Morpeth)

Very friendly, very outgoing, very helpful to one another and we have a lot of flexibility and entertainment on the walks so it's a great group. (Rothbury)

Warm, friendly, welcoming. (Stocksfield)

It's a talking group that goes for walks. (Stocksfield)

One interesting feature, also observed by the research team on the walks, was that the groups tended to function as a whole group on the health walk, rather than splitting into smaller friendship circles, even though people did often form personal friendships. On the walk participants described moving to talk to different people, this "natural movement of the group" meant that new people could be welcomed easily as walkers 'shuffled' around to speak to different people during the course of the walk, and those people who did not want to chat had the option of just walking along. The one exception to this was in one of the larger health walks

(Cramlington), where one participant perceived that although it was very friendly group, people did split into small groups of very good friends.

> *I will say that if for some reason you end up at the back of the walk and you want to be at the front of the walk, by the time you've worked your way up talking to everybody, you know it's half an hour later. It takes half an hour to walk through, you know. And I mean that's great. It's good that that can happen. (Focus group, health walk)*
>
> *I like the way that people intermingle because you look around and it's never the same two people that are walking together(Focus group, health walk)*
>
> *I mean sometimes you can walk and you don't have to talk. Sometimes you don't feel like talking so you just walk. And that's nice in itself and that's fine, not a problem. (Focus group, health walk)*

Social networks outside the group

The health walks were part of a range of activities taking place in local communities and many people described being part of other walks, fitness activities or community education. So in that way the walk was one of the menu of activities undertaken in the week. Some described being made aware of new activities through the walk, but equally others found out about health walks through those other activities. Thus health walks could be seen as part of that community infrastructure. One heath walk group had even set up a regular craft group.

> *I mean one of the groups that we have, they sometimes actually organise weekend trips away, you know where they all go off. They go off to the Lake District or somewhere like that. You know, it's just, it's really great that they're doing that. I guess that's the whole sort of social side of it as well, is that they've all bonded really well together. You know and it's great that they can go off and do that. (Interview, professional stakeholder)*
>
> *Well since we've joined this group and we've met other people, Bill introduced us to another walking group that we're members of now which we wouldn't have known about if we hadn't. (Focus group, health walk)*

What was of particular interest in the evaluation was whether the process of engagement supported stronger networks. Certainly friendships were formed that spilled over to community life. What was described as "spin-off activities", meeting for lunches or coffee, were not uncommon and were additional to the organised activities like trips. People could meet new friends, and this was important if people were new to the area or recently retired.

> *We've got a fantastic group there's no doubt about it. Everybody's friendly and there's been a lot of friendships made through the group, people that didn't know each other before, they've made really good friends. (Focus group, health walk)*

In contrast others talked about their town or village being a tight knit community and knowing people for years, sometimes having met them "at the school gate". One person explained that the walking groups had allowed them to renew friendships. Overall the health walks were seen as a way of socialising and this could mean increased knowledge of the community and recognition within it.

> *But since I've come on the walks, I can go to the shopping centre meet half a dozen people who I know. So I know a lot more people now than I did three-four years ago. (Focus group, health walk)*

> *My husband said something a few weeks ago. He said, "That group is your life now." It's true. (Focus group, health walk)*

4.2 Findings - Monitoring data

4.2.1 Walk Schemes

There are 10 Natural England walk schemes in Northumberland that consist of one or more walking groups (Appendix 5). For example, in North Northumberland there are five walk schemes that consist of one walking group each, whereas in West Northumberland there is one scheme that consists of multiple walking groups. From 1st April 2009 to 30th June 2011, the 10 walk schemes[5] promoted and organised a total of 2571 walks that were attended by 1253 registered walkers. Over this two year period, each registered walker attended on average about 52 walks[6] (nearly two per month) and walked on average 188 hours (nearly 2 hours per week).

Demographic characteristics

Three quarters of walkers were females (74.5%), which compares to the regional and national figures of females registered in the Natural England walk schemes. However, there were significantly fewer younger walkers in Northumberland compared with the regional and national levels (12.3% walkers aged 16 to 54 compared with 27.7% in the North East and 27.3% in the national sample) and significantly more walkers between 55 and 74 years old (78.4% compared with the regional figure of 64.4% and the national figure of 63.2%). The percentage of walkers aged 85 and over in Northumberland was similar to those at the regional and national levels (see Table 3).

There were significantly fewer walkers from Black and Minority Ethnic groups in Northumberland compared with the regional and national levels (0.6% non-white participants in Northumberland compared with 2.1% in the North East and 5.2% in the whole of England). In contrast with the national sample, where the majority of

[5] There are currently around 40 active walking groups within the 10 schemes in Northumberland.

[6] This number was calculated after subtracting the number of new walkers from the total number of registered walkers. This was done to reduce the skewness of the data because the number of registered walkers included all the new walkers who joined at any point in time up to the 30th of June 2011, some of whom may have not actually walked over that period or only recently started.

walkers (52.2%) lived within the second least deprived IMD areas, in Northumberland the majority of walkers (62.1%) lived within the first three most deprived areas (see Table 3). However, there were significantly fewer walkers in Northumberland (8.8%) living in the 20% most deprived areas compared with the regional (21.1%) and national (10.6%) levels.

Table 3. Demographic characteristics of walkers in Northumberland, the North East and England[7]

	Northumberland	North East	England
Characteristics	%	%	%
Gender			
Female	74.5	74	72.5
Male	25.5	26	27.5
Age groups			
16-24	1.1	4.2	3.1
25-34	1.5	6.8	6.1
35-44	3.1	7.4	7.4
45-54	6.6	9.3	10.7
55-64	41.2	32.0	31.9
65-74	37.2	32.4	31.3
75-84	8.8	7.2	8.7
85 and over	0.5	0.6	0.8
Ethnicity			
White	99.4	97.9	94.8
Non-white	0.6	2.1	5.2
Residential address by IMD			
IMD 0-20%	8.8	21.1	10.6
IMD 20-40%	16.2	N/A	15.4
IMD 40-60%	37.1	N/A	21.8
IMD 60-80%	22.9	N/A	25.3
IMD 80-100%	15.1	N/A	26.9

Notes: Figures do not include non responses
Multiple Deprivation
N/A = Not Available

Health characteristics

Walkers with a disability were slightly under represented in Northumberland compared with the regional and national levels (see Table 4). However, the numbers of walkers with one or more health screening conditions, with one or more health diagnosed conditions or who were referred to walk schemes by health professionals compared to those in the North East and in the national sample.

[7] Figures from North East and England were obtained from Fitches (2011) Who took part in Walking for Health? Natural England Research Report NERR041. Figures do not include non responses.

Table 4. Incidence of disability, health screening conditions and health diagnosed conditions in Northumberland, the North East and England

Characteristics	Northumberland %	North East %	England %
Disability			
Disabled	7.8	11.4	10.3
Non-disabled	92.2	88.6	89.7
Health screening conditions			
One or more	18.6	16.9	16.0
None	81.4	93.1	84.0
Health diagnosed conditions			
One or more	31.3	31.5	31.6
None	68.7	68.5	68.4
Referred by health professionals			
Yes	8.3	8.3	6.9
No	91.7	91.7	93.1

New walkers - joining rates

The number of registered walkers attending Northumberland's walk groups almost doubled between April 2009 – March 2010 and April 2010 – June 2011 (see Table 5). A major increase can be found in the estimated number of guests joining walk groups, which increased more than threefold. However, the number of walkers who registered for the first time in a walk group declined by 22.6% between 2009 and 2010.

Table 5. Total number of registered walkers, new walkers and guests attending walk groups in Northumberland by year, from 1st April 2009 to 31 March 2011

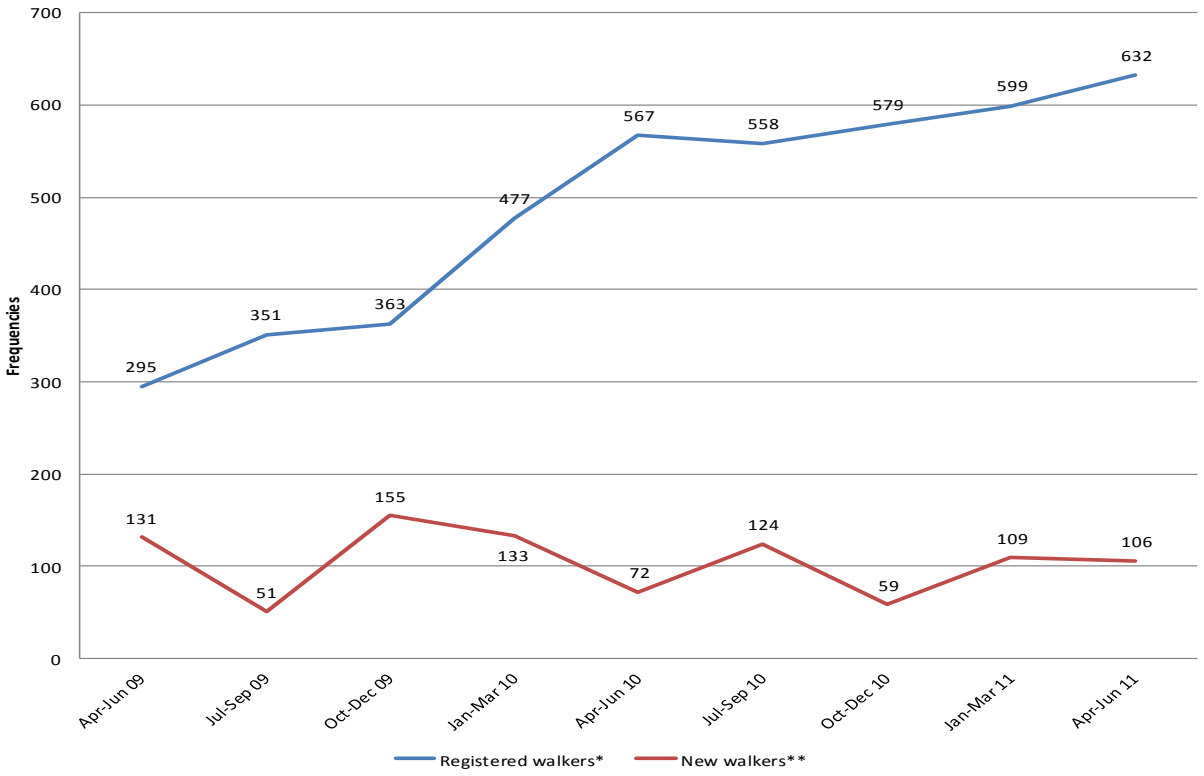
	Apr 2009 – March 2010	April 2010 – March 2011
Total walkers	310*	604*
New walkers	470	364
Total guests	15**	73**

Notes: * This number was calculated after subtracting the number of new walkers from the total number of registered walkers, see footnote 6.

** This is only an estimate that was calculated dividing the number of times that guests attended walking groups by the average attendance of registered walkers.

A closer look at the trends by quarter (see Figure 2) shows that the number of registered walkers steadily increased from the 1st April 2009 till the end of June 2011, whereas the number of new walkers had a somewhat more erratic trend.

Figure 2. Frequencies of registered walkers and new walkers in Northumberland by quarter from 1st April 2009 to 30th June 2011



Notes: * The number of walkers on the database who attended at least one walk minus the number of first time registered walkers.
** The number of first time registered walkers.

4.2.2 Sampled walk groups

Demographic characteristics

Monitoring data on the six sampled walk groups for this study started being entered on the Walking for Health national database from October 2008 to December 2010 (see Table 6 for a description of each walk). Because of insufficient data on the Rothbury walk, this was not included in the following analyses. The remaining five sampled walk groups showed similar demographic characteristics to those of the rest of Northumberland's walking group schemes (see Table 7), however, some aspects seemed to be more evident, for example the very low uptake of walks from people younger than 44 years, the ethnicity profile and the fact that the vast majority of the walkers were female. Nevertheless, there were more males in Morpeth Longer and less in Stocksfield.

Table 6. Description of the sampled health walks in Northumberland

Walk	Scheme	Description	Data from
Blyth Bootbenders	Blyth Valley Walkers	Flat costal walk 4 miles	2/10/2008
Cramlington - Concordia Crew	Blyth Valley Walkers	Flatish walks offering 2 mile, 4 mile and 6 mile options	6/10/2008
Alnwick - intermediate	CARAD Health Walks	Intermediate	7/1/2009
Rothbury - Starter	CARAD Health Walks	Starter Walk	17/4/2009
Stocksfield	Tynedale Health Walks	1 hour - 2 miles	3/12/2009
Morpeth Longer	Central Northumberland Health Walks	Longer walks taking in Morpeth Town and the surrounding area. Morpeth Short walks also available.	9/12/2010

Table 7. Demographic characteristics of walkers in the sampled health walks

	Alnwick	Blyth	Concordia Crew	Morpeth	Stocksfield
Gender					
Female	74.7 (62)	68.6 (70)	76.5 (140)	47.9 (23)	84.7 (50)
Male	25.3 (21)	31.4 (32)	23.5 (43)	52.1 (25)	15.3 (9)
Age groups					
16-24	3.6 (3)	0	0.5 (1)	0	1.7 (1)
25-34	3.6 (3)	1.0 (1)	0.5 (1)	0	0
35-44	6.0 (5)	1.0 (1)	1.6 (3)	0	3.4 (2)
45-54	8.4 (7)	8.8 (9)	8.2 (15)	4.2 (2)	1.7 (1)
55-64	33.7 (28)	49.0 (50)	53.6 (98)	29.2 (14)	47.5 (28)
65-74	36.1 (30)	36.3 (37)	31.1 (57)	54.2 (26)	33.9 (20)
75-84	6.0 (5)	3.9 (4)	4.4 (8)	10.4 (5)	8.5 (5)
85 and over	2.4 (2)	0	0	2.1 (1)	3.4 (2)
Ethnicity					
White	100 (82)	100 (102)	99.5 (182)	97.8 (45)	100 (59)
Non-white	0	0	0.5 (1)	2.2 (1)	0

Notes: Frequencies appear in parenthesis below the observed percentages

Health characteristics

Four of the five sampled walk groups showed a low uptake of walks from people with disabilities compared to the Northumberland, regional and national levels (see Table 8). However, the sampled walk groups showed an uptake of walks among people with one or more health conditions similar to Northumberland, the North East and the national level, with a significantly higher number of people with one or more health conditions in the Morpeth walk group and a significantly smaller number in the Blyth walk group.

The relationship between gender and health conditions was checked and found to be statistically significant ($p = .031$)[8]; with males more likely to have one or more health conditions compared to women. However, the relationship between gender and health was not found to be statistically significant when tested within each walk group[9].

Table 8. Incidence of disability and health conditions in the sampled health walks

	Alnwick	Blyth	Concordia Crew	Morpeth	Stocksfield
Disability					
Disabled	3.6 (3)	2.9 (3)	2.2 (4)	4.2 (2)	13.6 (8)
Non-disabled	96.4 (80)	97.1 (99)	97.8 (179)	95.8 (46)	86.4 (51)
Health conditions					
One or more	30.1 (25)	23.5 (24)	38.8 (71)	50.0 (24)	40.7 (24)
None	69.9 (58)	76.5 (78)	61.2 (112)	50.0 (24)	59.3 (35)

Notes: Frequencies appear in parenthesis below the observed percentages

Joining rates

Rothbury Starter and Morpeth Longer were the only two walk groups that did not have befrienders. Data on the joining rates for both 2009-2010 and 2010-2011 were available only for Alnwick Intermediate, Blyth Bootbenders and Concordia Crew (Cramlington). Consequently, it was not possible to fully evaluate whether the introduction of befrienders brought more people to join the walks.

Table 9 shows that there were no significant variations in the number of walkers joining Alnwick Intermediate, Blyth Bootbenders and Concordia Crew. Figure 3 shows that the number of walkers in these three groups remained substantially stable over time, with a slight decline in Concordia Crew and Alnwick Intermediate particularly in the quarters October-December 2010 and January-March 2011. These minor variations, which may be related to the particularly heavy snowfalls

[8] Although the Cramer's V was small (0.099).
[9] Given the small frequencies, Fisher's exact tests were run to test the relationship between gender and health within each walk group.

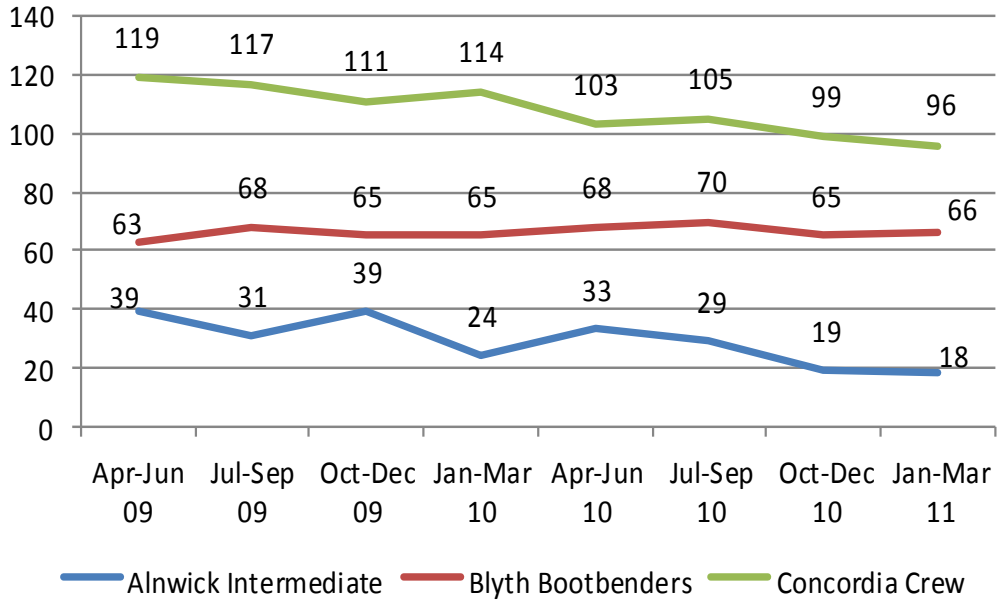
that characterised December 2010 and January 2011, did not seem to affect Blyth Bootbenders.

Table 9. Total number of walkers in 3 sampled walk groups by year, from 1st April 2009 to 31 March 2011

	April 2009 – March 2010	April 2010 – March 2011
Alnwick Intermediate	65	46
Blyth Bootbenders	80	83
Concordia Crew -Cramlington	153	139

Notes: Incomplete data for Morpeth Longer, Rothbury Starter, and Stocksfield

Figure 3. Total number of walkers in sampled walk groups by quarter, from 1st April 2009 to 31 March 2011



Walkers' attendance

Table 10 shows that the average weekly attendance in the walk groups for which complete data were available remained substantially stable between April 2009 and March 2010.

Table 10. Average weekly attendance by year from 1st April 2009 to 31 March 2011

	April 2009 – March 2010	April 2010 – March 2011
Alnwick Intermediate	9	8
Blyth Bootbenders	38	41
Concordia Crew - Cramlington	60	54

Notes: Incomplete data for Morpeth Longer, Rothbury Starter, and Stocksfield walks

Two walk groups showed a percentage increase in the total attendance of registered walkers between the year before the introduction of the scheme and the first year after the introduction, whereas two showed a percentage decline (see Table 11). In particular, total walkers' attendance increased 6.6% in the Blyth walk group and saw a major increase of 164.3% in Stocksfield. In contrast, total attendance of registered walkers declined by 37.7% in Alnwick and by 12.1% in Concordia Crew.

Table 11. Total walkers' attendance in sampled walk groups by year, from 1st April 2009 to 31 March 2011

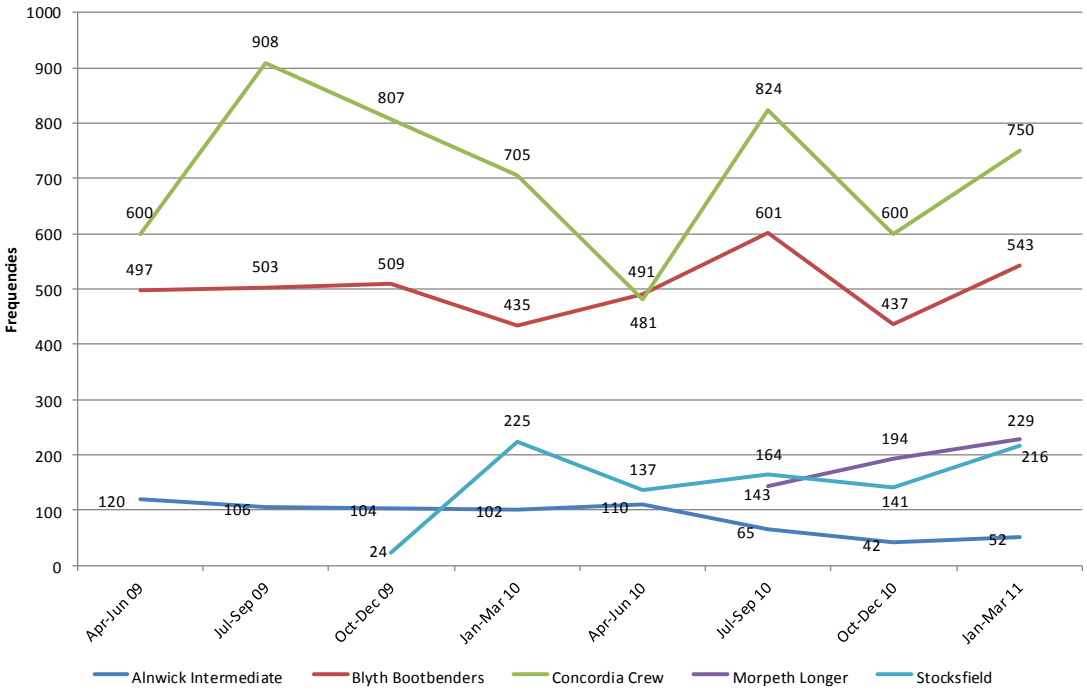
	April 2009 – March 2010	April 2010 – March 2011
Alnwick Intermediate	432	269
Blyth Bootbenders	1944	2072
Concordia Crew	3020	2655
Morpeth Longer	-	566
Stocksfield	249	658

A closer look at the attendance trends by quarter from 1st April 2009 to 31st March 2011 (see Figure 4), shows that three out of the four walk groups where data were available experienced a percentage increase in attendance in the quarter following the establishment of the Walking for Wellness project. In particular, between June and September 2010, walkers' attendance increased by 71.3% in Concordia Crew, 22.4% in Blyth, and 19.7% in Stocksfield compared to the quarter April – June 2010. In contrast, over the same period, in Alnwick walkers' attendance declined by 40.9%. The findings seem to suggest that the introduction of the Walking for Wellness project may have boosted walkers' attendance in Blyth Bootbenders and Concordia Crew beyond a potentially expected increase due to the coming of summer. In 2009, walkers' attendance had increased at a slower pace between the same quarters these groups (1.2% in Blyth Bootbenders and 51.3% in Concordia Crew).

Figure 4 shows that four of the five sampled walk groups experienced a drop in walker attendance in the quarter October – December 2010, which was then followed by a recovery in the following quarter. The only walk group that did not seem to be affected by such a decline was Morpeth.

Figure 4 also shows that the Cramlington health walk (Concordia Crew) experienced an uninterrupted decline in walkers' attendance from July 2009 to June 2010, when it reached the lowest level of attendance over the two years period here examined. However, attendance picked up again after the start of the Walking for Wellness project. On the other hand, Alnwick Intermediate experienced a decline in walkers' attendance after the introduction of Walking for Wellness, and then a 23.8% increase in attendance between October – December 2010 and January – March 2011. The differences both in terms of time of occurrence and entity of these declines in Concordia Crew and Alnwick Intermediate suggests that their causes are specific to the individual walk groups.

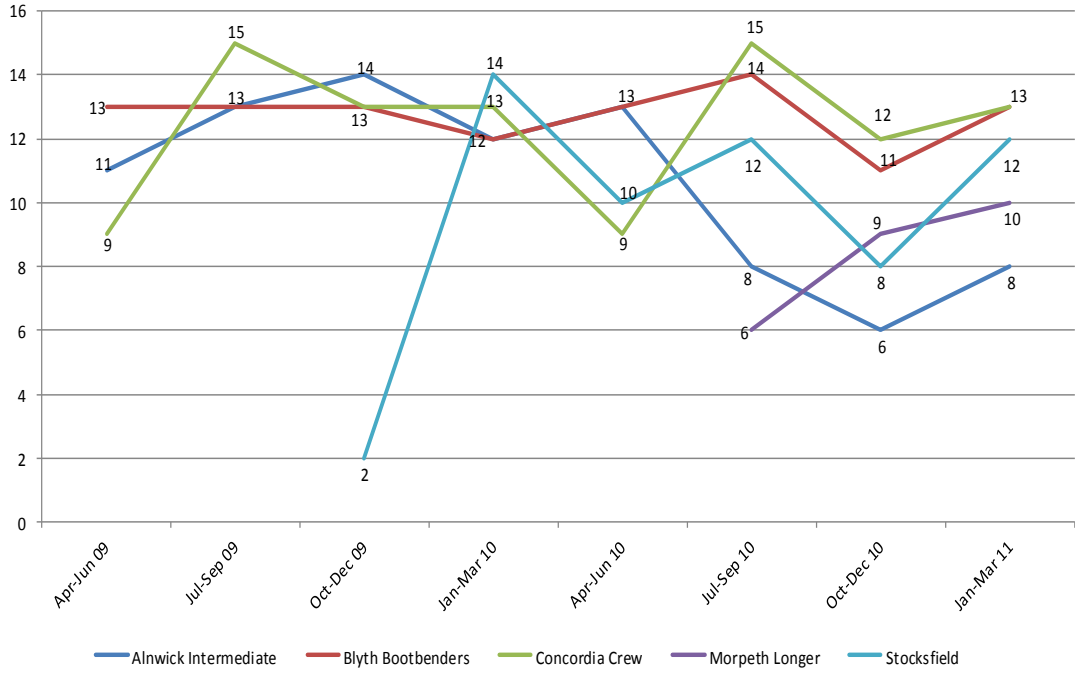
Figure 4. Attendance by quarter from 1st April 2009 to 31 March 2011 in sampled walk groups



A look at the trends by quarter of the number of walks organised from 1st April 2009 to 30th June 2011 (see Figure 5) shows that, apart from Alnwick Intermediate, the other walk groups presented similar patterns in terms of the number of walks organised over the period. Morpeth Longer was a new walk established in 2010 and data were only available from 2010. Figure 5 shows that all the walk groups organised a slightly smaller number of walks between October and December 2010, probably because of the heavy snowfalls that characterised that period. Alnwick Intermediate is the only walk group that experienced a decline in the number of walks organised in the last year (see Figure 5), in the number of

registered walkers and in their attendance (see Figure 3 and Figure 4). This may be due to specific causes that would need to be further investigated for this group. Overall, the walk groups organised a consistent number of walks each quarter over the last two years.

Figure 5. Number of walks organised by quarter from 1st April 2009 to 31 March 2011



5 Summary of evidence and issues for consideration

This evaluative study has aimed both to assess whether and how the Walking for Wellness project has worked and to begin to answer some wider questions about the processes that support engagement in walking groups in the context of the Walking for Health initiative and in what way those processes are connected to outcomes relating to mental wellbeing and social capital. In this section, the quantitative and qualitative evidence is summarised in relation to each of the evaluation objectives. The strength of the evidence is considered, as well as possible explanations for emerging findings.

5.1 How do people join health walks and what facilitates engagement?

Taking a broad picture, the Walking for Health initiative has proved a successful and popular intervention, and in comparison with many public health initiatives, has resulted in large scale engagement in walking (Fitches, 2011). The Northumberland area reflects a similar pattern to England as a whole, over a two year period 2571 walks took place and these were attended by 1253 registered walkers. Most of the walkers were in older age groups and three quarters were women. The evidence collected from the interviews and focus groups showed that people join health walks for a variety of motivations including to improve physical health, to meet people, to prevent loneliness or to get to know the local area. Sometimes joining was associated with a period of transition such as retirement, bereavement or moving to a new area. Others simply saw the opportunity or were invited along by friends or family. There was very little evidence of referrals through the GP or other health services, although referral routes for mental health service users were still under development. This was also reflected in the monitoring data which showed that around 8% of all registered walkers in Northumberland come through referrals from health professionals. Given the proven health benefits of walking for the sedentary population, there is clearly scope for increasing NHS referrals.

In terms of facilitating engagement, the most natural way to join was to go along with friends or family. Walkers reported that the act of going to a health walk the first time was a big step and could be daunting. The two main barriers were fear of not being able to complete the walk and anxiety about joining a social group for the first time. Once over the barrier of attending, new people were welcomed by existing members and introduced to other walkers. The evidence showed that walking groups are experienced as friendly, welcoming groups, have a mix of people taking part and those who stay generally find it easy to integrate. The social aspects, making friends, and being able to have a chat, were key factors that supported sustained engagement. We were only able to speak to people who were

attending, although not all these were regular walkers and some were relatively new to the groups. There is clearly scope for more research to investigate why people choose not join health walks and why they choose not to stay.

A further facilitating factor appears to be having different options for walk lengths, including a shorter walk, and having flexibility in the health walk to walk at one's own pace. Walkers spoke of how groups frequently accommodated slow walkers and the back marker was an important role. Potential walkers drawn from sedentary population may be put off health walks because of misunderstandings about the level and nature of the walks. Walkers potentially have a role in spreading the word as many commented on the nature of the health walk and the fact that they are 'not the Ramblers'. Having different options for walks may also help those who want to walk further and faster as some younger people with mental health needs may require.

The monitoring data showed that health walk schemes in Northumberland are involving people with health conditions, and this trend was also seen in the sampled walking groups, some of those had relatively high proportions of people with health conditions. There was qualitative evidence that people with physical difficulties were accommodated in walks, and the expectation was that groups would adapt to their needs until it got too difficult. Some individuals brought carers or persuaded a partner to come. Mental health issues were less visible, but nonetheless it was clear that people with mental health needs were involved in groups and indeed several participants highlighted the positive choice they or some other member had made to address mental health needs through joining a group. In terms of widening access, a facilitating factor is that group members were active in providing peer support to people who they perceived to have either physical or mental health needs.

Box 2: Issues for consideration – how can access be improved?

There is clearly scope for enhancing referral routes from health and other community services to health walks and possibly raising awareness with health professionals. Walkers can also help spread the word as they will be the best ambassadors for walks.

Having an option of both short and long walks appears to facilitate involvement as there is a concern of 'not being able to keep up'.

Consideration should also be given to the type of information that potential walkers receive. Targeted information may help if it explains what a health walk is, if it explicitly addresses concerns about not keeping up with the pace, if it highlights the mix of people taking part, and if it explains how new walkers can expect to be welcomed and generally find it easy to meet people. The voices of the walkers themselves, captured in a leaflet or DVD, may offer the greatest reassurance.

5.2 Has the befriender role worked?

The introduction of the befriender role to support the recruitment of people with mental health needs was a central concept for the Walking for Wellness project. The evaluation found that implementation of the role was patchy, often coordinators had problems putting it into practice, and it was difficult for the evaluation team to gather sufficient data on the impact of the befriender training from individuals identified as befrienders. It appears that the introduction of the Rosenberg self-esteem scale and the resistance to using it from some quarters posed an additional barrier.

Delays in implementation in community projects are not unusual, nevertheless the evaluation findings indicate that the introduction of befrienders has not worked for the more fundamental reason that the formal befriender role has not chimed with walkers and other stakeholders. Indeed the reluctance to discuss befriending in any depth in the focus groups was almost universally met with the response 'we do that anyway'.

It is important not to dismiss the befriender role because it has not worked in the way envisaged. The role is based on sound logic – the qualitative findings show that joining a walk for the first time is a major step for those not accompanied by relatives or friends. Those with mental health needs are likely to find that step more of a barrier. Once in the group, our evidence shows that the process of befriending occurs naturally – it was described in both groups with befrienders and those without. It appears therefore that befriending is a function of the group and that may explain why the introduction of a formal role did not fit. Identifying people with the right skills and attributes to take on the role informally may be useful. Participants were able to describe the characteristics of befrienders as caring, empathic and friendly and it was seen as a distinct role from the walk leaders, who had to concentrate on organising the walk. Moving away from a focus on people with mental health needs to befriending new recruits more generally emerged as a common sense strategy that provided a better fit with health walks.

The role of the coordinator in forming new groups and linking people to existing groups was also important, particularly since befrienders did not see their role as extending to going to people's houses or recruiting in the community. The funding of the Walking for Wellness project brought an additional focus on widening access. The monitoring data show that there has been an overall increase in walkers, but it is not clear whether this is as a result of the Walking for Wellness project or reflects more long term trends in participation. There is a need to monitor trends in order to identify the overall impact of the Walking for Wellness project.

Another factor that needs consideration is the stigma around mental health. The evaluation found that walking groups accommodate people with both mental and physical difficulties, indeed the social aspects of groups are positively helpful for

those mental health needs. However, walkers do not appear to want to talk about mental health, or take the responsibility for knowing about people's problems. This finding was echoed in the stakeholders' interviews where the stigma of mental health was seen as a major issue. The Walking for Wellness project, while raising awareness of mental health issues through the training, had also encountered some strong resistance to talking about it. Paradoxically many individuals spoke about their personal experiences of mental health in the interviews and focus groups.

Box 3 Issues for consideration – should the befriender role continue?

Befriending is an important function of the walking groups and this should be recognised when considering the need for any formal roles to support people with mental health needs. The evidence suggests that the natural befriending processes in the group can be enhanced by walk coordinators identifying people who have the skills and attributes to take on informal roles. This may be more about reinforcing what those individuals do naturally. Formalising roles, with additional training, is not seen as necessary.

There is also a role for walk coordinators in linking any referrals into groups and smoothing the way for new recruits by making sure some of the best 'befrienders' in the group are aware that they are new. Another potential strategy is to encourage new people, especially those referred from health services, to bring a friend or family member along if they feel nervous.

A broader issue for the development of the project is the evident and deep rooted stigma surrounding mental health. Being open about personal mental health needs is incredibly difficult and therefore the therapeutic role of walking groups is not always evidenced. A strategic approach to challenge some of the stigma is required.

5.3 What are the benefits of participating in a health walk? Is there an impact on mental health?

The evidence on the physical and mental health benefits of walking are well versed. One of the objectives of the evaluation was to improve understanding of the links between engagement processes and any mental wellbeing outcomes. The use of qualitative methods allowed participants to articulate benefits in their own terms; the result was identification of a wide range of health and social outcomes. Walkers and other stakeholders were overwhelmingly positive about the mental and social benefits of health walks. In this small scale evaluation, we were only able to speak to those individuals who were on the walk and who wanted to join a focus group. This may have resulted in a positive bias, as those who gained less from health walks may have chosen not to participate. Despite open ended questions, it may have been more difficult for participants to express negative views. On the other

hand, the sampling strategy achieved variation in groups, communities and attendance patterns, and moreover, the focus groups were well attended, with a mix of different experiences represented.

Overall the results show that a range of outcomes can result from participation (see Box 4). In terms of physical health, the finding on improved physical function through regular walking, particularly when that relates to transition periods such as retirement or recovery from surgery, merits further investigation. Again having walk options allows people to step up physical activity as they improve fitness.

Box 4: Benefits of health walks

- Increased physical fitness
- More regular exercise
- Improved mental health e.g. more relaxed, increased confidence, having an outlet
- Better local knowledge
- Reduction of social isolation
- Improved social networks
- Links to other community activities.

The social benefits identified were regarded as significant for wellbeing. The findings indicate that health walks should not be considered solely as a physical activity intervention, as they promote good mental health and address some of the determinants that impact on mental health, such as social isolation. Furthermore, there was evidence based on individual experiences that participation was a positive choice for those experiencing or recovering from mental illness or from those facing various stressors, like recent bereavement. There was good evidence that health walks are accessible to those with mental health needs and that individuals can expect to receive peer support through the group. Undoubtedly there are going to be challenges in capturing this evidence quantitatively, as the inclusion of questions like the Rosenberg self-esteem scale within the registration process added barriers and risked exposing confidentiality.

5.4 Do walking groups help strengthen social networks?

Strong, resilient communities are one of the determinants of good health (Marmot, 2010). The evaluation found that walking groups can contribute to building social capital. This is done through the relationships formed within the group and the connections outside the group. Not all walkers may gain through the connections made in the group and we were not able to interview those who had left the group. Participants may have been more positive about group dynamics within a focus group at the walk that they would have been if interviewed at a different time.

Notwithstanding these limitations, the themes of bonds within the group and external links emerged across all the sampled groups, and were raised by other stakeholders.

Within the group, there was evidence of various social processes contributing to group being a genuine community. These included:

- mutual peer support between participants, including offering support to those having mild difficulties.
- multiple social interactions occurring in the health walk as people 'shuffled' around to chat to people.
- friendships formed through the group and continued outside of the group.
- value given to social aspects, such as stopping for coffee and scones afterwards.
- additional group activities planned, such as holidays and Christmas parties.

One of the strongest themes was that the social benefits from participation, such as friendship, enjoyment, and a chance to meet people, were an integral part of the experience. Moreover these social aspects provided a motivation for engaging in the physical activity of walking, reinforced attendance, and led to further mental health outcomes in terms of reduction of social isolation. This suggests that engagement processes are inextricably linked to health and social outcomes and that the immediate sense of wellbeing generated from taking part in the walk - the enjoyment experienced - is only part of the picture.

There was evidence that the health walks in Northumberland are part of the infrastructure of community life. Walkers linked to other community based activities and also people found out about health walks through those activities. More research is needed to find out if these findings are replicated in other areas, as communities in Northumberland were described as close knit. There is also a question about whether health walks attract people who are 'community-oriented' in some way.

One notable finding in terms of social benefits was the use of walks as a mechanism to cope with loneliness or lack of social contacts, especially when moving into the area. The act of joining a walk could help people integrate into a community. This appeared to be important at times of transition, like retirement.

5.5 What is the potential for further research?

As the Walking for Wellness project develops, it will be important to continue to evaluate components of the scheme. This formative evaluation has highlighted some issues over the effectiveness of the befriender role and the impact of any changes in this role need to be examined. The long term impact of the project in widening access needs to be followed up. In addition, the scheme level monitoring data of total number of walkers will show whether the increase in new walkers and guests is sustained.

The evaluation as a pilot study has given some pointers for areas of further research. It has provided some strong evidence about social processes within groups and how these relate to health outcomes. However, it is a small scale study and therefore more research is needed to investigate if these findings are replicated in other population groups and areas of the country.

In terms of health inequalities, the issue of widening access to health walks is a significant challenge and there is scope for more research on effective mechanisms of engagement, particularly where groups are at risk of social exclusion. Consideration needs to be given to the choice of research methods in order to capture the views of those who do not engage or who choose not stay.

6 Conclusions and recommendations

Walking for Wellness aimed to widen access to health walks coordinated through the Walking for Health initiative and to increase uptake. Within that broad aim, the project has sought to establish support systems for people with mild to moderate mental health needs, notably through the introduction of a befriender role. Participation rates have increased since the start of the project and new walks have been formed. The evaluation found evidence that health walks are being accessed by individuals with mental health needs and physical difficulties, and moreover the walking groups accommodate and support participation. Areas where there is potential for further widening access include increasing referrals from health professionals and making both short and long walk options available.

Befriending is an important process within walking groups. The evaluation found that new walkers can expect to be welcomed and introduced to people. Walking groups are friendly and members offer peer support to each other. The formalisation of the befriending role did not chime with walkers nor with other stakeholders, but encouraging people to recognise their ability to undertake the role informally may increase capacity to expand health walks.

Engaging in a health walk is as much about the social aspects as the physical activity; the two elements are inextricably linked and result in a range of health outcomes. The evaluation found good evidence that participation can increase wellbeing and can help people cope with some of the factors that negatively impact on mental health. There was also evidence that being part of a health walk group increased or enhanced social networks.

6.1 Recommendations

- Increasing the number of schemes that have more than one walk option available – both short and long walks – is a practical strategy to increase access.

- Consideration should be given to producing targeted information (e.g. a leaflet or DVD) suitable for people interested in becoming involved. This would need to provide more detailed information on what people can expect in relation to the two main barriers –worry about keeping up with the pace and joining a new social group.

- Increasing referrals from health professionals is a recognised priority; focused publicity may assist if it explains about the range of benefits

and how people with various health problems can engage in health walks.

- Befriending is an important process in the groups, but consideration should be given as to how this role develops, with a focus on enhancing informal processes rather than formal training.

- Walk coordinators can potentially have a key role in bridging between health/community services and health walks and in linking new recruits with informal befrienders.

- Further evaluation should attempt to follow up those who chose not to join or who drop out to see if any specific barriers exist.

- The Walking for Wellness project has uncovered a deep rooted stigma about mental health. A strategic approach to addressing this stigma is required.

References

Agresti, A. (1996). *Categorical data analysis*. Hoboken, NJ: Wiley.

Ball, K., Cleland, V. J., Timperio, A. F., Salmon, J., Giles-Corti, B., & Crawford, D. A. (2011). Love thy neighbour? Associations of social capital and crime with physical activity amongst women. *Social Science & Medicine, 71*(4), 807-814.

Braun, V. & V. Clarke (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3, 77-101.

Connell, J. P. & A. C. Kubisch (1988). Applying a Theory of Change approach to the evaluation of Comprehensive Community Initiatives: progress, prospects and problems. *New approaches to evaluating community initiatives*. K. Fulbright-Anderson, A. Kubisch and J. Connell. Washington D.C., The Aspen Institute.

Department of Health. (2009). *Be active, be healthy: A plan for getting the Nation moving*. London: Department of Health.

Eyler, A. A., Brownson, R. C., Bacak, S. J., & Housemann, R. A. (2003). The epidemiology of walking for physical activity in the United States. *Medicine & Science in Sports & Exercise, 35*(9), 1529-1536.

Fitches, T. (2011). *Who took part in Walking for Health?* Natural England Research Reports, Number NERR041.

Green, J. & South, J. (2006). *Evaluation.* Maidenhead, Open University Press.

Heron, C. and Bradshaw, G. (2010) *Walk this way: recognising the value in active health prevention*. Local Government Information Unit, Natural England.

Hooker, S. P., Cirill, L. & Wicks, L. (2007) Walkable Neighborhoods for Seniors: The Alameda county experience. *Journal of Applied Gerontology,* 26**,** 157-181.

IPSOS Mori. (2011). *Natural England Walking for Health evaluation*. London: Natural England.

Jackson, L. E. (2003). The relationship of urban design to human health and condition. *Landscape and Urban Planning, 64*(4), 191-200.

Jones, J. A. & N. Owen (1998). Neighbourhood walk: a local community-based program to promote physical activity among older adults. *Health Promotion Journal of Australia* 8(2), 145-147.

Kahn, E. B., Ramsey, L. T., Brownson, R. C., Heath, G. W., Howze, E. H., Powell, K. E., et al. (2002). The effectiveness of interventions to increase physical activity. A systematic review. *American Journal of Preventive Medicine, 22*(4 Suppl), 73-107.

Kelley, G., Kelley, K. S., Hootman, J., & Jones, D. L. (2009). Exercise and health-related quality of life in older community-dwelling adults: a meta-analysis of randomized controlled trials. *Journal of Applied Gerontology, 28*(3), 369-394.

Lee, I. M., & Buchner, D. M. (2008). The importance of walking to public health. *Medicine & Science in Sports & Exercise, 40(7) Supplement*(1), S512-S518.

Lindström, M., Hanson, B. S., & Östergren, P.-O. (2001). Socioeconomic differences in leisure-time physical activity: the role of social participation and social capital in shaping health related behaviour. *Social Science & Medicine, 52*(3), 441-451.

Lindstrom, M., Hanson, B. S., Wirfalt, E., & Ostergren, P.-O. (2001). Socioeconomic differences in the consumption of vegetables, fruit and fruit juices. *The European Journal of Public Health, 11*(1), 51-59.

Marmot, M. (2010). Social determinants of health inequalities. *The Lancet, 365*(9464), 1099-1104.

McNeill, L. H., Kreuter, M. W., & Subramanian, S. V. (2006). Social environment and physical activity: A review of concepts and evidence. *Social Science & Medicine, 63*(4), 1011-1022.

Morris, J., & Hardman, A. (1997). Walking to health. *Sports Medicine, 23*(5), 306-332.

Natural England. (2010). *Walk this way. Recognising value in active health prevention*. London: Natural England & Local Government Information Unit.

NICE. (2006). *Four commonly used methods to increase physical activity: Brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling*. London: National Institute for Health and Clinical Excellence.

Ogilvie, D., Foster, C. E., Rothnie, H., Cavill, N., Hamilton, V., Fitzsimons, C. F., et al. (2007). Interventions to promote walking: Systematic review. *BMJ, 334*(7605), 1204.

Paluska, S. A., & Schwenk, T. L. (2000). Physical activity and mental health - Current concepts. *Sports Medicine, 29*(3), 167-180.

Patton, M. Q. (2002). *Qualitative research and evaluation methods*. London, Sage.

Pawson, R. & Tilley, N. (1997). *Realistic evaluation*. London, Sage.

Plescia, M., M. Groblewski, et al. (2006). A lay health advisor program to promote community capacity and change among change agents. *Health Promotion Practice* 9(4), 434-439.

Renalds, A., Smith, T. H., & Hale, P. J. (2011). A systematic review of built environment and health. *Family & Community Health, 33*(1), 68-78.

Siegel, P. Z., Brackbill, R. M., & Heath, G. W. (1995). The epidemiology of walking for exercise: Implications for promoting activity among sedentary groups. *American Journal of Public Health, 85*(5), 706-710.

Sjosten, N., & Kivela, S. L. (2006). The effects of physical exercise on depressive symptoms among the aged: a systematic review. *International Journal of Geriatric Psychiatry, 21*(5), 410-418.

The Countryside Agency (2005). *Walking the Way to Health 2000 – 2005 Summary of local health walk evaluations*. Cheltenham, The Countryside Agency.

Trost, S. G., Owen, N., Bauman, A. E., Salllis, J. F., & Brown, W. (2002). Correlates of adults' participation in physical activity: review and update. *Medicine & Science in Sports & Exercise, 34*(12), 1996-2001.

Appendix 1 Focus group schedule – walking groups

An evaluation of Walking for Wellness
Focus group schedule – Walking Group

Introduction

1) Explanation of the project: Aims and reason to run the focus group
2) Detail consent / right to withdraw / confidentiality / recording

NOTE. The numbered questions represent the key questions of the focus group. Underneath them there are prompts or further, more specific questions).

1. How did you become involved?

- How did you find out?
- When did you first join?
- What happened when you first joined?
- How would you describe your group to other people?

2. What about new people – how do they become involved?

- How often do new people join?
- What happens in the group when someone new joins?
- What helps and what hinders new people joining in?
- Do you have any friends who have left the group, why do you think this is?
- What happens if people have physical difficulties/conditions? (Does it stop them joining?)
- What happens if people have mental health issues – e.g. feeling very anxious?

3. What do you think you gain from being involved in walks? What don't you like about it?

- What do you think you gain from being involved in walks? Are there any drawbacks?
- Has it increased your knowledge and experience of the area/community where you live?
- Benefits has taking part in the walks led you to join any other activities?
- Do you do anything connected with this walk during the week? (meet people from the walk etc)

4. Would you say that being involved in health walks is mainly about walking or about socialising?

- Do you talk to everyone in the group or just one or two?
- During a typical week, do you talk to or meet these people only during the walk or also in different occasions?

Have you meet new people through the walking group?

- Are these people you would normally meet through your network of friends or are they people you would not normally meet?
- Are you involved in deciding where to walk and how far you walk?
- If you need information about walking how do you get that?

5. Have you heard about the befriender role?

- What do befrienders do?
- If you have befrienders in your group, how do you see them working?
    - Are they leading the walk or supporting/complementing the walk provided by walk leaders?
    - Do the provide support to community members (social support, any other type of support)?
    - Do they provide education/information/advice?
- How are befrienders different from walk leaders?
- Are they involved in the planning of the walks? Can they suggest new routes etc.?
- What do you think are the most important skills or qualities that befrienders need to have and why?

6. If we are to expand our evaluation and set up a new scheme to help us understand about social and mental well-being; are there any areas/topics that you think would be good for us to explore?

- Would questionnaires be appropriate to investigate these topics?
- What methods do you think would be best to explore issues around mental health and wellbeing?
- What methods do you think would be inappropriate?

---

7. Any other comments

Appendix 2 Focus group schedule – befrienders

Walking for Wellness
Focus group schedule – Befrienders

1.a) Pathways - How and why did you become involved in the befriender project?
Probe re:

- Why it's important to them to be involved, what do they gain from participation? Social aspect? Helping others?
- Why volunteer now? Do they have previous experience of volunteering?
- Are they simply interested in leading a healthier lifestyle; if so, why now?

1.b) How many of you are walk leaders?

2. What does the role of a ' befriender' involve?
Probe re examples such as:

- Provision of support to community members (social support, any other type of support).
- Provision of education/information/advice
- Providing access TO communities
- Helping communities access services; are they leading the walk or supporting or complementing the walk provided by walk leaders?
- Are they involved in the planning at all? Can they suggest new routes etc?

3. What do you think are the most important skills or qualities that befrienders need to have and why?
Probe re:

- Importance of local knowledge
- Empathy/social skills
- Languages (other languages/colloquial)
- Common experience/characteristics (peers)
- Street intellect'/'knowing how it is for people like us'
- Not being judgemental
- Community insight and knowledge of the area
- Being committed to their own communities etc

4. What skills did you bring to the project?
Probe re:

- Previous work or other experience which might be relevant to their role as a befriender.
- What training/qualifications had they had prior to this work?
- Did they have to have any prior knowledge of mental health?

5. When you went on the training what did you learn that you didn't already know?

- Was there any training around mental health and wellbeing?
- How much did it prepare them for the role?
- What skills do you think you have developed? What impact has the training had?

6. How would you support new people join a health walk?

- **Have you changed anything as a result of the training?**

- People with mental health needs?
- What works best? Any difficulties?
- **Do you feel that the task that you have been given (helping people with low-moderate depression and anxiety to join walks) is within your reach or is more help and support is needed to make their role work?**
- Has the training made a difference to what you do?

7. What do you perceive are the main benefits that the walkers get from being involved in health walks?

- Social aspects, someone to talk to etc
- Advantages to their health
- Increased knowledge of area and community
- Help with mental health needs

8. Are there any aspects of the role that you do not enjoy?
:

- Paper work/filling in forms
- Providing information in a questionnaire
- Register taking?

9. If we are to expand our evaluation and undertake further research around Walking for Wellness; area there any areas/topics that you think would be good for us to explore?

- What methods are most appropriate for use with walking groups & walkers? What methods are inappropriate?
- How can we explore mental health and wellbeing?

---

10. Any other comments

Appendix 3 Interview schedule – stakeholders

Walking for Wellness
Interview schedule – stakeholders

1. **What is your current role within your organisation and what does your organisation do?**

2. **Could you tell me how you know of, or are in contact with Walking for Wellness?**
   Probe re:
   - What they know about the w4w and the nature/extent of their contact with it.
   - What do they know about how the walk leaders and befrienders fit in with the objectives of the w4w.

3. **Do you know anything about the role of befrienders and their involvement in the project?**
   Probe re:
   - Provision of support to community members (social support, interpreting)
   - Provision of information/advice
   - Are they leading activities or supporting or complementing activities provided by a professional walk leader?

4. **What do you think are the most important skills or qualities that befrienders need to have and why?**
   Probe re:
   - Importance of local knowledge
   - Empathy/social skills
   - Languages (other languages/colloquial)
   - Common experience/characteristics (peers)

5. **How has the befriender training worked?**
   - What are issues covered?
   - How has it helped develop role?

6. **How well are referral and recruitment processes working?**
   - How easy has it been to recruit befrienders?
   - How have they been supporting new walkers?
   - How are people with mental health needs referred? How are these processes working?

7. **Do you perceive there to be any evidence that joining a walking group helps wellbeing or helps people form social networks? What is your experience?**

8. **If we are to expand our evaluation and undertake further research around Walking for Wellness; area there any areas/topics that you think would be good for us to explore?**

- What methods are most appropriate for use with walking groups & walkers? Are there any methods that are inappropriate?
- How can we explore mental health and wellbeing?

7. Any other questions

Appendix 4 Cover letter - walkers

16 July 2013

Dear Walker

An evaluation of Walking for Wellness

We are writing to you because you are a member of a health walk coordinated through Walking for Health to see if you would be willing to take part in an evaluation of the Walking for Wellness project. Walking for Wellness is a new project based in Northumberland that seeks to widen access to health walks through setting up a network of befrienders.

We would like to ask if you would be willing to take part in a focus group **[delete as appropriate]** with one of our team of researchers after the walk on **[date]**. We would like to get your views on how well the project is working, how and why people become involved in health walks, and whether joining a walking group helps wellbeing.

Please carefully read the Information Sheet enclosed. Someone from the research team will be attending the walk on **[date]** and will ask if you are happy to take part in a focus group with your fellow walkers. If you agree to take part in the focus group, this should take approximately 45 minutes and will take place after the walk. Refreshments will be provided.

If you have any questions, please contact Karina Kinsella Research Assistant at k.kinsella@leedsmet.ac.uk or direct dial 0113 812 7651. Alternatively contact Coral Hanson, Health and Fitness Manager, Blyth Valley Arts and Leisure, Tel: 01670 542535 or email CHanson@bval.co.uk

Yours sincerely

Dr. Jane South
Director, Centre for Health Promotion Research
Tel: 0113 8124406
Email: j.south@leedsmet.ac.uk

Appendix 5 Walk schemes in Northumberland

Table 12. Active walk schemes in Northumberland

Walk schemes
CARAD Health Walks
Bell View (Belford) Walking for Health Group
Berwick Walking for Health Group
Berwick Wallace Green
Glendale Walkers WHI
Seahouses Walking to Health Group
Blyth Valley Walkers
Central Northumberland Health Walks (Castle Morpeth)
Tynedale Health Walks
Central Northumberland Health Walks (Wansbeck)