

Health and Social Care Committee

Oral evidence: Healthy Ageing: physical activity in an ageing society, HC 1180

Wednesday 10 December 2025

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Dr Beccy Cooper; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Alex McIntyre; Gregory Stafford.

Questions 155 - 255

Witnesses

[I](#): Charlotte Osborn-Forde, CEO, National Academy for Social Prescribing; Graeme Sinnott, Director of Place and Strategy and Deputy CEO, Active Partnerships National Organisation; Huw Edwards, CEO, ukactive; and Jeanette Bain-Burnett, Executive Director for Policy and Integrity, Sport England.

[II](#): Ryan Hughes, Head of Programmes and Partnerships, Active Norfolk; Siobhan Farmer, Director of Public Health, Gloucestershire County Council; and Bethany Badrock, Ageing Well Programme Manager, GM Ageing Hub, Greater Manchester Combined Authority.

Examination of witnesses

Witnesses: Charlotte Osborn-Forde, Graeme Sinnott, Huw Edwards and Jeanette Bain-Burnett.

Q155 **Chair:** Welcome to this session of the Health and Social Care Committee. This is the last of our sessions on “Healthy Ageing: physical activity in an ageing society”. We start today with quite a large panel. Will everyone please introduce themselves and, very briefly, their organisations?

Jeanette Bain-Burnett: I am Jeanette Bain-Burnett, executive director for policy and integrity at Sport England. We invest in getting the nation active, particularly through communities and places.

Graeme Sinnott: Good morning, all. I am Graeme Sinnott, director of place and strategy and deputy CEO at the Active Partnerships National Organisation. We connect, strengthen, support and represent a network of 42 local active partnerships across the country who are focused on addressing physical inactivity.

Charlotte Osborn-Forde: Good morning. I am Charlotte Osborn-Forde, chief executive at the National Academy for Social Prescribing. We are the national organisation dedicated to advancing social prescribing and supporting the health system.

Huw Edwards: Good morning. I am Huw Edwards, chief exec of ukactive. We are the industry body for fitness, leisure and physical activity in the UK.

Q156 **Chair:** Thank you all very much. We are particularly focusing on the older population and trying to get them moving. What is your organisation’s role, and what are some of the barriers that you face in trying to do that?

Jeanette Bain-Burnett: First, I should say that we at Sport England recognise that getting older and being active at 55-plus can be challenging—there are lots of barriers, which I can talk about—but we also realise that this is a life course issue. The youth strategy was launched today. Sport England is mentioned in it quite a few times, because we think, we believe and we know from our evidence that if you get active at a younger age, it is much more likely that you will keep that habit for life.

One of the really challenging things is that particular life transitions—moments like the transition into retirement or into being a grandparent—are turning points for an individual. There is a real opportunity to recognise those transition points. We work directly with communities and places. We invest in the places where we see the highest need, and we make sure that we are targeting our work at populations that are older or moving into later life. All our work comes from the ground up and looks at working really closely with the needs of the communities that we are working with.

Q157 **Chair:** The chief medical officer’s report on an ageing society pointed to



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rural and coastal areas, in particular, as places in the country that are ageing faster than others. Does that mean that you are targeting those kinds of areas?

Jeanette Bain-Burnett: Yes. We target areas depending on a number of different needs, but we recognise that there are distinct needs in rural and coastal areas. Transport, in particular, is a barrier in rural and coastal areas; even if you have good provision, people may not be able to reach it. We realise that social isolation is a compounding challenge when it comes to getting active. Many of the places that we invest in are rural and coastal areas, but we have a mix.

Q158 **Chair:** What proportion of rural versus urban—

Jeanette Bain-Burnett: I will have to send you that detail.

Chair: I am just curious whether the money is flowing to the places where the Government have already identified need in terms of the ageing population, but feel free to write to us.

Jeanette Bain-Burnett: Absolutely.

Q159 **Chair:** Graeme, what are you guys doing?

Graeme Sinnott: We support a local network who cover the whole country, and they work with health and care partners to try to join up things to support this agenda. They understand the needs, the local barriers, the local people, the local assets, the networks and the opportunities across sectors to try to address some of the issues in their local context. I know you will hear about a range of local examples from the next panel.

Our role within that as a national organisation is to try to support the strengthening of the whole country. We think about all the different contexts that you have just mentioned, from rural communities to small market towns and urban areas—those are the factors that we know exist across our whole country. We try to support our network to adopt approaches that embrace the local context they will be facing, whether that is in Norfolk, Greater Manchester or Gloucestershire, so that those approaches are grounded in the local challenges around ageing. We try to support that network to take local approaches that all feel part of a national effort.

Q160 **Chair:** What is your biggest barrier?

Graeme Sinnott: As an organisation, I would say that it is probably the join-up at national level. There is really good stuff happening at local level, and there are places where things can really come together across sectors, policies and investments. If we had similar cross-working at national level, it would really allow the local level to thrive. It is about how we get local autonomy and national coherence to address this quite complex agenda, on which Jeanette just set out some of the evidence.

Q161 **Chair:** Jeanette, you were nodding along. Would you agree?

Jeanette Bain-Burnett: Yes, it is about recognising that there is a role for a national framework that supports local areas to do this well. Many of the things that would be barriers are environmental factors: access to green and blue spaces, facilities, transport and those kinds of things. Some of those things can be unlocked locally, and some of them need a national framework. Across a lot of the strategies that have come out from the Government, there is a nod to working cross-Government. We really support that, because we do not think sport can do it alone.

Charlotte Osborn-Forde: At the National Academy for Social Prescribing we advance social prescribing, which is an all-age service. Social prescribing means looking at the root causes of somebody's health—the social determinants. That is things like debt, employment, loneliness, and for older people, things like bereavement and becoming a carer. Social prescribing means really listening to what people's needs are, helping them to think about what is in their lives that could improve their health and wellbeing, and then connecting them to community groups and services.

Social prescribing is now part of the NHS, and it is funded through the GP contract. Many of the people who are accessing it are in middle-to-late age. The most popular demographic is 60 to 70-year-olds. It plays an important role for people who might not necessarily fit into the boxes of other services, such as young people's services or older people's services, as social prescribing is all age.

The primary barriers and challenges we face are recognition, awareness and support for social prescribing within the health service and the NHS. It is still a relatively innovative and new approach. It was developed by GPs and community leaders over the last decade or so, and then it was embedded within the NHS in the last long-term plan. But since then, the NHS has been through huge change. We have had a pandemic and incredible pressures on the NHS. Social prescribing is not able to reach its potential yet.

Q162 **Chair:** Are you concerned that you are being forgotten?

Charlotte Osborn-Forde: Not necessarily forgotten, because I think we have made huge progress over the last five years. It is a real success story for the NHS. But there is so much more we could do, and when the NHS is under vast pressure, it is important that we continue to think about and focus on preventive and personalised measures.

Huw Edwards: We represent gyms, pools and leisure centres across the country—there are circa 7,000 across the whole UK. Our role in this, in terms of the immediacy around older people, would be giving them the programmes and services that support their physical, mental and social wellbeing. What we have seen in the last 12 months, which is really positive, is a 19% increase in over-65s visiting our facilities. That has been driven by a combination of the price point being really affordable, a programme and service that really speaks to them, a growing recognition post-pandemic of the importance of this agenda, and also that a number

of these facilities, which is interesting in the context of neighbourhood health schemes, have co-located other services, such as GPs. What you are seeing here is positivity about what these facilities are providing.

When it comes to barriers, I echo what colleagues on the panel have said. This is not the environment to grow these services. Never mind whether they are public or private, there is a real demand for services right now, but that is not being matched by the opportunity to grow these services within the communities in which they operate.

Q163 Chair: In your submission to us, you pointed out that the 10-year plan barely mentions your sector. What do you make of that?

Huw Edwards: My assessment would be that no one in the political leadership at the top of Government actually understands the sport and physical activity sector and the role it can play in prevention. As a result, you get what we see, which is generalisation about sport and physical activity in the men's health strategy and the 10-year plan.

Q164 Chair: Why do you think that is? Is it a lack of evidence that they have seen? Is it just that they don't know? Is it that they know but they are actively not trying to do it because it is too expensive? I am putting words in your mouth. From your perspective, what is going on?

Huw Edwards: With colleagues here, there is probably enough evidence about the role of sport and physical activity to fill Westminster Hall, but there is no seriousness in Government around this agenda. What you have right now with gyms, sport, digital health, urban design and active travel is a growing movement economy. We had 600 million visits to gyms, pools and leisure centres last year. There is a huge growth in demand for our members' services, but we can't meet that demand because the infrastructure and the economic environment are not there for us to support that. There is a lack of seriousness at the top of policy.

Q165 Chair: What would that look like? If you saw something serious, what would it be?

Huw Edwards: No. 1 is bringing the commercial and business leadership of our sector into these conversations with the Government, and then you can do three things. First, you can create really credible campaigns that target such audiences and not have, with the greatest respect, tokenistic campaigns that are conceived and die in Whitehall and have no impact.

Secondly, let us look at the priority audiences: mental health, musculoskeletal, fall prevention and obesity, especially in the context of GLP-1. Create and co-create plans, and give our sector targets to hit in that space.

Thirdly, create a fiscal environment for the consumer and the industry that incentivises more people to be active. Doing that and working with the sector in that way could have real, tangible results in this Parliament.

Chair: Thank you. That brings us on very nicely to the next set of questions.

Q166 Gregory Stafford: I will touch briefly on the funding. Jeanette, in Sport England's submission, you say that you would welcome "the development of a funding model that incentivises action and impact on tackling inactivity." From your point of view, what would that look like, and how would it compare with what we have now?

Jeanette Bain-Burnett: At the moment, we have a very vibrant sport and physical activity sector that works in lots of different ways and contexts. The settings in which it can be expanded are education, across transport through active travel, recognising the opportunity for preventive health. We believe that if we can have cross-Government agreement that getting active—getting people to move more—is a priority because of the social value it drives, we could see a change.

NHS England did a really great piece of policy work about how the NHS could prioritise physical activity. It talks about four ways forward. It talks about clinical practitioners having the tools they need to advise their patients about physical activity and movement as part of their everyday practice. It talks about the NHS workforce itself becoming fit and well. That is not the kind of thing that an arm's length body can take on alone; we need the support of the Department of Health and Social Care.

Q167 Gregory Stafford: Let me push you on that. Just to be really clear, what would the funding model look like? You want a new funding model that incentivises action. What would that look like?

Jeanette Bain-Burnett: The funding model would be based on the outcomes that communities get from physical activity. It would have to have an element of place-based funding, recognising that local systems can be joined up. Education, health, community, gyms and leisure centres can be joined up. You can fund a system that is built from the ground up to serve local residents, but it should have a framework across the national policy context that allows it to flourish and thrive. That is what I think it would look like.

We do that at a smaller scale. We can do that to drive the core physical activity outcomes, but other Departments and other parts of different sectors can drive other outcomes. We cannot fund the fixing of pavements, but other Departments might be able to. It is about understanding that there are lots of pieces to this really complex puzzle that help design in activity. We have designed it out of our lives now. The way that we live our lives now is sedentary, so we are trying to find ways to design that physical activity back in.

Q168 Gregory Stafford: What is the barrier to that happening? I suppose it is similar to the question the Chair put to Huw. Is it simply a lack of political leadership, or are there other barriers that need to be removed in order to achieve what you are trying to achieve?

Jeanette Bain-Burnett: I think we need joined-up political leadership. Leadership on this issue doesn't need to come from only one Department. It would be great to have Secretaries of State from a number of Departments—I know they all think that physical activity and addressing

inactivity is really important—coming together to understand how their piece of the puzzle fits into this picture, and to be really vocal advocates for it. There is definitely a place for political leadership, and I think it is happening in individual Departments. But there is also space for join-up at every level: regionally, locally and at community level.

Q169 Gregory Stafford: Huw, what are your reflections on that in terms of a funding model?

Huw Edwards: I echo what Jeanette said. You have to look at demand and supply. The fiscal measures that the Government has at its disposal can be about reducing the costs associated with physical activity. There are many ways of doing that. You can look at issues around VAT. In the last week, our members have been going through all their business rate assessments, which are not pretty, in terms of the Budget. That puts operational costs on to the sector, which will then be passed on to the consumer. That is unfair on the business, and it is also unfair on the customer. There are areas around business rates and VAT.

You can think creatively about some of the other fiscal measures that the Government has at its disposal. You can look at the cycle to work scheme. How can you extend the cycle to work scheme to include other measures? Especially when you are looking at working-age, and especially if you are looking at economic inactivity and productivity issues, how can we leverage the full sector in the economic stimuluses that the Chancellor has at her disposal? There is an opportunity to bring in our members and look at payment by results. Set us targets on MSK and mental health. There are areas of demand.

On the supply side, you have to look at the infrastructure that is supporting society. Jeanette mentioned some of the basic infrastructure, such as active travel and urban design. The fundamental issue that a number of colleagues here and across the parliamentary estate are talking to us about is swimming, which covers all ages. This Government has inherited an accelerated market failure on swimming. Five hundred swimming pools have been lost in the last 15 years, with 75%—three quarters—of them lost since 2020. That is a real issue, because it is across life. It is from learning to swim through to older people using and loving swimming as part of physical, mental and social wellbeing. There needs to be a plan for the infrastructure that is required from both the public and private perspective. Any plan around fiscal incentives needs to marry demand stimulation, supply and infrastructure.

Q170 Gregory Stafford: That is really helpful. Charlotte or Graeme, do you have any thoughts on a better funding model or a different funding model?

Graeme Sinnott: Jeanette and Huw have explained potential technical models. For me there is a human barrier, which is the extent to which we trust local people to decide the things they would like to achieve in life. There is really good evidence from Sport England's local delivery pilots that if you trust local, invest in local, and trust the power that local people have to convene communities to create outcomes, you can shift outcomes



over time. There is the work that 150 Big Locals across the country, supported by local trusts, have done over a 10-year period, giving every community £1 million. There is evidence that we can create positive shifts in some quite complex outcomes, such as those we are talking about here today, when we put trust in local communities and local assets, and allow that sense of pooled budgets, pooled resources and some of the technical components that Huw and Jeanette mentioned.

Q171 Gregory Stafford: Just to push you a little further on that, who would hold the purse strings for the stuff you are talking about? Trust local? How local? Local authorities? Individual operators? Just give a £50 voucher directly to every person who wants to go and do x? How local does this money go?

Graeme Sinnott: The current model, from a physical activity perspective, has Sport England as the primary holder. It will distribute that to a local level. We are talking about investment in places, and places then decide and determine who is the best person to hold the purse, to hold the money. At the moment, that looks like a range of the active partnerships that I support. Some of the money goes straight into local authorities, and some goes straight into community centres.

The question is the right question, but I go back to the point around trust and letting local people trust where the money best sits. There is a governance question, of course, about how we appropriately govern public money. There is a model of evidence showing that, when we trust that money can get local, we can find the right way to fund it, and it is not necessarily a one size fits all.

There is definitely some efficiency in how my network works side by side with Sport England and the leisure sector, so we can create the structures for that money to get local. I would not want to say definitively that there is a single model to achieve what I am talking about.

Jeanette Bain-Burnett: What we have learned through the pilots that we started back in 2015-16 is that it depends on the maturity in a local setting. Where there is leadership and real warmth towards this agenda, people will be more active, essentially. It really depends on whether the strength of leadership is in the local authority or a particular community centre. At the moment, I think we have signed three or four memorandums of understanding with mayoral authorities, where they are elevating this agenda and saying, "We want to join up the local system across our region to make this work." It depends, but we go where the leadership is.

Charlotte Osborn-Forde: It is important to see this sector as part of a wider ecosystem in a community. Yes, of course, there will be all the provision from the organisations that other panel members will talk about, but actually there are huge amounts of really diverse community activities, services and groups that provide opportunities for people to be active in other ways. For many of them, there is not any national funding or framework, and many are under huge, intense pressures and facing



closure. Whether they are older people's social clubs, nature-based activities where people come along for nature conservation or community gardening, or heritage activities such as vintage steam trains, they are all active in the community. People can come along and do something physical and social that directly improves their health, and it may suit people who do not necessarily feel comfortable coming to a mainstream sport or physical activity session.

Those wider organisations can often be forgotten in the conversations. That risks two things. It can risk nobody noticing that they are under incredible pressure and not recognising or valuing them, but equally it can risk not connecting and utilising the rich capacity that they have. For example, we are starting work with faith communities, which provide a huge range of different activities in the community. Many involve physical activity of different types. They are really keen to be connected into the health ecosystem and the local authority system and to be recognised for what they bring. Any strategy needs to see the physical activity system within that wider ecosystem.

Andrew George: Following up on that point, I want to look at the barriers that older people find when engaging in any ageing-well physical activity. There is a lot of two-dimensional thinking that older people need to get fit, meaning leisure centres, gyms, dumbbells, treadmills, putting on Lycra and perhaps changing their whole lifestyle. Then they go into these places, get intimidated, lose confidence, walk away and give up.

There is a lot of activity out there. I am a member of a running club, and I am an OAP. At the weekend, I run 10 miles over the Cornish hills with a load of friends.

Chair: You are putting us to shame.

Andrew George: Actually, last weekend we squelched. There are about 10 different groups in that club, from walk-run up to Olympic. Everyone praises each other and they all get along fine. There is no public money; there is no state intervention. A lot of them are engaged in park runs. There is a big community out there of activity in the voluntary sector and, as you say, conservation groups and so on, where you get sweaty and muddy, lift a lot of things, bend and stretch. The question—I am talking from experience—

Chair: You are painting a great picture, but we need a question.

Q172 **Andrew George:** The question is this: is there a role for the voluntary sector? Why is the state not utilising that enormous wealth of activity and trying to encourage more of it, rather than the more conventional methods that seem to be pursued by many organisations?

Charlotte Osborn-Forde: That is exactly why social prescribing was embedded by the NHS in the last long-term plan. It was a recognition that there is a wealth of health-creating and preventive activities in the community, but many people do not know that they are there. If you are somebody who is not well connected in the community, if you are isolated,



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if you have mental health needs, if you have physical health problems—mobility issues or disabilities—or if you live in a rural area, you would not necessarily know what is on your doorstep and you might be frightened to go along and take part if you do not know somebody there.

The idea of social prescribing is that there will be link workers in every GP practice who will sit with the person, spend time getting to know them, and do two things. First, they will help them set a goal for their physical activity. Some older people think, “I don’t want to wear Lycra or go to a gym.” The link workers will say, “What is your personal goal?” Some older people might say, “I want to play football with my grandson,” or “I want to be able to maintain my garden as my mobility decreases.” The link workers will think of that goal and then help the person to work backwards: “Okay, if you want to be able to play football, you need to keep being mobile. You might need to do some more exercise. Did you know that there’s a walking football group in the local area?” Some people will never want to engage in more formal things like running clubs, but what a social prescriber will do is think really creatively about all the assets in a community and ask, “What are your interests and passions?”

You mentioned dumbbells. One person I read about was in the faith community and wanted to do bellringing. You would not think that bellringing was good physical exercise, but it is incredible aerobic exercise. It is social. It is musical. Dumbbells are called dumbbells because they mimic the bellringing motion.

That is the beauty of what a link worker will do. They will not just think through the lens of physical activity, although they will absolutely work very closely with Active Partnerships and link into all the provision that is available. They are not just aware of that provision; they are aware of cultural provision, faith provision and heritage provision. The barrier we have is that there are simply not enough link workers. Already, we know that their caseloads are much higher than NHS guidance says. There are about 3,300 link workers. The current—

Chair: We are going to come back to this point, if that is okay.

Charlotte Osborn-Forde: I will pause there, then.

Q173 **Andrew George:** In terms of ensuring that there is enough provision out there, we are looking at barriers. How much need is there? How do you bridge the gap between what is needed and how we get people into the physical activity?

Charlotte Osborn-Forde: My experience is that there are vast amounts of provision. It is not lack of provision that is the issue; it is lack of pathways and guidance.

Huw Edwards: Just for the *Hansard* record, Lycra is not a prerequisite for going to our members’ facilities, but this is a really important point. The No. 1 thing is that all activity is good when trying to hit the CMO guidelines of 150 minutes a week and twice-a-week strength training.



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I echo what Charlotte said. The work that we can do with our core membership to connect to the outside community is a really good opportunity for gyms and sports and leisure centres to—as they are doing in areas now—go beyond the four walls of their facility, connect with the local community and support walking and rambling organisations, which can then use that facility as a base. The connectivity to wider areas of a local place or constituency, making sure that we are joining the dots up in the best possible way, is the right outcome.

We are seeing positive increases in relation to over-65s, especially in our members' facilities. However, we also know that there is a big cohort of over-65s who have not yet crossed the threshold into our members' facilities. How can we work with them, and work with partners on this panel, to be—

Andrew George: Members' facilities, did you say?

Huw Edwards: Yes. Visits have gone up by 19% in the last 12 months from over-65s in gyms, pools and leisure centres, but there is a lot more we can do. This is a really important area. Falls cost the NHS £2.3 billion a year, which is £6 million a day. What can we be doing, working with partners on this panel, to support the strength and independence of older people as they get into that stage of their life?

Q174 **Andrew George:** It seems to me that it is about the bridge between ill health and the GP surgery and wherever else that presents itself, and the variety—not just gyms, but exactly what Charlotte was saying. How do you get over that bridge? You are only mentioning the link workers; there is no other methodology at the moment.

Huw Edwards: We were talking about this before we came in. A big project that we are working on with Jeanette at Sport England right now is around digital integration. It is about how we can connect not just our facilities but community facilities to the NHS and GPs, so that there is a stronger, seamless journey and the GP can then signpost to what physical activity is happening in the community. That digital integration does not exist right now at the level it should. How can we work with partners to get that digital integration there? In terms of cost, we are really talking about a rounding-up number for the NHS.

Q175 **Chair:** I want to follow up on strength and balance, if I may. You have just mentioned falls. We have spoken a lot about aerobic activities and walking, but actually the evidence that we have heard so far is that strength and balance should be the priority shift for physical activity. Have you any data on this? More over-65s are coming, but what are they doing? Are they just on a treadmill, or are they actively lifting the dumbbells?

Huw Edwards: They are using weights, free weights and strength exercise classes as well. Our members are providing these programmes and services, whether it be business as usual on the private side or more bespoke programmes on the public leisure side. You are 100% right: the emphasis has been on the cardiovascular 150 minutes a week, but what is

hugely important for ageing across all levels of life is a greater focus on muscle training and strength training.

Q176 **Chair:** Are there plans to do more?

Huw Edwards: Correct. We have some new research coming out in January, which I will be delighted to share with the Committee. It bridges from the report that we have done this week on muscle mass loss associated with weight loss medication and GLP-1, and an ambition to ensure that we are part of the solution for the wraparound associated with the scaling of weight loss medication in the UK, knowing that it leads to a significant loss in muscle mass.

Q177 **Danny Beales:** Charlotte, I have a couple of questions for you about social prescribing, building on a point that Andrew touched on. Evidence that the Committee has received suggests that your survey work indicates that close to half of link workers suggested that the biggest barrier to social prescribing was a lack of provision of services to prescribe to. What are your views about the tools available to address that challenge? What tools should be provided to address the challenge that link workers face?

Charlotte Osborn-Forde: I should say that that is generic evidence around all sorts of activities, groups and services, not just physical activity. Actually, our survey shows that there is not necessarily a shortage of physical activity provision for people to refer to. The biggest gaps are typically around mental health support—community-based mental health support, as well as clinical mental health support—and around advice and financial support such as for debt and housing. The primary reason for referral, and the primary source of support that link workers are providing at the moment, is around poverty, debt, housing and those sorts of issues, which are really complex and hard to unpick, and for which we know there is not a great deal of capacity and services available. That is probably why that response is coming through.

In fact, link workers reported that they feel knowledgeable and comfortable to refer people into physical activity provision. Because of activities from Sport England, Active Partnerships and others, they are more comfortable with physical activity. Of course, for many patients, their support will be holistic. There might be capacity if they want to be more active, but often those other issues need to be addressed first before a person can think about physical activity. That has been a big barrier.

We are advocating for strategic long-term investment in the voluntary and community sector, targeted at those organisations that are providing direct support for people's health and wellbeing in the wider community. We are also advocating for a national fund to support them, alongside existing funds and local provision. That is important.

It is also about link workers having the time to go out into the community to understand and map what is available. To go back to an earlier point, they are under so much pressure with high patient demand and very complex needs that they often do not have the time to form relationships with local organisations and understand what is available in different

sectors or go out and experience it. If we had an increase in the number of workers—

Q178 **Danny Beales:** We will come on to the number of link workers, and my colleague will ask about staffing specifics in the workforce. I do not want to step on his toes. To clarify what you said, the lack of provision you have seen is not about physical activity but about other forms of support, finance, debt, mental health and housing?

Charlotte Osborn-Forde: That is right.

Danny Beales: That is interesting. Your perspective is that there are enough physical activity opportunities in local areas to refer to, but it is the other barriers and other forms of support that people need where the challenges arise?

Charlotte Osborn-Forde: I would not necessarily say that there is enough, but it is far less of a priority that is being flagged than those other areas.

Jeanette Bain-Burnett: Our health policy team has been doing some really significant investment in pilots around the connection between mental health and physical activity. We are recognising that there is an ongoing positive association between more activity and mental health. Mental health is just one of several long-term health conditions for which we have really strong evidence that physical activity is one of the prevention and treatment options.

The connection that needs to be made is recognising that physical activity is not just about physical health or very specific clinical or medicalised outcomes; it also links to holistic wellbeing. It provides an opportunity to connect into some of the agendas where a link worker, for example, might not think physical activity is the right thing for mental health, but we know that getting out in blue and green spaces and moving is significant.

Q179 **Danny Beales:** Very true. Charlotte, what would a social prescription for physical activity look like in practice? As you say, there are many activities available. Is it about making people aware of them? Is it accompanying them to one of those activities? Is it dealing with the barriers and, as you say, the cost of a gym membership?

Charlotte Osborn-Forde: The first thing to say is that all social prescriptions should include physical activity. It should be a core part of what any link worker asks. They should ask, "How physically active are you and do you know the benefits of physical activity?"

What it looks like in practice is incredibly diverse, but it will almost always come alongside connection and support for other issues. The first question is what the person's goal is; we then need to think about how they can achieve it. To Jeanette's point, that is about recognising that if improving their mental health is their goal, a walk in nature every day is absolutely going to make a significant contribution to that.



There will typically be a range of referrals to a range of different organisations. Subject to what the person or patient wants, social prescribing is strengths-based. The most important thing is that it builds a person's confidence and independence. Yes, it might mean going with a person to a local activity if that is the only way for them to go, but ideally the person will be encouraged to do that themselves, perhaps with some tips about how they can build confidence with a phone call in advance or by giving them the name of somebody they might meet. It is personalised, so it is whatever the person needs.

Q180 Danny Beales: We heard from Sir Muir Gray in our earlier evidence about the increasing drugs budget and that many people on drugs and pharmaceuticals should be getting other forms of support. We also heard that we should be shifting the money we spend on lifestyle-related drugs to deal with diabetes, cardiovascular disease and other conditions to preventive interventions. What you have said is important. Do you think there is a lack of parity of esteem between these sorts of interventions and medical prescriptions? One might argue that what a social prescription is in practice feels a bit nebulous: it is a conversation or a suggestion. Do you think the NHS should formally prescribe physical activity on an NHS script that you could take to a gym, in the same way that you can fulfil a prescription for Metformin at your pharmacy?

Charlotte Osborn-Forde: Whether or not the mechanism or process is up for discussion, I completely agree. I just wanted to highlight this report, which I am sure you will have seen and read: "Exercise: The miracle cure". This report came out 10 years ago, and when it did, I thought, "Wow—finally, the evidence. This is groundbreaking." It is from the Academy of Medical Royal Colleges—so the top medical bodies and doctors in the country.

I will quote one section that I think is important: "Exercise has been called a 'wonder drug' or 'miracle cure'. Increasing physical activity improves health for those with chronic conditions and prevents many common serious medical conditions. The health improvements with physical activity are often greater than many drugs."

If the Academy of Medical Royal Colleges is saying that exercise potentially has a greater effect than many drugs—and of course it has extra benefits around community engagement and environmental improvements—we need much greater parity of esteem between evidence-based interventions that improve health and pharmaceutical, medical interventions.

Graeme Sinnott: On your question about that sense of equity in how we prescribe physical activity, it does not sit alongside other behavioural factors that we know, such as smoking and weight management, which have a big role in health. I think that is the big thing in the question we are exploring: if you were creating a hierarchy, physical activity does not sit alongside those.



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As Charlotte and this panel have set out—and as I am sure you have heard from others—all the evidence showing the power of physical activity in addressing some of those issues is there. However, there is a hierarchy, and physical activity sits low down in that hierarchy, against those other behavioural factors.

Q181 Danny Beales: Through stop smoking services, you would be formally prescribed fake cigarettes, patches or other interventions, but you are not formally prescribed physical activity.

Graeme Sinnott: Physical activity could be a prevention engine, but it is just not viewed or geared in that way.

Jeanette Bain-Burnett: To be fair, it already is, because we already save, looking at my notes, about £500 million-worth of GP visits because people are active. So there is a well-maintained offer to communities across England for physical activity, and we are already preventing quite a lot.

If we were able to address the inequalities in access to physical activity—if we examined the way that we look at health inequality metrics in specific places—we could save about £20 billion more for the NHS. So we are already preventing; it is not that we are not but could be—we are already preventing a lot of ill health.

Q182 Chair: Where does the £20 billion figure come from?

Jeanette Bain-Burnett: From the social return on investment research that was done by State of Life, which came out very recently—about three months ago.

Huw Edwards: To reinforce Jeanette's point, there is a very strong existing relationship between the NHS at the local level and sport and physical activity in those areas, especially in the context of gyms, pools and leisure centres.

The question is more about how that is scaled on each level. For example, two thirds of prehab and rehab cancer treatment takes place in leisure facilities across the country. Existing programmes, such as musculoskeletal programmes, are taken out of the clinical setting into community settings, as well as mental health, pulmonary and cardiovascular programmes. There is a wealth of evidence showing that there are existing relationships, but to Jeanette's point, it is not universal or consistent. It is not systemic across the whole country.

When it comes to the pharmaceutical question, the big testing ground for this Parliament would be the opportunity to see parity between nutrition, diet and exercise and weight-loss medication.

The current position right now, as far as I can understand, is that this Government's approach is, "Let's roll it out and get as many people on this drug as possible by the election, to try to get immediate weight loss." However, we know—and all the evidence shows—that without sustained



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behaviour change around diet and exercise, it is not a sustainable situation. The test case around pharmaceutical parity is weight-loss medication and GLP-1.

Q183 Danny Beales: Charlotte, on the changes to the GP contract in 2022-23, have you noticed any impact from the shift to a more proactive social prescribing approach? Has that fed through the system?

Charlotte Osborn-Forde: Just to be clear, are you asking about the changes in the GP contract—the addition of the proactive social prescribing requirement—or the broader changes around the additional roles reimbursement?

Danny Beales: Social prescribing, specifically.

Charlotte Osborn-Forde: There was an addition to one year of the contract focused on proactive social prescribing. It asked GP practices to identify particular cohorts of patients using data. GPs would look at their medical records and pull off a list of patients with, for example, diabetes and mental health issues, and proactively offer them social prescribing. That was a helpful mechanism because we saw lots of practices start to think more strategically about social prescribing, instead of seeing a link worker as just receiving referrals on an ad hoc basis from when a GP identified a need.

Q184 Danny Beales: Did that work in practice?

Charlotte Osborn-Forde: It did. There was limited support nationally to enable it, so we saw some variation, but there were some really good examples of where it did happen.

Q185 Danny Beales: What support would have been needed nationally?

Charlotte Osborn-Forde: Better examples of how to do it—some practical support. Some GP practices were not clear how to run the searches on EMIS or Vision, which is the medical records system, to pull off the correct list, and they were not clear on the best ways of engaging somebody. A patient might not have heard of social prescribing and might not want to be texted. What are the most effective mechanisms to engage people? How do we scale it? How do we offer groups led by a link worker so that peer support can be encouraged? I think a national programme could have enabled better knowledge sharing among GP practices.

Q186 Danny Beales: Would you recommend the national roll-out of a proactive programme?

Charlotte Osborn-Forde: Definitely.

Q187 Danny Beales: Lastly, because time is pressing and other colleagues need to ask questions, we have heard about the limitations of social prescribing in care home settings, and that many residents—often the most vulnerable and the most frail—are not getting social prescribing offers or opportunities. Do you agree with that assessment, and if so, what could be done to address that problem?

Charlotte Osborn-Forde: There is very limited evidence about social prescribing in care homes. I think there is an assumption that because somebody is in a care home, and often paying a lot of money to be in that care home, the staff and others will provide social engagement and connection. You are absolutely right that it does not necessarily meet all the needs. We have started an innovative project, funded by the Rayne Foundation and others, looking at music in care homes and how staff can be trained to bring in music to improve the wellbeing of patients. That will include movement to music, but it is a new area and one that we could focus on and grow.

Q188 Josh Fenton-Glynn: I declare an interest as an officer of the all-party parliamentary group on running, the secretariat of which is supplied by England Athletics. It is a group for mediocre runners such as me to encourage more physical activity. Charlotte, you said that the national infrastructure to support social prescribing link workers has been reduced. What has been lost?

Charlotte Osborn-Forde: Originally, there was a large team of about 20 in NHS England focused on social prescribing. It looked at everything from data to education. There was also a large regional team: two or three regional development officers and managers in each NHS region who would go out into GP practices and the community to share information and develop that. At the end of the five-year period, in 2022, that team was merged and disbanded in NHS England so now the only provision available for link workers is online training. It is digital training, so they can access a website and watch videos.

Q189 Josh Fenton-Glynn: There is no central provision of support or training?

Charlotte Osborn-Forde: Not from NHS England. Obviously NASP exists, and we are currently funded by the Department of Health to provide support, education and resources nationally—that includes to the NHS and link workers—but there has been a big shift since it was initially deployed. The rationale for that was that it was a new and innovative initiative when it was first embedded in GP practices, and it would never have developed and scaled without that national support. Perhaps there is a sense that it is embedded now, and we do not need that, but I would say that we still really need to make a significant shift to prevention, and to community and neighbourhood health.

Q190 Josh Fenton-Glynn: You talked about NASP as a central group that is providing some support. What kind of support are they getting?

Charlotte Osborn-Forde: What kind of support are link workers getting?

Josh Fenton-Glynn: You said that NASP offers that central support.

Charlotte Osborn-Forde: The sort of support that we offer includes events, education, training, resources and guides. For example, next week we have a conference for link workers, and others in social prescribing, on neighbourhood health. We will explain what the Government policy is on neighbourhood health, what the opportunities are, what the potential funding mechanisms are and how you can engage. We also provide data



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and evidence. We work closely with University College London to produce reports and data that show the scale of social prescribing and evidence of need.

Q191 Josh Fenton-Glynn: Does the upcoming workforce plan give the Government an opportunity to address the gaps in support for link workers?

Charlotte Osborn-Forde: It is absolutely key. We have produced a very detailed submission looking at the evidence, forecasts and projections, which I am happy to email to you after today.

Q192 Josh Fenton-Glynn: In your honest opinion, given your conversations with Government so far, how committed are they to the future of that sort of central support for social prescribers and social prescribing link workers?

Charlotte Osborn-Forde: Government is not just one big body, but lots of individuals. I have had lots of very positive and enthusiastic conversations with officers and Ministers saying that they value and understand this, but that there are incredible financial pressures. That is true whether you talk to national Government or local government. My response is always that social prescribing—there is now very robust evidence for this—actually saves money. I think that if we genuinely want to improve the health system, we have to invest to save.

Q193 Josh Fenton-Glynn: You said that the shift to preventing things is important. Are you confident that will have ongoing support from Government?

Charlotte Osborn-Forde: Yes. I think it would be pretty catastrophic not to continue to support a service that reaches over 1 million of the most vulnerable patients a year and that, as we have heard today, links people to amazing community assets that improve their health. It would be a dreadful backward step.

Q194 Josh Fenton-Glynn: Thank you. Graeme, in your written evidence, you said that the 400,000-strong physical activity workforce is being underused. How can we use them better?

Graeme Sinnott: That links to the question about the voluntary sector. An asset there is hidden in plain sight. For me, when asked that question through a local lens, it is there. It is doing outstanding stuff that you have heard about throughout from all the people you have heard from. For me, it is about recognising what that workforce is—its size, its strength, its skillsets—and then supporting it, and supporting it to be considered as fundamentally part of the solution. That, for me, is the gap at the moment. That workforce can enhance the capacity of the health workforce to address the issue we are talking about, but it is not formally recognised. It is not integrated into commissioning pathways, as Charlotte and others have talked about. How do we properly embed, with recognition, those 400,000 as part of the solution? That goes back to one of the first things we talked about on national leadership.



Q195 Josh Fenton-Glynn: There is embedding them and understanding the local voluntary sector, but we also have the healthcare professionals. What more can we do to build with healthcare professionals the knowledge and understanding of what your sector is delivering?

Graeme Sinnott: There are certain assets we can build on. Jeanette mentioned the four ways forward that the NHS worked on. I think there is a real policy commitment and framework there for us to educate, to show the potential of physical activity and to scale it up. I think scale is a big thing here: 400,000 people and the voluntary sector together, that is a huge asset in this country. If we can do that education and connection, maximise policy levers like the four ways forward and the devolution agenda that is going on, and maximise other policy levers on the importance of ageing, as well as the fact that we are having this conversation, for me, there is a real opportunity there—that that 400,000 can be seen as the recognised and integrated asset that it is.

Q196 Josh Fenton-Glynn: Yes. They are the seeds to help physical activity grow. Jeanette, Sport England said that health professionals need the “tools, time and confidence” to talk about movement with patients. What do the tools look like, and who should provide them?

Jeanette Bain-Burnett: We led a programme called Moving Healthcare Professionals. We had a group of clinical champions who were able to break down the benefits of physical activity across a number of health needs and to support GPs and other practitioners in practices to have simple conversations and to signpost physical activity. The very on-the-ground, practical information that they need to understand the value of it is really important.

In that programme, we also recommended that basic medical training should include more information about physical activity. I am trying to remember the stat, but it was something like only one day of training across a GP’s entire medical training looked at the benefits of physical activity. We have piloted some work at undergraduate level. We just think there is so much evidence, and the chief medical officer speaks about this in all his reports, so it feels like a missed opportunity to put those practical ways of having a coaching conversation with a patient into the hands of a practitioner. Then they can do it every single day.

Q197 Josh Fenton-Glynn: So your message to Wes Streeter is that this needs to be embedded in all our GPs if we are going to have a proper shift to prevention.

Jeanette Bain-Burnett: Yes, absolutely. We also have a charter for GP practices to become active practices, so the staff can become more active, and they can become advocates for activity. We should absolutely embed it in primary care, as well as having health literacy across the community.

Q198 Josh Fenton-Glynn: It is no mean feat to get the biggest employer in the country to have more activity among their staff, so that is something that seems obvious.



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Jeanette Bain-Burnett: It would make their staff better. It would make them more productive. It would make their whole workforce healthier. As they become healthier, they become advocates for the people who they serve. I think it is a win-win.

Q199 **Alex McIntyre:** Huw, you have called for public leisure facilities to be a statutory service for local government. Is that the right way to protect spending on those services?

Huw Edwards: I think it is an important factor but not the complete situation. What needs to happen in the context of public leisure facilities is that the Government need to work with industry and do an overall facilities strategy to know what is in local areas. In my local area of Wandsworth, I have Tooting leisure centre very close to where I live, but there is also a lot of private provision. Across the whole country, what is the need? What do we currently have in terms of public and private provision? How does that service individual communities? What is the gap? What then needs to be invested in association with that? There is obviously an importance for certain provisions, such as swimming, where there is acute market failure developing in that space, as I mentioned earlier. How do you then look at the renewal and growth of those facilities? If being statutory could help on that, that would be good, but it is not the totality of what is required for looking at the long-term provision of infrastructure across the country.

Q200 **Alex McIntyre:** You touched earlier on the co-location of health services in leisure settings. What are the barriers to that being rolled out across the country?

Huw Edwards: It is interesting in the context of the Budget announcement last month when the Government announced 250 new neighbourhood health schemes or hubs, and looking at a capex project there. I would say that hundreds and hundreds of those already exist in the country—I could give examples of our members, such as Plymouth Active, Graves in Sheffield, and in Sandwell in the west midlands. What you see there is a really interesting combination of a GP with other parts of medical provision, and then you have banks and other local services alongside the gym and leisure facilities.

It comes down to having those conversations and having a really clear national framework around what facilities we want to be building going forward. Then you look at what the local need and the local requirements are for the consolidation and renewal of facilities, and the growth of facilities. Money is not going to come from the Exchequer, especially in the current climate, and there is really a need to look at alternative investment streams and pension fund investment to come in to support local authorities on the renewal of facilities and the growth opportunities that could generate.

Q201 **Alex McIntyre:** Jeanette, you have called for national and local policy that prioritises accessible infrastructure to support things like walking, wheeling and everyday movement. What specific changes would you like



to see? Are there any policy vehicles on the horizon that could be used to make those changes?

Jeanette Bain-Burnett: First, the 10-year health plan is the first national framework that has acknowledged the need to do this at neighbourhood level. The development of those neighbourhood health services is a really important vehicle for this. For each unitary local authority or regional authority, it is about understanding that for any individual, being able to move can be designed into their life through accessible infrastructure on people's doorstep, the quality of the infrastructure and the inclusive cultures within that infrastructure. There should also be day-to-day access to green and blue spaces.

There are some basic things. We do something on active design guidance, so for any local authority that is designing a new space or built environment, but also local places where people can walk and wheel, we have some guidelines. They are about simple things like lighting. We did some research into girls' and women's activity. If a place is well lit, girls and women will be active there, so I think our active design guidelines are a really good way forward. Understanding the relationship between different local services, community health and physical activity, and those services collaborating to create a single pathway for their residents, is essentially what we want to do, as well as working with people to understand what they want and need, so that we are not creating things that people will not access because they do not really meet their needs. Those are some of the things that are important for us.

Q202 **Alex McIntyre:** This is something of a leading question, but what is your view on the proposal to remove Sport England as a statutory planning consultee?

Jeanette Bain-Burnett: First, I think the decision, or the proposal, is based on a false assumption. We do not actually oppose a lot of planning, but the work that we do protects playing fields for communities across this country, and once a playing field is gone, it is gone. Our view is that, whatever the proposals end up being, we want to have a say in supporting playing fields and green spaces to remain, so that communities have those opportunities to move.

Q203 **Alex McIntyre:** In practical terms, how else can we ensure that enabling physical activity—obviously we are looking at the older population today—is considered in the planning system?

Jeanette Bain-Burnett: I think MHCLG is considering a slightly reformed role for Sport England, so that we would have some say and some consultative input. We do not mind what it is called on paper; what we want is to be able to make a really strong case for those spaces to remain. I think this is still in consultation, so I will not comment on the open consultation, but we are happy to discuss a reformed and more impactful role. We think that the community need for green spaces needs to stay at the centre of that conversation. Of course, we know that we need more houses, but we do not think that there is a real conflict between the two.

Q204 Danny Beales: On the design of leisure facilities, and gyms specifically, I recently visited a PureGym opening in my constituency. They talked about some lessons they had learned—I understand that they are now the biggest gym chain in the country—about designing spaces to make them accessible for women and older people in particular. Do you think there is a greater role for guidance to the sector, formally or informally, on how to design spaces to be inclusive?

Huw Edwards: That is a really good question. We are doing a lot of work, again with Jeanette and the team at Sport England, on safer spaces for women, looking at the societal challenges around behaviour and harassment at the highest level, because that does not stop when you cross the threshold of a gym, a pool or a leisure centre. The work we have done with the This Girl Can campaign, alongside Sport England, on guidance to support the look and feel, design and layout of facilities is hugely important, as is the cultural and workforce training that goes alongside that. That work is hugely important, and it also sits alongside the wider areas of inclusivity, supporting older people and people with disabilities to access these facilities in the best possible way.

Q205 Danny Beales: Do you think that this best practice is widely known and used in the sector?

Huw Edwards: We have worked with our core membership and with the public and private organisations that we represent, and they have been very engaged in that design work. It has been a really good three-way piece of work, between ourselves and Sport England, with the operators on one side and the campaign groups on the other. There is more work to do, and one thing we would like to do—going back to strength—is to look at how we can ensure a greater focus on female participation in the weight areas, because of the importance of strength. There is always more work to do to make sure we are as inclusive as we can be, but I think this has been a good stepping stone, especially as evidenced in the work that we have done with PureGym.

Chair: That brings us to the end of the first panel. Thank you very much, all of you, for your very rich evidence.

Examination of witnesses

Witnesses: Ryan Hughes, Siobhan Farmer and Bethany Badrock.

Q206 Chair: Welcome, and thank you very much for being here. Could you please introduce yourselves and very briefly describe the organisation you are part of and its role?

Ryan Hughes: Good morning. I am Ryan Hughes, head of programmes and partnerships at Active Norfolk, which is part of the Active Partnerships network. We are hosted by Norfolk county council. We look to create opportunities for the people of Norfolk to be physically active through system leadership, innovation, design and creation, and the co-ordination of programmes, the distribution of funding and workforce development and training, to name a few examples.



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Bethany Badrock: I am Beth Badrock, and I represent the Greater Manchester Ageing Hub. We sit as part of the Greater Manchester combined authority. I am also here to represent our work as a GM system: I work with local authorities, the NHS and the voluntary sector, and we are responsible for delivering on the Greater Manchester age-friendly strategy. We are also the world's first age-friendly city region, and we have received global recognition for our approach to supporting older people to age well and supporting thriving communities.

Siobhan Farmer: Hi, I am Siobhan Farmer, director of public health at Gloucestershire county council, which is an area of around 660,000 people in the south-west of England—it includes Alex's constituency, although he has now left! I am here to represent the partnership across Gloucestershire. I certainly would not want anybody to think that this is the sole local authority view. We do everything together in the county.

Q207 **Chair:** Thank you very much. We are looking at this from the point of view of how we can help to roll out more of this kind of activity throughout the country. ICBs are of course key to that, as the strategic commissioners. How well do you feel current ICB strategies are doing in helping to roll out these kinds of programmes? How could they be made more effective?

Siobhan Farmer: At the moment, we are coterminous with our integrated care board in Gloucestershire, and that has been absolutely fantastic for our partnership working. We have a health and wellbeing board that covers the whole of the county, but also the integrated care system covers the same patch. Of course, with the latest Government changes that will be changing, and the integrated care board will reduce significantly in size. We all have to keep one eye on what that will mean for our ability to work at the Gloucestershire level, and also at the sub-Gloucestershire level, as the ICB footprint becomes bigger. However, if we look to combined authorities like Greater Manchester, we see it is possible to do it on a bigger footprint. It is then about how we maintain the place-based level for Gloucestershire, and our areas underneath it.

To speak to how we are doing currently, our health and wellbeing strategy has seven priorities, one of which is physical activity, which is embedded through our overarching strategy. When the integrated care board were writing their integrated care strategy, they took on board our health and wellbeing strategy and made physical activity run through their own strategy. That means that we are linked as a system, so we see that true journey from primary prevention, meaning the things we do to help people to stay well—the previous panel talked about creating health and wellbeing in communities—right the way through to when people are older or frail, and how we delay any further harm through prevention strategies at that end of the scale.

We have a strong joined-up strategy, but we are also working with the voluntary sector; our district authorities are absolutely key because they hold the leisure services; and we are making sure that we listen to our communities in how we design the strategies.



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Finally, we are currently consulting, as part of the NHS 10-year plan, for the local five-year plans that are being developed. What is brilliant to see is that we have people saying things like, "Get out and get moving. Prevention is the best thing you can do." That shows that the community are hearing the messages.

Q208 Chair: I get that, but one of my concerns is these smaller staffed ICBs, with, as you say, a lot of flux going on in the system. What does a good strategy that can be rolled out across the country look like? What is the role for Government? What is the role for local authorities and mayors, for example? What is the role for communities? How do we make sure ICBs have what they need to get this right first time?

Bethany Badrock: That is a really good question, and it is something that is not very easy to do. We are very well placed to work in this way in Greater Manchester. It is our bread and butter to work across community, clinical and care to reduce those silos. Within the ICB, we work really closely with the strategy team and population health, and we support them to embed the voice of our populations and communities within our strategies. For example, we have local infrastructure organisations, which bring together all the people and voices from across all parts of our region. We feed in through specific themes. We have a specific focus on the NHS and health and social care. What matters to people? How do we actually embed a strategy at a local level and enable that partnership, resident-led approach?

Q209 Chair: Is that the bit that is difficult to do?

Bethany Badrock: I do not think it is necessarily difficult. It is time-consuming.

Chair: You said it is difficult to do. I am trying to understand which bits are difficult.

Bethany Badrock: I guess the way that structures are set is that we do to people rather than with them. In Greater Manchester, the difference we have is that the voice and the communities lead our strategy. We have a Greater Manchester strategy now, "Together we are Greater Manchester". That is every resident, every part of every institution and every organisation. Essentially, we have to put older people—not just older people, but everyone—at the heart of strategy, and we have to look at how we embed that and how we do it properly.

The neighbourhood approach was mentioned earlier. One of the challenges I would make to that is that a neighbourhood might be 30,000 to 50,000 people. We really have to get down to street-led neighbourhoods. People do not necessarily associate with a whole locality. We have to make sure we understand at that level what it means to age in that place, but also what it means to live and thrive in that area.

Chair: I am trying to focus on ICBs here.

Ryan Hughes: From a Norfolk perspective, within our ICB we have our joint forward plan. Physical activity predominantly sits within two points

underneath that: we have an ageing well strategy, and we have a health inequalities framework for action. Both have been proactive in building physical activity into that, and they have also commissioned physical activity to develop our Active NoW programme.

But it is fragile, and it will be fragile through the changes that are happening. We are going to become Norfolk and Suffolk ICB. When we go through change and cuts, prevention is still one of the first things to go, so we do not know if health inequalities will stay at this point. If that goes, there is a good chance that physical activity will go from a strategic point of view.

I think we have a model in place that, in principle, is key from a deliverable aspect, which is integrated care systems, which goes beyond the ICBs; they form a part of that. That is more around shared responsibility across our local systems, where we can build prevention in and how we have shared responsibility and pooled budgets. The model is there, but it is how we implement it that I do not think we have quite got right yet.

Q210 **Chair:** What is the role for national Government?

Ryan Hughes: For me personally, national Government would be about holding the delivery of integrated care systems to account—how do we evidence and show what an integrated care system is doing?—and ringfencing some of those budgets within integrated care systems for prevention and physical activity, so that they cannot be shifted into other areas.

Siobhan Farmer: In his evidence, Sir Chris Whitty talked about how different Government Departments can potentially work in silos. We have tackled that at local level through integrated care systems. We do work together, but ultimately, the way we are performance-monitored and measured at the local level forces us back into siloed behaviour at times. It is that bit about, “The apples don’t fall in my side of the orchard.” If we invest a lot of money in prevention from the local authority, the benefit accrues to the health service. There has to be something in the way that national policy goes to a local level while seeing it as a whole-system delivery.

Q211 **Chair:** Sir Chris Whitty spoke about pooled budgets being one of the ways to tackle that. Would you endorse that view?

Siobhan Farmer: There are examples of where it has been successful. I think there have to be shared risk agreements within that, though, so that the risk is balanced as well as the benefit. Otherwise, you can end up with people not willing to try innovative things because it might not work, and that might be a risk to the budget.

There is some interesting work around system control totals, which I think Greater Manchester has looked at, whereby you are looking at the total budget for the system, and the system is measured on how well it does all together. That allows you to start to shift money around from the tertiary prevention end—as we talked about—right the way into primary



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prevention. Local authority funding is the poor relation compared with NHS funding. We could talk a little later about the challenge there, particularly in rural counties, and I am sure that the Committee would be interested to hear that. In terms of national Government, addressing performance through silos is not necessarily helpful to us at the local level.

Q212 Dr Cooper: I will ask a few questions about local leadership and place-based approaches—which we are all very aware of. Beth, on Greater Manchester’s ageing hub, am I right in thinking that it has been going since 2016?

Bethany Badrock: Yes.

Q213 Dr Cooper: Excellent. That is nearly 10 years of data and evidence, which is fantastic. Could you explain to the Committee the key reason why it has worked well? It would then be helpful to hear about anything that has not worked well, why not and what you have learned from that.

Bethany Badrock: The ageing hub model is unique, and we are the only one in the country. We now have a team of around 10 people. We have developed an ecosystem of age-friendly partners, and we work with organisations across the GM system.

Q214 Dr Cooper: Just to be specific, are these the things that are working well? Are you telling the Committee that this is part of the success story and why it is working well?

Bethany Badrock: Yes. One of our fundamental successes is working with research institutions and our universities in Greater Manchester, which are world leaders in healthy ageing and provide us with an evidence-based approach to everything we do. We work very closely with our Manchester Urban Ageing Research Group colleagues to look spatially at how and where people are ageing and then layer that with the health data that we have as a system.

We work very closely with the voluntary sector and national partners: the Centre for Ageing Better and the national What Works Network on ageing. Fundamentally, our biggest success is our integral approach to embedding the voice and lived experience of older people and centring them in everything that we do so that it is led by our communities, and that we are hearing what needs to change.

Q215 Dr Cooper: Okay, that seems very good. In terms of funding, do you have enough to do what you need to?

Bethany Badrock: No, absolutely not. We have one core-funded member within the organisation, and our funding comes through constantly looking at different bids, funding streams and philanthropy.

Q216 Dr Cooper: That takes up quite a lot of energy and work?

Bethany Badrock: Yes. We are also on short-term contracts. Predominantly, our team are on 12-month contracts. As soon as you are three months in, you are then looking to continue the work and constantly



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advocating for the need for older people to be embedded in our work and across the organisation.

Q217 Dr Cooper: Sticking with funding, you are predominantly grant funded and you are applying for grants all the time?

Bethany Badrock: Yes.

Q218 Dr Cooper: Okay, that is quite work-intensive. It sounds like it is a good model if it has survived since 2016, which is great. Is there anything that has not worked during that time, and what lessons were learned?

Bethany Badrock: Some things that do not work are because we have no national strategy on ageing, so there is no actual requirement for us to deliver on this locally. Luckily, we have Andy Burnham, who is a huge advocate for our work. However, the ability to influence local leadership and embed this across policy does not always work. People have views, and we have entrenched ageism within our systems. People always challenge us on starting with prevention in children and young people, but we can prevent at any age, and we know that there is a huge amount that we can do when people are in mid to later life to really change that trajectory and reduce the cost to the NHS. That would be our biggest challenge.

Q219 Dr Cooper: That is interesting. Obviously, we are looking at ageing well here, but ageing well means from zero to 100—that is an ageing well philosophy. How does your ageing well hub interact with the other age groups? How does it embed the voice of older people, but also the interests and thoughts of people who are going to be older one day? How does that work?

Bethany Badrock: We sit within the public service reform directorate. We have a children and young people's team, a homelessness team and an asylum team. We look at everything through a public service lens whereby everything we do and support our localities to deliver has a whole view of every cohort. What does it mean to layer an age angle on to all those other areas? We have work on intergenerational approaches to ageing and how we interact with other parts, systems and policies. We cannot just look at ageing as a silo. We must absolutely make sure we are approaching this as a whole population.

Q220 Dr Cooper: Great. Just to be clear before we move on, for your ageing hub model, your mandate is from the Greater Manchester authority and leadership, in the sense that you exist and are endorsed at Greater Manchester level, but you perhaps feel, because of the lack of a national ageing strategy, that a national mandate would be helpful for your ageing hub to develop and thrive.

Bethany Badrock: Absolutely. We have huge recognition globally. We had Amsterdam come to visit us only last week to learn about our approaches.

Q221 Dr Cooper: Did you get to go to Amsterdam?



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Bethany Badrock: Unfortunately not. They much preferred to come to Manchester, and it didn't rain, so they were really pleased. We often get asked, "Why is this not recognised nationally here, when the work you're doing is world leading?"

Q222 **Dr Cooper:** You have just reminded me of the World Health Organisation's global network for age-friendly cities. You were the first in the UK. Is that right?

Bethany Badrock: We were, yes.

Q223 **Dr Cooper:** Fantastic. Presumably you have taken global learnings as well, and they have learned from you.

Bethany Badrock: Absolutely. We have eight core age-friendly principles, which we think do not have to be age-specific. If they are adopted and transport, housing, social participation, civic participation, green and blue spaces and so on are seen through that lens and made accessible for all, we will support people to age well.

Q224 **Dr Cooper:** Lovely. That sounds very comprehensive. Let me take those themes and move to Siobhan and Ryan. Could you talk about your roles in local authorities and local places, and how age-friendly principles could be, should be or are embedded in the planning and commissioning of services? Feel free to talk about local authority planning, Siobhan, as it is very interesting.

Siobhan Farmer: I am glad you have raised planning, because the ambition to build 1.5 million homes gives a huge opportunity to embed physical activity into the communities that are being built.

Q225 **Dr Cooper:** How are you finding that? Public health is not a statutory consultee, is it?

Siobhan Farmer: We are involved very closely in the local plans; of course, the challenge is that once your local plan is set, each individual development requires planning permission, and I believe that viability arguments are often made about why some things can or cannot be delivered within a local development. I still wonder whether the national planning framework goes far enough in setting expectations around wellbeing as a whole, including for things like green spaces, blue spaces, transport connectivity and lighting—all the things we have heard about today.

Q226 **Dr Cooper:** I couldn't agree more, Siobhan, and you are completely right about the national planning policy framework. It is an ongoing conversation. In terms of ageing well, in planning, how do you find right-sizing the accommodation in your area? How is that going?

Siobhan Farmer: Again, adaptability or accessibility standards are key. We have an ageing population, and I think we are expecting something like a 38% increase in our over-65s in Gloucestershire in the next 15 years. That is incredible. If we build homes that are accessible to anybody in a wheelchair from the start, they will be right for most of our population

for the rest of their lives. It comes back to viability arguments and the extra costs for the developer. I think that national Government could be stronger in those expectations.

Q227 Dr Cooper: You are being very diplomatic, Siobhan. I completely agree. I think the NPPF is a real stumbling block for the ageing well issue; you have really hit on something there. Thank you.

Ryan, could I bring you in on ICBs? They are becoming the strategic commissioners, and there is all that shift. How do you think ageing well currently sits in commissioning strategies, and how should it sit?

Ryan Hughes: It goes back to integrated care systems. I do not think we should focus purely on ICBs. They are a strategic commissioning lead at a local level—

Dr Cooper: Not yet, but they will be.

Ryan Hughes: Yes. Actually, in the work that we do, they are our biggest—

Dr Cooper: Already?

Ryan Hughes: They are already performing that function for us. But working alongside public health, adult social care and the different levels of maturity that each one will have in each place, from our perspective the ICB is really proactive in commissioning towards physical activity and the work that it can do from an ageing well perspective. It is very focused on deliverable models: "What can you show us in terms of KPIs, outputs and stuff like that? We want to see numbers of people flowing through." That is fine; we can demonstrate that, but from a commissioning point of view, there is not yet that great belief in the longevity of change. That is a point that we need to get to.

Q228 Dr Cooper: Why do you think that is the case, Ryan?

Ryan Hughes: I think it comes from financial pressure to show that you are achieving against your goals in a quick state. Historically, that put pressure on the sector from a physical activity point of view. That gives unrealistic achievements and goals, which is why we find ourselves at this point, from an ageing well perspective. We have had fall services decommissioned across the country for years because they have been asked to fix fall prevention in a six-month timeframe, which is just not feasible, and if they don't do that, they are seen to have failed.

Q229 Dr Cooper: To push you a little, with the NHS 10-year strategy and hearing once again the mantra of prevention not treatment—we have all heard that for quite a long time, but here we are with renewed focus—do you see any change, any shift, in the local conversation? Is the NHS 10-year strategy giving that more national push again?

Ryan Hughes: Yes. You see change in the conversation. I think you see willingness in the people who are working at that level, and a belief in doing that. You also see constraints in their belief in being able to shift and



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make the change. I think they are unsure about how to do that for certain. It comes back to the point of permission being given: if we are writing a 10-year strategy, why are we not commissioning for 10 years?

Dr Cooper: That is a very good point, Ryan.

Ryan Hughes: And why are we not measuring the right things? Rather than measuring the big outcomes, we should measure the impact of the intervention that we are putting in place.

Q230 **Dr Cooper:** Excellent, thank you. That is very clear. In my last few minutes, let me move you all on to health inequalities. I have heard some great things about your place-based approaches. In your time, in your experience, in your roles, what evidence do you have for the Committee that place-based approaches are actually reducing health inequalities in that particular age group?

Siobhan Farmer: That sort of relates to Ryan's point, because some of the outcomes we would need to measure for a reduction in health inequalities are very long term. It is difficult to say, "Here's an intervention. We have done it for a year and therefore we have reduced inequalities," particularly if we are looking at something like healthy life expectancy or years lived in good health.

Q231 **Dr Cooper:** In your directorate, what is the longest-running programme relating to this area?

Siobhan Farmer: It is usually within an election cycle, so it relates to our council strategy, which is a four-year cycle.

Q232 **Dr Cooper:** You do not have any 10-year programmes running for ageing well?

Siobhan Farmer: We have a 10-year health and wellbeing strategy.

Dr Cooper: That is not the same as a programme.

Siobhan Farmer: Yes, but within that, the way we deliver it is changeable, probably on a four to five-year cycle, maximum.

Q233 **Dr Cooper:** A four to five-year cycle? So in your 10-year health and wellbeing strategy, with its outcomes and indicators of success, in terms of reducing health inequalities, are you seeing a substantive shift, or is that disrupted by the electoral cycle and commissioning?

Siobhan Farmer: It is not just the electoral cycle and commissioning, but organisational change. If you look at Gloucestershire, we are going through local government and integrated care board reform, and the office of police and crime commissioner will be changing. I believe a police review is also imminent. That is our entire system changed. What we have to do through that period to keep it working, and to reduce inequalities, is maintain the relationships not just with other statutory sector partners, but with the voluntary sector—we have heard so much about the role that sector plays. We have early indications through our health data about the number of people we are reaching, but I would say at the moment that it

is probably more output data than outcome data. We will need longer to understand if we are truly affecting outcomes.

Q234 Dr Cooper: For context, is inequality data in your part of the world worsening, getting better or steady state? What does it look like?

Siobhan Farmer: We have an ageing population, and they are—

Dr Cooper: If you account for all that, how is it looking?

Siobhan Farmer: I suspect it is getting worse. We have challenges with the cost of living nationally, and we see the impacts of that. The way we are able to understand what is happening in the local population is through things like what comes through the citizens advice bureaux—which people are accessing support for things that maybe they were not 15 or 20 years ago. Food is a huge issue. I know we are talking about physical activity today, but it is all related to ageing well and being well. Even in parts of the Cotswolds, which people imagine as chocolate-box villages and very affluent, we have some incredible rural deprivation. There are food banks there.

Q235 Dr Cooper: We are going to come to rural poverty later, so hold that thought. Beth, we are looking at physical activity. Do you have data showing that the physical activity aspect of your ageing hub is helping to reduce inequalities in this age group?

Bethany Badrock: Yes, absolutely. We have some great examples of our work with GM Moving, a local active partnership, that we delivered back in 2018. We looked at an active ageing programme, which was all about place-led initiatives in some of our poorest neighbourhoods with the poorest outcomes, and asked: "What would it mean for you to engage in physical activity?" Through some of the national data we are seeing that GM is starting to reduce that inequality gap, which is great.

We have other, broader examples beyond physical activity, including an ageing in place pathfinder programme, which we delivered over the last four years. The foundations of that were all around voice. They were also data-led, and we worked with local leadership and stakeholders. We asked three simple questions. We went out into communities, door-knocked and asked: what is it like to live in this neighbourhood; what would make it better; and how can you work with us to improve it? Fundamentally, a lot of those barriers were things such as needing to bring planning in on pavements that were not accessible because people could not get out and about and feel steady and safe.

One of the really great examples was where we found that people were not attending the GP surgery. They were not going, and appointments were really poor. We knew that the neighbourhood was on a hill and people could get down to the GP surgery but could not get back up. A&E was at the top of the hill, so they went there instead. We found that out through door-knocking to understand why people were not going. We have worked with the GP, and they now come up on the hill and do a pop-up clinic in our community hub, where we have a green allotment and places



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for people to have a brew and a chat. It has embedded itself in the neighbourhood, built trust and we therefore now have 100% attendance at that surgery.

Q236 Dr Cooper: I love that. I am pretty much out of time, so Ryan, very quickly, are there any particular indicators that we are not using at the moment that would allow us to track the reduction of health inequalities through physical activity—perhaps ones with more longevity than we are seeing?

Ryan Hughes: It is about getting the assumptions right in any programmes and work that you put in place. There is now a strong literature and evidence base around the benefits of physical activity. Lean on that and do not measure it now. At the moment, we are not going to be able to distinctly measure the impact we have on health inequalities. That is a longer-term plan. However, we can show that we are engaging with the right communities and people, and whether we are getting them active. The assumption is that if we are engaging with the right people and getting them active, the big change should come.

Q237 Paulette Hamilton: To follow on from Beccy, I will be talking about under-represented communities. Those are communities that are under-represented or marginalised—rural communities, black and Asian communities and what have you. In all the work you have done, what have you found to be the challenges in reaching more rural and ethnic minority or diverse communities?

Ryan Hughes: We have already heard about some of the infrastructure barriers around access. Rather than repeat that, I want to talk about systemic barriers as well. Within Norfolk our demographic is around 90% white British. On the face of it, it appears to be a stereotypical and quite affluent place to engage, but it has real pockets of diversity, deprivation and rural isolation. We have to appreciate the nature of the place in how we engage with those communities.

We have three prominent urban areas, a multitude of small market towns, and then real rural isolation, where there will not be another house for five miles or so from where someone lives. The needs of those people are going to be completely different. The level of engagement that we need to focus on comes down to a real hyper-local, place-based approach—a neighbourhood-based approach. Within those small areas, you need to ask what is the make-up of your communities and populations? Where are your ethnic groups? Where are your disabled communities? Where are your older populations? For Norfolk, it is dispersed all over the place.

That is our approach, but we also have to be mindful within that approach that we do not just assume that all our older people live in north Norfolk—that is where our highest demographic of older people is—and put all our resource there. We also have to be careful of our hidden older populations, for example, who are living in our urban areas and surrounded by a predominantly younger cohort.

Q238 Paulette Hamilton: We know that the communities are there, that they



are rural and that they do not speak English as a first language—you have that issue in Manchester. How are you engaging them?

Bethany Badrock: I can start with a practical example. We know that we have a hugely diverse population in Greater Manchester, and we have some brilliant voluntary sector organisations who work closely with different communities. They know them best and have built trust, so we work through our partners to reach those people. To give one example, we work very closely with the Caribbean and African Health Network. They have specific groups that we can engage with, and we take our policies and strategies to them.

As you mentioned, language can be a huge barrier. A lot of our comms or engagement are all in English, and we know they will not reach all our communities, so last year with Independent Age, a national charity, we developed a “Winterwise” What Works guide to support people on where to get support, how to improve their health and how to stay well during winter. We were able to produce publications in different languages that we knew were predominant and spoken across Greater Manchester, so that we could get those messages out and reduce some of the language and cultural barriers to engagement with communities.

Q239 **Paulette Hamilton:** How do you measure success? How do you measure that this is all working? I will start with you, Siobhan, because I know you have quite a lot of rural areas in Gloucestershire.

Siobhan Farmer: We use a combination of methods. In public health we like to do triangulation, so we have the quantitative data—the numbers—but it is also about speaking to people. The real key for us is that the statutory sector does not have the resource or the capacity to go out and do that hyper-local engagement. The VCSE sector are not funded to do this, but somehow they still manage to come forward and support the statutory sector to understand what the needs of those local communities are. They act almost as the conduit for that two-way feedback to enable us to understand what the needs of communities are and then whether or not we are making a success of it.

Sometimes this is also about what success is for the individual, as opposed to what I think success is. It goes back to how we have the chief medical officer’s guidance, and although many people are never going to be able to achieve 150 minutes of activity a week, if they were previously inactive and now they are able to walk down to the local bench that has been installed, to sit and enjoy nature, or maybe go to a café and have a coffee with a friend, that is success for them. Those are the things we need to be hearing from communities: that their lives have changed in a meaningful way for them.

Eventually, over time, that will start to impact on inequalities, but as we said, it is a long-term piece of work. I think it is really about listening to people and understanding. When we consult or engage with people, the feedback we get quite a lot is, “Well, we told you this two years ago—why has nothing changed?” When we have that engagement, there is a

massively important role in saying, "This is what we have done as a result of what you told us. Has it worked?" We are always closing that loop with the communities.

Bethany Badrock: To echo what Siobhan said, it is absolutely fundamental that we take the voice and the qualitative data from this work. We know that prevention works. You heard from the previous panel about the number of reports and evidence that we have. Physical activity, working in this way with communities at the heart of it, will change and reduce inequalities, and it will improve outcomes for all people.

Q240 **Paulette Hamilton:** I am going to be awkward. I worked in local government for many years, where we talk about co-production and listening to people. I need you to tell me how we measure all that to say, "Government, you are not doing this, so we cannot achieve that on the ground." We keep talking about it, but please help me to understand what we are doing differently so that we can ensure Government is hearing our voices and making the changes that are needed.

Bethany Badrock: The issue is that we keep talking about it and saying, "We need to do it," but no one is unlocking the funding to do that.

Q241 **Paulette Hamilton:** Is it funding that is lacking here?

Bethany Badrock: Fundamentally, all our funding is pumped into crisis response, because that is where the demand is, yet we are constantly after, "Shift left—shift to prevention." How do we do that and shift our resources when we cannot free up resources over here? One of the challenges and tensions we very often have is, "Oh, that is a public health issue; the money should come from there." It absolutely should, but then there is the argument that the saving will be over here in the NHS. Until we start to break down the silos and look at this as whole system, pool budgets, and share the responsibility to respond to communities, we will never make a true change.

Paulette Hamilton: I think we should leave it there. That is a good place to stop.

Q242 **Jen Craft:** That is a good segue into the questions that I have. I mainly want to focus on the additional steps that are needed to overcome geographical and transport barriers in rural and coastal areas, and what you said picks up on that quite nicely. You have hinted at the practical implementation in your areas, but what role do you think local authorities and integrated care systems should play in addressing that additional cost? Pooled budgets might be one way of doing it, but is there any impetus that works to mean that you have the funding in the right place at the right time?

Siobhan Farmer: It is an interesting question, and it almost talks to the point about silo working. In a rural community, in Gloucestershire, transport is an issue. We were chatting about this when we met before the panel. I used to work in Greater Manchester, and I did not realise how lucky I was: I could step out of my door in Greater Manchester and have a



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variety of modes of public transport. Some of our villages are so small that there is no economic justification for having a bus every 20 minutes. I understand the economic argument for that.

Nevertheless, when you want to catch the bus, it has to be there on time and it has to be accessible if you are to be able to get on it. That is the other problem. A lot of our buses do not enable somebody in a wheelchair to get on, and there is no support for them to manage their journey, or partially sighted people are not able to see the board to understand when the buses are coming. There are inherent structural barriers, which we have built in over decades and which will take a huge amount of capital revenue to fix.

I wonder what it would be like if the Government said to the NHS, "Invest in your local transport system to remove some of the barriers," and whether any ICBs would be able to do that, or whether that would remain quite downstream and in social prescribing. Social prescribing is absolutely fundamental and important, but if you cannot get to the leisure centre that we heard about earlier, because there is no transport, that is difficult.

In the local authority in Gloucestershire, we have therefore invested in something called the Robin, which is the name for the community bus. It is a dial-a-ride that people can ask for on demand. We have excellent community transport providers, who do this out of the goodness of their hearts, so you can ring them and say, "I'd really like to have a lift."

The upshot of all that is we cannot rely on things like leisure centres and physical buildings as the only way that we encourage people to do physical activity, because the transport issue is so insurmountable. How do we then build the local infrastructure? What can be done in the community village hall? How can we work with communities to hear what would work for them? It is an incredibly complex topic, which will require significant investment to fix, but there are some local successes that we can point to.

Q243 Jen Craft: In the interim, is it more about looking at the situation you are in now? I do not represent a particularly rural area, but we do not have anything like a decent public transport system, and we have similar issues. We have a wonderful new community diagnostic centre, but it is very underserved by buses and transport routes. Would you say that, looking at where you are now—with all the structural difficulties that are built in—the fix is to work within that, rather than trying to change the system? Is that the approach?

Siobhan Farmer: Yes. Ryan may have examples from Norfolk—our make-up as a county is very similar. We need enough resource to be able to listen to and work with communities. That is the bit that gets cut—those people who can go out. That is why we are relying on VCSEs to be the people who can understand those barriers. Yes, they are voluntary, but they still need funding for some of their core pieces of work. We are just not in a position, I think, to resource the VCSE in a way that would address the fact that we have structural inequalities that are difficult to tackle. Would you agree with that, Ryan?



Ryan Hughes: You have two coinciding issues: one is a longer-term change around infrastructural support and, alongside that, there is a cultural change that we need to make as well. We cannot assume that, if we build it, people will use it. We need to change people's attitude to want to use transport to get to physical activity. That is a longer-term solution, and it will take time and resource to change that, but we have assets that we can use at the minute to address some of the issues that are already there.

For example, we can take physical activity to people who are isolated. It is not always true that people have to go to the mountain; the mountain can come to them as well. It is about diversifying what leisure providers and the physical activity sector do. They can go out and deliver; they can be mobile. It is thinking about how we can best utilise our assets now to address those issues, while also trying to do some of that larger infrastructural change.

Q244 **Jen Craft:** Is there a role for integrated care systems to commission the VCSEs to deliver some of those services, rather than just providing funding? Would it be more effective to have a commissioning of services, rather than piecemeal funding?

Ryan Hughes: For physical activity delivery?

Jen Craft: Yes, and for transport and access.

Ryan Hughes: I think you are closer to getting health systems and ICBs to commission physical activity delivery than transport change—I think that would be looked at as someone else's responsibility. But we are further along in getting that narrative into health systems about what physical activity can do for their outcomes.

Bethany Badrock: To add to that, I will just give an example of how we are trying to bring together the system to look at some of those transport barriers, and how we support people to get out and about through that. We have the concessionary bus pass, for example, and one thing that we developed in Greater Manchester, predominantly with our younger population initially, was a younger people's Our Pass. That was very much a pass that connected transport offers to cultural and leisure offers in communities, where those things might be discounted or there might be offers for certain things that are designed with what young people want in their neighbourhood.

We are now looking at—it was in Andy's mayoral manifesto—an older people's Our Pass. We are co-designing that with the system, the leisure sector and GM Active at the minute to look at an offer that people would want to engage with, that is connected to their travel pass, and that would enable them to engage in some of the offers that are in their neighbourhood.

One thing connected to that, which was a barrier in terms of transport, was that the concessionary bus pass kicked in at 9.30 am. We know that there are health appointments before then, for example, so why was that?



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One thing that we piloted in August, and we have just held another one in November, was looking at removing the restrictions to enable people to travel when it suited them. We have seen a significant increase in the number of journeys pre-9.30 am, and we have supported people to get out and about. That is about bringing together those different offers, and different parts of the system, so looking at not just transport as an issue over here but how we connect that with all the other parts of the system to support that offer.

Q245 Jen Craft: Does that work because of the council model you have—because you have a metro mayor?

Bethany Badrock: I would say so. We are very fortunate in having the development of the Bee Network and the work that we have done on transport, looking at it as a fundamental to enable people to access communities, their health and what they need. We are very fortunate in that, and I recognise that it is not the case in other parts of the country.

The role of community transport, which you mentioned, is significant. We have a Ring and Ride service with a significant overspend, and the capacity is reducing even further. We know that people need it, and that it is their source for getting out and about. There are huge issues still, but we recognise that bringing the system together is really important.

Q246 Jen Craft: Looking at meeting the need where people are—I do not think anyone has touched on this, and I have a couple of minutes left—do you take part in any kind of digital inclusion in people's own homes to allow them to access technology?

Siobhan Farmer: Our active partnership, Active Gloucestershire, designed a Fall Proof programme, which they co-designed with older people in the community. That was about trying to introduce strength and balance for older people in an accessible way that was not about going to the gym, because I still think that some people find gyms really intimidating and it is not necessarily what people want to do.

The Fall Proof programme had little cardboard cards—I said to my colleague that I wish we had brought them along—that you put by the kettle. One was "Able like Mabel", and it gives you an exercise to do while you are waiting for your kettle to boil. One was "Carry like Harry", and it tells you to carry your shopping as often as you can. Those are things that you can do to make strength, resistance and balance training part of your everyday life, rather than going down to the gym, and then there were strength and balance classes alongside that. However, once they designed that, the pandemic hit, so that idea of getting people together couldn't happen, although they were able to deliver a lot of the sessions online.

We have other voluntary organisations in the county. Gloucestershire Rural Community Council have done quite a lot of work on digital exclusion. They would send out an officer to work with very excluded communities, in particular, and look at whether the issue was technology, skills or affordability. There are various equipment and SIM package offers that they can give to people to get them online, with digital skills

available. We have digital hubs in our communities where intergenerational skill development can take place.

One of the big things is not assuming that all older people cannot use technology, because many absolutely can. Certainly, in 20 years' time, even more will be able to. Again, it is about understanding where people are at and working to support them with an individual tailored model to help them access online offers.

Q247 Jen Craft: Should digital inclusion be seen as a core component of a healthy ageing strategy?

Siobhan Farmer: I think it is one part. As others have said, it is about having a range of offers for different people. Some people would hate to do an online clinic, and some people would rather go to the gym. There is a range, and it is one prong.

Bethany Badrock: Absolutely—we cannot have digital by default. There are older people out there who, because they have experience of scams, or perceptions or assumptions about using digital, will never want to engage, and therefore we have to have a non-digital offer. But there are some brilliant digital offers out there, particularly on strength and balance. The University of Manchester developed the Keep On Keep Up app, which is a strength-based app, and people can do that in their own home on a tablet. It is about gamification and the things that you can do to support yourself to age well.

But we know that an issue is that people do not have the devices, or are not digitally literate and are not able to use them. Inspiring Communities Together in Salford, for example, delivers Tech and Tea classes that bring people together to build social connection, shows them how to use devices, and lends them devices to take home so that they can embed them into their day-to-day life. As long as you connect that whole system and make sure the education is there with support, it definitely should be embedded as an offer, but we should have that consideration: it cannot just be the default offer.

Q248 Chair: We have heard compelling evidence throughout about the importance of getting people who do little or no activity to do something. If you are going to shift the dial in this space, that is where we should focus our energy, particularly with limited budgets. In your own systems, how easy was it to gather that data across local authorities, the health service and VCSEs? What could the Government do to make that process easier?

Siobhan Farmer: In terms of who is physically active and who is not?

Chair: Yes.

Siobhan Farmer: At the moment we rely on national population surveys, which are samples and not very frequent, so it is incredibly difficult to measure physical activity. Fundamentally, that puts us in a difficult position. As Ryan said, we almost need to measure the outcomes, because



measuring the physical activity is really hard. However, that requires people to believe that Active Partnerships and the work they do to get people active are what is causing the impact on outcomes. We are missing the ability to measure who is and is not taking activity if we do not ask people directly, but then there is evidence to show that people vastly overestimate how active they are.

It is notoriously difficult, but I think there is something in how we capture self-reporting. Many people wear digital technology now, and I believe that there have to be conversations around the digital space. Yes, you would have a slightly biased sample if it was just people who wear active watches and so on, but it would be another tool. It is about triangulation—looking at who is active in the population, when, and what are the periods they are active. You can use geospatial data to look at where people are walking.

I think there have to be some really exciting, innovative conversations with tech companies about how we can join that data up. A point that has also been made by other panels is that if one organisation knows how active somebody is, it would be great if that could be linked to that person's health record so that they do not have to be asked again five times.

Q249 Chair: You both have experience of this, so maybe we will go to Beth and then Ryan.

Bethany Badrock: To echo what Siobhan said, it is incredibly difficult to measure. People's perception of physical activity is a real issue. What we call physical activity is also a real issue. We know, as we heard from the previous panel, that bellringing and gardening, for example, are physical activities.

As soon as we start to understand what matters to people and what they want to be able to do—such as strength-based activities like carrying the shopping home—and simplify it, that is when we will get that population-level approach. Being able to measure that is incredibly difficult, but some of the structures we have in place, such as the Active Lives survey, are brilliant in getting that population view.

Q250 Chair: Who should be measuring it? I am imagining here, but is it a letter from my local authority asking me to fill in a survey? Is it my doctor pointing me to an app? How are we going to get this data, and whose responsibility is it?

Ryan Hughes: You can look at it from several points of view. If you look at it from whole population data, we have a strategic lead for sport and physical activity within Sport England, which works with Sheffield Hallam University. If we think it is a priority to measure activity levels and how to transform them, we ask at that point.

At a local level, Active Partnerships are working on programme-based interventions. They are measuring activity all the time. Similarly, it is self-disclosed, but at a closer level because you are working with people, and



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you can see. There are also ways to be innovative in how we look at measuring. We can start to look at observational tools and comparisons. If we start to look at active travel, for example, you can look at a high street 12 months before you put an intervention in place and then look at it after. Is there an observational change?

The answer to your question is that I think we are at the start of the conversation, to think about how we do it properly. I don't think we have an answer. What we have at the minute is Active Lives survey-based data and place-based programme data, which is limited in efficiency, but there is a will and appetite to grow around that, if given the opportunity.

Q251 Chair: It strikes me that, as ever in this place, something that is not measured is often something that cannot be changed. What I am hearing from all three of you is that we do not do this enough. Do you see that as a significant barrier to why we talk about political leadership, sharing budgets and commissioning, which we will come on to in a minute? If we do not have that data, is it fair to say that we are not going to shift the dial? Is that right?

Siobhan Farmer: Yes, although I think it is really difficult. It comes back to funding and expectations. By measuring it, we could set up a culture where we are driving targets for Active Partnerships and then saying, "Why haven't you improved the population activity by x%?"

Q252 Chair: We heard from the previous panel that it is something that some would welcome.

Siobhan Farmer: Yes, don't get me wrong. It is then about how it is used. It is not used as a stick to beat people with for not having delivered x target; it is about how we measure and understand that we are having an impact. There is something about how that data is used at local level.

For me, there is a little bit in the "two times a week and 150 minutes" that becomes something that we have to accommodate or an obligation. What I think we should do is shift the whole conversation to how we fit physical activity into our lives, and how we create a society where it is normalised. Then it does not become as important to measure it, because we see it and people feel enabled and capable to walk to the shop or carry their shopping.

Q253 Chair: That would work for the whole getting people moving a bit. There is another strand to this, which is strength and balance. We heard strong evidence that not everything works. Just lifting a few weights occasionally, without an evidence-based programme sitting behind it, is not going to help people, particularly if they are in pre-frailty and need more significant intervention.

In the work you do, how much are you focused on just getting people moving in that more general sense? How much of your work is based on evidence-based interventions that are followed through and will make a difference to how many people get admitted to hospital, and all those measures in which the NHS is particularly interested? Ryan, do you have

experience of that?

Ryan Hughes: It is a blended offer. If you are looking at it from more of a primary prevention point of view, where people are already physically capable, it is about maintenance and keeping that attitude going. That would be more about “keep moving” and “something is better than nothing”—everything will be a benefit. When you get into the realms of secondary prevention, working with people diagnosed with a long-term condition, you would look at more tailored programmes, such as an exercise referral scheme that provides a 12-week initial process to get them started from where they were to where they want to be. What can I do if I have been diagnosed with diabetes or have had a cardiac event in the last 12 months? A 12-week programme will get you started on that journey, and it will hopefully transition by giving you the skills to self-manage beyond that. We can all learn to self-manage our physical activity, and once you know what you have to do, you can look to carry that on.

Q254 **Chair:** That brings me neatly on to commissioning. How well are prevention and social prescribing understood in current commissioning frameworks? How easy is it to embed them?

Ryan Hughes: We have a good example locally with our Active NoW programme, which gives the health and social care workforce a referral pathway into physical activity for people with long-term conditions. That is understood locally and is held up as good practice, more because it was started rather than being commissioned. It came out of a legacy piece of work. Once we were able to demonstrate what it could do, and show the level of commissioning need against what we were able to achieve, it was accepted. If you were starting from scratch and went to an ICB that is not doing anything at the minute and said, “I want you to commission physical activity for this reason,” I think that would be a tougher conversation, at this point.

Q255 **Chair:** That is what we are aiming for, right? We want more ICBs to commission this, and that is where the money is going to flow from. What do we need to do to convince them that this is worth doing? You have spoken a bit about the data, but what else needs to be in these commissioning frameworks?

Bethany Badrock: On the falls prevention point, one element is that the programmes that are commissioned are not commissioned to reflect the true evidence base. On one of the Committee’s previous panels, Dawn Skelton and Chris Todd recognised that: we know that the full evidence base is for a 24-week programme. In some localities in Greater Manchester, we are commissioning eight weeks but expecting to see the same outcome, so in commissioning we need to make sure there is fidelity to the full programme. There is evidence that it is a primary and secondary offer.

One of the biggest things that we need to do is to raise awareness of strength and balance earlier in the life course. That is not necessarily about commissioning new programmes. There is an example that we are trying to pilot in Greater Manchester at the moment. When you are invited



in for the over-40 health check, that is predominantly for cardiovascular measures: your blood pressure, cholesterol and so on. That is incredibly important. If we were to do a handgrip dynamometer test, which takes 10 to 15 seconds to complete, we could provide information, saying, "Actually, your grip strength is quite poor. You have a high chance of sarcopenia. You should start to engage now. Here are some types of strength and balance exercises that you could do." We know from all the evidence about behaviour change and messaging that you might need to hear that message five to six times before it resonates and you start to do something about it. If we drip-feed that in during mid-life, so that someone mentions the importance of strength and balance every time you have one of those health checks or come into contact with the system, the likelihood of your taking that up and being connected to a local offer is much higher. It is not about commissioning new services; it is about everyone having responsibility and taking ownership to deliver that message.

Siobhan Farmer: I echo that entirely. There is another area that I do not think has been touched on by any of the panels: the role of the workplace. If we are talking about keeping adults healthy as they age, work is a place for social connection but also a place where people can go for a walk together at lunch time, or where we can encourage people to park further away from the workplace. There are things that workplaces can do to re-emphasise some of the messages. We were talking about that on the train. You pay into your pension, so what about paying physical activity into your later life? Everything that you put in now will benefit you in later life. There are some smart behavioural science pieces that could be done in the workplace, and that is probably fairly cheap to commission, compared with some of the interventions we are talking about.

Somebody on the last panel—I think it was Graeme—talked about trusting local communities. I think we should be looking at models where funding is devolved to local communities, perhaps via the ICB. We have a model like that locally in Gloucestershire. Our integrated locality partnerships are made up of system partners at the district level: the VCS partners, the doctors and the leisure providers. They are given a small budget—it is not big—and asked, "What are your local priorities? How will you use this locally? What will work for you in Gloucester? What will work for you in Cheltenham?" There is a lot of trust there from the ICB and the local authority, but it breaks down the power dynamic. It says, "Do you know what? We might not be able to measure that you have improved this by x%, but we trust that you know what is best and we believe that the evidence base for physical activity and social connection is strong enough that whatever you do will help." The ICBs and the local authorities then need to be measured on or asked what they are doing in that space, rather than, "How many heart attacks have you prevented?" or "What was your A&E admission rate?" Again, you might not be able to measure it, but you can certainly ask questions. You can have a key line of inquiry about what local models are there and an assessment on that, as opposed to a quantitative measure.



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Chair: I'm afraid that we have run out of time—I'm sorry. We could have continued. As ever with these inquiries, the session could go on forever. Thank you to the panel, and to the MPs.