The Richmond Group of Charities – Written evidence (NPS0141)

About The Richmond Group of Charities

1. The Richmond Group of Charities[1] brings together a range of major national charities who are all key players in England's health and care system, investing many millions as significant delivery partners for the NHS and other public services. Together we hear the concerns of and provide advice and information to millions of people. This aspect of our work has accelerated enormously during the pandemic. Our purpose and credibility flow from the shared insights we generate from our substantial individual contributions, through direct service delivery and our own staff and volunteers, our support for NHS services and staff, and our funding for research.

1.1 The Group has a focus on the needs of people with long-term conditions – especially multiple conditions. We aim to use the power of our united voice to enable better value for money in the health and care system, helping decision-makers understand how to achieve the best outcomes for the people we support. We are striving, in a changing world, to develop our own services and activities so that together we can support people with multiple needs more collaboratively with services that recognise and respond to the realities of people's lives and model the changes we want to see in others' policy and practice. We are committed to contributing to the long-term recovery from the pandemic.

About Movement for All and the We Are Undefeatable Campaign

2. Movement for All (M4A) is a collaborative programme that seeks to support the least active people living with physical and mental health conditions in England to become more active by delivering and evaluating the effectiveness of interventions to increase physical activity (namely peer support, helpline coaching, guidance initiatives) and through delivery of a mass marketing campaign.

2.1 We Are Undefeatable (WAU) is a physical activity campaign aimed at people with health conditions. It is built upon behaviour change theory and audience insight and brings to the forefront the real stories of people living with health conditions and their journey to be physically active despite the ups and the downs of their condition/s. The campaign is led by 15 charity partners made up of Richmond Group members, Mind, MS Society and Parkinson's UK with support from Sport England.

How can local delivery, including funding structures, of sport and recreation be improved to ensure that people of all ages and abilities are able to lead an active lifestyle? For example, how successfully do local authorities and other bodies such as Active Partnerships, Leisure Trusts, local sports clubs and charities work together, and how might coordination be improved?

[1] The Richmond Group of Charities brings together the following members: Age UK, Alzheimer's Society, Versus Arthritis, Asthma UK and British Lung Foundation Partnership, Breast Cancer Now, British Heart Foundation, British Red Cross, Diabetes UK, Macmillan Cancer Support, Rethink Mental Illness, Royal Voluntary Service and Stroke Association

3. Improving participation in sport and recreation requires a whole system approach, as identified and evidenced in Public Health England's Everybody Active Every Day physical activity framework that focusses primarily on addressing inactivity. Investment in sport and recreation should seek to address under-representation and inequalities by supporting those with the greatest barriers to participation to take part. This will only be achieved through a combination of short-term funding to innovate and explore new approaches alongside long-term sustainable funding streams to maintain, replicate or scale tried and tested, evidence-based initiatives. There is a requirement for overall investment in sport and recreation to take account of the resources needed to engage effectively with communities and support sustainable changes in their behaviour. Funding structures should also consider people and services holistically rather than focusing on single issues or pigeon-holing groups of people, e.g. people with long-term conditions, from particular ethnic groups or from lower socio-economic groups.

3.1 Insight from the We Are Undefeatable campaign in 2020[2], gathered by interviewing a small sample of sport, leisure and health sector policy professionals, indicated that there is some accord about the lack of integration and coordination between the broad range of organisations invested in keeping people active. Respondents were asked to what extent organisations were starting to take a joined-up approach to promoting activity to people with long-term conditions. The mean score on a scale of 1 (low) to 5 (high) was 2.9. The mean score on the question of whether there are streamlined systems in place to support people with long-term conditions to be active was 2.2.

3.2 In improving the coordination of physical activity delivery locally, alongside the sport and leisure sectors and local government, health and care organisations also have a role to play. Yet our research with health policy makers identified a limited and inconsistent approach to prioritising physical activity, in some cases put down to an ongoing lack of understanding of *'the innate value of physical activity'*, with physical activity interventions being seen as '*discretionary*'. A survey[3] of organisations including Active Partnerships and local authorities suggested that campaigns such as We Are Undefeatable help to bring collaborations together with a common message and call to action but these need to be replicated at a local and regional level as well as nationally and require considerable staff resource and focus to gain traction. One respondent said: 'We do not currently have the capacity to help develop the work and connections in the community that needs to take place to help drive this campaign.'

3.3 Our findings about a lack of coordination are echoed by emerging research findings from Sheffield Hallam University and the National Centre for Sport and Exercise Medicine. Their 'Easier to be Active' consultation[4] highlighted that person-centred approaches need to be taken to reducing barriers to participation for people with health conditions and we need to create seamless pathways into physical activity. The research also identified that a better understanding of the professional and organisational barriers to promoting

[2] Insight Angels,DJS Research: Policy Maker Insights Report (October 2020)
[3] Insight Angels: We Are Undefeatable Supporter Survey and Sport Sector Interviews Report (September 2020)
[4] Clever Together, National Centre Sport & Exercise Medicine, Sheffield Hallum University: Making it easier to be active with a health condition: a national conversation. Approach and findings from phase one (July 2020)

and supporting physical activity would be beneficial for tackling some of the lack of coordination and the blockers that persist. This is corroborated by other sources, such as PHE's survey into GP awareness of activity guidelines and confidence in promoting activity with patients. This identified a lack of training, confidence and awareness of physical activity evidence, guidelines and tools and prompted PHE, with funding from Sport England, to develop their Moving Health Professionals programme to upskill professionals in physical activity and behaviour change. The programme includes peer to peer training of clinical champions as well as resources such as Moving Medicine that seek to equip GPs with the information they need in patient consultations to provide very brief advice about physical activity.

3.4 The evaluation of the M4A programme[5] and the WAU campaign[6] indicates that undertaking audience insight and using behaviour change modelling is a critical approach firstly to understanding why people do not participate in physical activity and, secondly, developing appropriate interventions to address barriers relating to their capability, opportunity and motivation to be active.

3.5 Our research and experience of delivering physical activity interventions has demonstrated that it is essential that local delivery structures factor in social/peer support elements as an integral part of any physical activity initiative. The projects our members have delivered via their helpline services also demonstrate the value of providing remote health coaching and support structures, especially for those with more complex support needs and low motivation. Reduced social connection and increased loneliness due to reduced mobility and inactivity is also something that featured in our ethnographic research with people living with multiple conditions.

How can children and young people be encouraged to participate in sport and recreation both at school and outside school, and lead an active lifestyle?

4. Research from We Are Undefeatable[7] highlights that time and 'other commitments' including childcare/family commitments affect the ability of people with health conditions to be active. To address these barriers, we promote activities that can be done together with children and that are flexible, not reliant on finding the time and money to attend structured sport activities.

4.1 Asthma UK have identified[8] that living with asthma can be a significant barrier to physical activity for children and young people. However, their research highlighted that it wasn't so much children themselves creating barriers to being active as barriers being created by parents, teachers or coaches:

- For children, play and social aspects are very important elements of why they want to be active but if they're struggling with the emotional burden of their asthma they might not outwardly show this and it may not be spotted by teachers or coaches who are less aware of this impact than parents.
- For parents there are inconsistencies in support and advice for children with asthma regarding being physically active which makes it confusing and

[5] Traverse: Movement for All programme evaluation (October 2020)
[6] Insight Angels, DJS Research, RDSi, Richmond Group of Charities, Sport England: We Are Undefeatable Insight pack (November 2019)
[7] Insight Angels, DJS Research, RDSi, Richmond Group of Charities, Sport England: We Are Undefeatable Insight (due for publication March 2021)
[8] Asthma UK, CX Partners: Increasing Physical Activity in Children with Asthma (August 2019)

difficult to know what to do. Parents don't want to isolate their children from physical activity and play but are concerned about the level of awareness and the 'duty of care' amongst teachers at school and coaches in clubs. Interventions to address these concerns could increase confidence in parents encouraging children to participate in physical activity.
- Teachers and coaches have varying knowledge of asthma and the impact of the condition on children. They struggle to balance inclusion of children with asthma with the needs of a group to be stretched and make progress. Guidance and support for teachers and coaches could improve confidence in supporting and including children safely in activity and provide reassurance for parents.

While these findings relate only to children with asthma, it seems reasonable to infer that the same or similar barriers might exist in relation to other conditions.

How can adults of all ages and backgrounds, particularly those from under-represented groups, including women and girls, ethnic minorities, disabled people, older people, and those from less affluent backgrounds, be encouraged to lead more active lifestyles? If possible, share examples of success stories and good practice, and challenges faced.

5. NHS Health Survey data from 2018 indicates that 43% of adults over 16 years old in England live with a longstanding health condition. This represents a large proportion of people who may have condition specific barriers to activity in addition to the commonly cited generic barriers (time, money, access). The Chief Medical Officer Guidelines for physical activity clearly evidence the benefits of physical activity for prevention and management of many long-term conditions and associated symptoms. Correspondingly, there are almost 50 NICE products such as pathways, guidelines and quality standards that cite physical activity as an evidence-based option. Despite this, the most recent Sport England data from their annual Active Lives survey makes clear that inactivity is more prevalent among people with health conditions (37%) than those without (26%). Inactivity increases with the number of impairments: 56% of people living with 3 or more impairments are inactive.

5.1 People living with physical and mental health conditions are twice as likely to be inactive (do less than 30 minutes of physical activity a week) compared to people without health conditions. This is despite evidence (as stated in the Chief Medical Officer's Physical Activity Guidelines of 2019) that physical activity supports self-management of at least 20 chronic conditions and symptoms such as pain and fatigue, as well as reducing the risk of many conditions by up to 40%.

5.2 Our research and evaluation[9] of various physical activity interventions targeted at people with long-term conditions has highlighted that intervention design is crucial, requiring careful analysis of audience barriers and motivations; use of behavior change models such as COM-B to develop appropriate interventions; and co-design of interventions with the target audience. Common elements of successful interventions are person-centred approaches, peer/social support, flexibility and choice in how to be active.

[9] Traverse: Movement for All Programme Evaluation (October 2020)

5.3 The We Are Undefeatable campaign evaluation[10] indicates that using peer to peer messengers as storytellers has been a successful approach to engaging people living with health conditions from a diverse range of backgrounds with physical activity. This diversity and use of real people makes it relatable (59% of our target audience agree) and over the past year we have found this approach specifically resonates with people who have been shielding (64%), who come from BAME backgrounds (71%), or who are in lower socio-economic groups (63%). This relatability of messenger, combined with a non-traditional communication style, was tested with our audience through focus group research, which informed our decision to avoid using the words 'sport', 'fitness' or 'exercise' or any imagery associated with those words. Instead our use of language aims to create a more identifiable message and realistic goals, focusing on support, on achievable action, on building movement into daily life in small ways and weathering setbacks. Our inclusive campaign messaging and imagery has resulted in 42% of our audience taking an action as a result of seeing the campaign and 27% re-starting or increasing their activity.

5.4 Some of the barriers that WAU research has identified for people with long-term conditions, when mapped to the COM-B behaviour change model, provide useful insights into the development of potential physical activity support and provision. Barriers related to capability affect the least active, people with multiple conditions and those from lower economic groups the most. Motivational barriers affect people with long-term conditions significantly - particularly those aged between 18 and 44. Opportunity restricts people from BAME backgrounds the most.

5.5 People with long-term conditions could be encouraged to be more active if inclusive and accessible facilities and services were consistently available to a recognised quality standard. Some such benchmarking standards do exist (such as the QuestNBS Gplus37 facilities module aimed at increasing participation for disabled people and those with long-term conditions) but they are not well-promoted to the physical activity and leisure sector or to the public. The Alzheimer's Society Dementia Friendly Guide is an example of how person-centred approaches can improve services and facilities for a wide range of people, not just those living with dementia, and these need not be large or expensive changes to have impact.

5.6 Insight work over the past year about the impact of COVID-19[11] has indicated that the pandemic has become another significant barrier to participation for people with health conditions and Sport England surveys demonstrate a decline in activity. Similarly research from Activity Alliance highlights that disabled people are twice as likely to feel that COVID-19 has reduced their ability to be active compared to non-disabled people. 39% of respondents in WAU research[12] suggested that pain reduced their ability to be active and 28% indicated worries about COVID-19. People indicated a concern that their reduced activity as a result of COVID-19 restrictions was causing them to feel more pain and have reduced mobility. This has been echoed by Age UK in their research looking at the impact of COVID-19 on older people where physical deconditioning was a significant issue. WAU research found that

[10] Insight Angels, DJS Research, RDSi: We Are Undefeatable Evaluation (December 2020)
[11] Insight Angels, DJS Research, RDSi, Richmond Group of Charities, Sport England: We Are Undefeatable COVID-19 Insight (June 2020)
[12] Insight Angels, DJS Research, RDSi Richmond Group of Charities, Sport England: We Are Undefeatable Insight (for publication March 2021)

people with health conditions struggled to adapt their activity habits when services and support went online during the first lockdown. Our charity members shifted their services to providing telephone support as well as online support in attempts to engage with those at risk of digital exclusion. Responding to COVID-19, WAU developed a leaflet of activities to do at home and sifted and curated online content on our YouTube channel to help select the most suitable and appropriate content for our audience. This was done in response to the awareness that many people felt totally overwhelmed by the influx of exercise videos and support available and didn't feel it was targeted at them due to the unrelatable instructors delivering the content and the lack of accessibility of the exercises. These resources tested very well with WAU research groups.

Is government capturing an accurate picture of how people participate in sport and recreation activities in its data collection? How could this be improved?

6. Collectively, those funding, delivering and evaluating physical activity and sport participation are still focusing on measuring defined bouts of structured sport and recreation as opposed to the understanding the impact of a much broader range of physical activity and movement that may occur informally and in short duration.

6.1 Sport England's Active Lives survey measures physical activity participation and provides samples of people living with up to 3 or more 'impairments' which could be related to a disability or a chronic health condition. It is essential that this type of data continues to be collected to understand audience attitudes and behaviour. Sport England's new strategy puts a considerable emphasis on connecting physical activity with health and wellbeing. Given the prevalence of health conditions and the barriers people with those conditions face, reporting in more detail about the participation levels and behaviours of this group of people would aid the ability of commissioners and providers to direct resources and tailor their interventions most effectively.

6.2 Evaluation of physical activity interventions does not necessarily reflect the diversity of participants. Standardised validated measurement tools developed in academic settings are often not easily applicable in practice to people living with long-term conditions or disabilities. This can affect the quality of data generated or the credibility or lead to reduced credibility for evaluations necessarily conducted using un-validated tools. One example of this is a Sport England funded physical activity project run by Stroke Association, working with their peer support groups for stroke survivors to incorporate physical activity and understand how effective this is for engagement and behaviour change. When developing their evaluation, Stroke Association found a scarcity of appropriate validated measurement tools that took into consideration physical and cognitive impairments as a result of stroke, such as aphasia which affects speech. Subsequently they developed their own person-centred tools to meet their needs, but they did so in the knowledge that this might affect the external use of their evaluation.

What can be done to improve and implement effective duty of care and safeguarding standards for sports and recreation actives at all levels?

7. It is important to provide appropriately supportive and reassuring processes and procedures that enable effective duty of care and safeguard people participating in sport and recreation. However, it is critical that these procedures are proportionate and pragmatic, that they avoid creating barriers to participation and that they minimise unintended consequences by being person-centred. An example of current practice, highlighted through our own and other research with people living with health conditions, is screening people taking part in structured physical activity such as visiting a gym for the first time or taking an exercise class. Screening should be about enhancing and tailoring the support provided to an individual. Unfortunately in some cases the current system is deterring people from being active on the grounds of safety, despite the fact that evidence suggests physical activity is safe for the large majority of people and there is minimal risk of adverse events. This is happening in sport and leisure settings when an activity provider notes via their screening process, typically called a 'health commitment' statement or 'physical activity readiness questionnaire' (the PARQ form), that a participant has a long-term condition and may require them to get medical sign-off from their GP before taking part in activity. This approach triggers a potentially complicated and expensive process by referring participants to GPs who often don't feel equipped to undertake this sign-off and indicate that this falls outside their current contractual responsibility, generating a fee for the letter. On the other hand, a GP may be looking to signpost a patient to physical activity but because of a long-term condition may screen the possible physical activity opportunities on behalf of a patient, thereby avoiding recommending activity unless delivered by highly qualified specialists and potentially reducing the opportunity of the patient to participate due to barriers such as cost, time and travel. Understanding if, when and how screening is required is a priority in a review of sport and recreation duty of care and safeguarding standards.

Should there be a national plan for sport and recreation?

8. Any national plan intending to encourage the population to be active should consider a broader view of sport and recreation in order to be inclusive and relatable for the whole population. In practical terms this could be as simple as naming the plan a sport, recreation and physical activity plan and referring to activity and movement throughout. While the national plan would largely be aimed at professionals, changing the language used in a plan could go a long way to changing the wider public narrative, which our insight suggests may have impeded our collective progress to encourage greater participation. This shift would reflect the change Sport England have also made for their next 10-year strategy Uniting the Movement.

8.1 Any national plan would benefit from cross-governmental input to ensure that a whole system approach is embedded. This would help to harness every opportunity to promote an active lifestyle, thereby reinforcing social norms of an active society. It would also help to make sure that inequalities are addressed through a collective effort to remove barriers to participation.

8.2 We would encourage those writing any successor national plan to address the wider points made here about improving inclusion and using behaviour change techniques and audience insight to guide investment and delivery.

19 February 2021