Online surveys

CCHC Call for Evidence

Response ID	Start date	Completion date
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1	Title	[redacted]
1.a	If you selected Other, please specify:	
2	First Name(s)	[redacted]
3	Surname(s)	[redacted]
4	Contact email address	[redacted]
4.a	Additional email address (please complete this if you are submitting evidence on behalf of someone else)	[redacted]
5	Location	United Kingdom (GB)
5.a	If you selected Other, please specify:	
5.b	City	LONDON
6	Institution/Company/Organisation	Centre for Ageing Better

7	Summary of evidence	This submission focuses on our research on health, communities, homes and work for people aged 50 to 70. It presents evidence and arguments for a preventative approach to healthy ageing that is grounded in the priorities and circumstances of local areas. Our contribution on health focuses on the inequalities that the COVID-19 pandemic has revealed in the last 18 months in older age population and calls for better prevention as highlighted in the Healthy Ageing Consensus. We share evidence on the impact of poor housing and inactivity on our cohort and the unequal impact of COVID-19 on different groups. We include evidence on how the age-friendly communities network is championing holistic approaches at the local level to design places to be age-friendly and promote healthy ageing. We offer some good practice examples such as the Leeds Neighbourhood Network where local voluntary sector and local government is working together with local people on people led approached to community led support. Learning from our Good Home Inquiry and work on housing for older people we set out our evidence and a number of priorities for delivering home improvement support to address the high number of non-decent homes and improve the sustainability of new housing. Lastly, our contribution on work emphasises the strong links between health and or ability to perform well in a job.

8	Please select which exposure(s) your evidence relates to. Further explanation on these exposures can be found on a PDF file here. Please select all that apply.	• Workplaces and employment • Deprivation (e.g. income, poverty, diversity etc.) • Governance and policy • Technology and innovation

9	Please select which outcome(s) the submitted research relates to. Please select all that apply.	• Health (physical): (e.g. non-communicable diseases, communicable diseases, behaviours etc.) • Mental Health • Quality of Life • Lived experiences: (e.g. social health, social wellbeing, social behaviour etc.)

10	Method of evidence submission: If you need to provide further evidence, please submit this either digitally via email or hard copy via post.	Digital (via email to gchu@kellogg.ox.ac.uk)

11	How did you hear about the Commission on Creating Healthy Cities and the associated call for evidence?	

Centre for Ageing Better response to: Commission for Healthy Cities

September 2021

About the Centre for Ageing Better

The UK's population is undergoing a massive age shift. By 2050, one in four people will be over 65. The fact that many of us are living longer is a great achievement. But unless radical action is taken by the government, business and others in society, millions of us risk missing out on enjoying those extra years.

At the Centre for Ageing Better we want everyone to enjoy later life. We create change in policy and practice informed by evidence and work with partners across England to improve employment, housing, health and communities. We are a charitable foundation, funded by The National Lottery Community Fund, and part of the government's What Works Network.

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Governance/decision making processes

How best can City leaders ensure that the voices of citizens/users of services shape their policymaking and keep the public genuinely engaged with the process of policymaking as it proceeds from consultation to decision?

The UK Network of Age-friendly Communities is a growing movement with over 40 member places across England, Scotland, Wales and Northern Ireland. It is affiliated to the World Health Organisation's Global Network for Age-friendly Cities and Communities.

An Age-friendly Community is a place where people of all ages are able to live healthy and active later lives. These places make it possible for people to continue to stay living in their homes, participate in the activities that they value, and contribute to their communities, for as long as possible.

The Age-friendly Communities Framework was developed by the World Health Organisation, in consultation with older people based on the Vancouver protocol which developed a methodology for working with older people and stakeholders in 33 cities across the globe. In these communities, older residents use these methods to help to shape the place that they live. This involves coming together with local groups, councils, businesses and other stakeholders to identify issues, and prioritise changes in both the physical and social environments, for example transport, outdoor spaces, volunteering and employment, leisure and community services that will help local people age actively and healthily.

By signing up to be part of the network, and an age-friendly community, city leaders commit to involving older adults in the process of making the city a better place to grow and be older.

Examples from the network include:

- Age-friendly Walk Audits invite older adults of differing physical capabilities to walk, often alongside local stakeholders such as councillors, to consider the streets and communities through the lens of an older adult and identify things that need to change to increase their walkability, a key component in health and active cities. Examples being those done on the routes into the town conducted in Melksham, Wiltshire, leading to the provision of more benches on some write ups.
- Engagement in transport planning, working with Merseytravel and other providers to improve access to rail and busses in Sefton and the Liverpool City Region;
- Setting up community reporting and a local radio station in Newcastle Upon Tyne and Hackney (link to come) where older people lead on these programming and can share information about local opportunities to participate and also health-information sharing.

Another example from Ageing Better's work to engage the wider public in the task of creating of healthy cities is the Leeds Neighbourhood Networks, a network of 37 grassroots charities, commissioned by Leeds City Council to achieve four outcomes for people ageing in the city. These outcomes include to 'increase contribution and involvement' and to 'increase choice and control'. It illustrates the importance the city places on ensuring older people have a role in their community and in their city. The Networks are run by older people, for older people, genuinely helping shape the offer for their local community in terms of supporting healthy ageing. The long-term, city-wide

investment in this model meant that community infrastructure was in place to pivot quickly, and support the harm minimisation agenda during the COVID-19 pandemic. (LNN, Real Time Evaluation, Sheffield Hallam University, 2020)

In our work to understand the strategic context of the LNNs (Simply the Best), a senior stakeholder in Leeds stated: 'The relationships and resources in communities are building blocks for good health. Leeds has brilliant and diverse communities, well-established neighbourhood networks and a thriving third sector; we must harness these strengths.' (Simply the Best, 2020).

The Built Environment, Design and Placemaking (Housing, Planning and Urban Design and Regeneration)

What is the evidence that poor quality housing leads to physical and mental ill health, excess (winter) deaths, accidents in the home, increased hospital admissions and readmissions, premature moves into residential care and fuel poverty?

England has the oldest housing stock in Europe and our research shows that warm, safe and accessible homes are critical to the nation's health and wellbeing. To put this into context, one in five homes (4.1 million in total) did not meet the Decent Homes Standard in 2019 and of these around a third were occupied by someone aged 55 and above. (MHCLG, 2020)

The vast majority of people will live all, or nearly all, of their lives in ordinary housing (i.e., homes that were not built specifically for a particular age group). With 80% of the homes that people will be living in by 2050 already built (Boardman et al, 2005), the condition of existing housing is critical in determining quality of life for people of all ages. For older people, the issue becomes even more crucial to ensuring that they can live in homes that enable them to be independent, and lead healthy and fulfilling lives.

The cost of non-decent homes in England to the NHS is estimated at around £1.4 billion per annum for all ages (Nicol et al, 2015). Our research shows that the NHS spends £513 million alone on first year treatment costs for over 55s living in the poorest quality housing. An investment of £4.3 billion could repair all these homes – a cost that would be paid back in just over eight years, and would immeasurably improve the quality of life for millions of people, now and in the future. (Centre for Ageing Better, Home and dry: the need for decent homes in later life, 2020)

The research conducted for our Home and dry: the need for decent homes in later life report noted that there are noticeable differences in non-decency between the three tenure types: home owners, private and social renters.

The Good Home Inquiry chaired by David Orr CBE is an evidence-based analysis of England's housing policies to determine the causes and solutions to the poor quality of so many of our

homes. It was commissioned by the Centre for Ageing Better and reported in September 2021. The final report makes a series of recommendations about how poor housing can be tackled. The key recommendations include a call for a cross-departmental strategy to address non-decent homes, a national mandated network of local delivery agencies providing a range of support with repairs, energy retrofit and adaptations and the creation of more government backed loans ad

The majority of people living in a non-decent home are homeowners (2.8 million), followed by the private rented sector (1.1 million), which has the highest proportion of non-decent homes (one in five) (Centre for Ageing Better 2020).

There is a growing number of older people living in the private rented sector. 799,000 over 55s rented in 2019 privately compared to 366,000 in 2003-04 (MHCLG 2020). While the overall proportion of older private renters is relatively low compared to other age groups, estimates suggest this figure could skyrocket over the coming decades. Already, nearly a quarter (24%) of people aged 35-44 rent privately, meaning in the future, private renting will be the norm for many in mid and later life. By 2040, an estimated third of those aged over 60 could be living in the private rented sector (CIH 2015).

This leads to a growing concern about affordability in retirement. Those renting privately have the least security of tenure which can often lead to stress, anxiety and physical ill-health (Shelter 2020).

Can the gains from improved housing be quantified financially?

At the moment in England around half of “non-decent” homes are lived in by someone over 55. As the age structure of our society is changing dramatically- in 20 years time there will be 17 million people aged 50 to 70 (ONS 2019).

found that 1/3 of non-decent homes could be repaired for less than £1000. Research from Public Health Wales quoted in our Homes, Health and COVID—19 report highlighted that for every £1 spent on improving warmth in “vulnerable” households can result in £4 of health benefits. Even minor improvements to the physical condition of the home are found to improve quality of life and wellbeing, particularly when adaptions are made for later life (Garrett and Burris, 2015; National Institute for Health and Care Excellence, 2015; Poortinga et al., 2017; Powell et al., 2017; Rodgers et al., 2018).

It is estimated that the NHS spends approximately £500m a year for over 55s living in the poorest housing (Centre for Ageing Better, 2020). Many of the chronic health problems experienced by older people, including respiratory conditions and reduced mobility, have a direct link to poor housing.

Evidence suggests that generally, high-quality social housing provided by housing associations are more secure and more affordable homes that enhance wellbeing and could result in a reduction in costs to the NHS (Buck et al., 2016).

Does the evidence from the pandemic show links between susceptibility to the Covid virus and health inequalities such as: overcrowding; multigenerational households; cold and damp conditions; lack of space to work or study at home; lack of garden/balcony/green space?

The COVID-19 pandemic has exposed and amplified housing-related health inequalities in two ways. The emerging research suggests an association between accelerated transmission of the virus and areas of poor housing, having significant impacts on groups who tend to live in poor housing: older people, people with existing health conditions, those with lower incomes and people from ethnic minority groups. Secondly, the measures taken to control the virus have led to deepening health inequalities.

Our report Homes, health and COVID-19 produced in collaboration with the King's Fund has revealed that of the 20 local authorities with the highest COVID-19 mortality rates, 14 have the highest percentage of households living in homes with fewer bedrooms than needed. Looking at our age cohort, 20% of homes headed by occupants over the age of 65 contain none of the key accessibility features and only 7% of all homes meet the minimum standard of accessibility.

From a mental health perspective, a systematic review conducted by Pevalin et al. (2017) found that the length of time spent in poor housing had an adverse, cumulative effect on mental health. While the mental health impact of living in poor housing for one year was found to diminish over time, living in poor housing for four years may result in longer term mental health problems, extending as long as five years after. Moreover, people currently living in decent homes but who have had experiences of poor housing in the past, have poorer mental health than someone who had not experienced living in poor housing previously.

Recommendations:

- Make the improvement of thermal standards in current homes a central tenet of national government policy around energy efficiency and the environment.
- Create and support new mechanisms to enable low-income homeowners, particularly those with health conditions to bring homes up to basic standards of decency.
- Local and national government embedding action on housing quality as an outcome in all health and care integration, prevention and improvement initiatives.
- Increase levels of collaboration between health and housing at the local level. Health and wellbeing boards, sustainability and transformation partnerships, and integrated care systems should include housing as a focus.

- Address the poor state of existing homes. National and local government should protect people from the effects of damp and mould, trip and falls hazards, and fuel poverty on their physical and mental health in preparation for a potential second wave and lockdown in winter months.

- Focus support on those with the greatest risk of housing-related health inequalities. Older people, people with existing health conditions, those with lower incomes and people from ethnic minority groups are also often more vulnerable to COVID-19.

- Local and national government should consider the broader impact of shielding and lockdown on people's wellbeing. Access to green space, face-to-face and digital social connections and local amenities varies significantly between communities and has an impact on people's physical and mental health.

What changes to mandatory Building Regulations (e.g., in relation to standards for accessibility) can be shown to improve health and wellbeing?

Everyone, no matter their age, background or ability needs a good home. For most of us that means a home that keeps us safe and healthy and enables us to live the life we want at every age, whether that be studying, bringing up a family, working, volunteering or socialising with family and friends. The reality is that millions of us live in homes that don't meet our daily needs (ONS, 2019; MHCLG, 2016). England's housing is simply not suitable for the diverse and changing needs of our ageing population.

The design of many homes is inflexible and outdated, which can result in a daily struggle for some that impacts on every aspect of life, from the ability to simply get up and dressed, to maintaining social contacts. While specialist housing and care homes are the right choice for some and an important part of the mix of housing provision, more than 90% of older people currently live in ordinary housing (ONS, 2014).

Nevertheless, just 9% (1.7 million dwellings) of the current English housing stock has all four accessibility features that make them 'visitable' by most people, (MHCLG 2020) including those with mobility impairments, i.e., Level access to the entrance, a flush threshold, sufficiently wide doorways and circulation space, and a toilet at entrance level.

The Centre for Ageing Better co-chairs the Housing Made for Everyone (HoME) coalition which campaigns for more accessible homes. Building new accessible homes that are better designed not only for older people but also disabled people of all ages is an important part of creating a more age friendly built environment.

Our report Adapting to ageing has identified positive examples of innovation in the provision of adaptations, and also common features in the ways that localities are working to improve provision.

Changes are urgently needed to support local areas to improve planning to deliver an adequate and diverse supply of accessible housing that is fit for people of all ages and is adaptable as we age, and our ageing population should be justification enough for government to set a new mandatory minimum standard to future-proof all new homes.

Recommendations:

- Having consulted on changes to make new homes more accessible and adaptable, the government must move ahead as soon as possible to raise the mandatory minimum requirement to ensure that all new builds meet Part M(4) Category 2 – adaptable and accessible - standard of Part M of the national technical housing standards
- Where need is demonstrated locally for M4(3) homes, the government should lower the current high bar needed to introduce relevant planning policies.

Is there evidence that Home Improvement Agencies, providing advice and support for home retrofitting for older owners, are enhancing health and wellbeing for those living in poor conditions?

Working with BritainThinks on the Good Homes Dialogue we brought together members of the public living in poor quality homes with experts and policy makers to work together to test and refine possible solutions suggested by the Good Home Inquiry. The findings of this report have informed the recommendations of the Inquiry.

Some of the challenges described by the participants in accessing and using the current provision of home improvement services including Home Improvement Agencies are detailed below along with some options for improving access to support to improve homes:

- Participants were often concerned about unintended consequences if problems were uncovered (for example by an assessment service, such as the Home MOT) that they couldn't address, or if higher standards drove up rental prices.
- We heard mixed views on who should or could pay for improvements, with many participants arguing that older people and those on low incomes needed financial support, even if they owned a valuable property.
- Many of the solutions participants were most supportive of weren't things they felt they would use themselves, suggesting that providing more information on issues and types of improvements needed on its own might not be enough to drive change. Participants felt they were likely to need proactive advice and support on implementing and financing the improvements needed for their homes.

The Good Home Inquiry makes the following recommendations:

- Place a duty on local authorities to ensure every authority has a **local 'Good Home Agency'**, a public-facing hub providing access to information and advice, finance schemes, and a range of home improvement services including maintenance and repair, accessibility adaptations and energy retrofit
- Develop a new **cross-departmental national strategy** to improve England's existing housing stock led by a ministerial Good Home Champion, recognising our housing stock as a critical national asset and part of our essential infrastructure
- **Replace the current Decent Homes Standard** with an enhanced Good Home Standard that is applicable and enforceable across all housing tenures and for the government to direct Homes England to make improving the quality of existing homes a strategic objective
- Lead the development - alongside local government and industry – of a national model for a **home improvement check or 'Home MOT'** that provides an assessment of the condition of a home and where action is needed. Home MOTs should be available to everyone, regardless of housing tenure

What is the evidence of benefits from achieving a mix of incomes and housing types, for young and old, and an absence of segregation?

Despite a common misconception that most people in later life live in specialist accommodation or want to downsize, more than 90% of people over 65 live in mainstream housing and intend to stay there. Our report with Greater Manchester Combined Authority **'Rightsizing: Reframing the housing offer for older people'**, revealed that many over 50s cannot move home in the way that they would like, due to a lack of suitable housing options and inadequate provision of support and advice. Just 3.4% of people over the age of 50 move each year, half as many moves compared to the rest of the population. Although those with higher levels of wealth can more easily move, a lack of decent, affordable and accessible housing options leaves many on low and middle incomes trapped in homes which are no longer appropriate for them as they age.

Our follow-up research with Manchester Metropolitan University has also highlighted the vital role of place – the wider community and physical infrastructure which exists – as a key determinant to older people's housing choices. It shows that those on lower incomes who want to move have little choice to do so at present. It is therefore vital that we improve the provision of good quality social housing in well-connected neighbourhoods.

Transport and movement, infrastructure and technology (smart cities)

The Centre for Ageing Better commissioned Sustrans to carry out research to understand the barriers and facilitators to participate in active travel in mid to later life.

The evidence found that levels of physical activity drop in midlife. This is also true for active travel- that is walking and cycling for everyday journeys. Although it is one key approach to building regular physical activity into daily life, people in mid and later life are less likely to participate in active travel than younger age groups.

The evidence review on attitudes to active travel identified the following motivators and barriers to active travel among people aged 50-70 in the UK:

Active travel - general	
Motivators and enablers	**Barriers**
Health benefits of being physically active Mental health benefits (relaxation and stress reduction) Enjoyment of the outdoors; enjoying the fresh air; being in the community and seeing what's going on Feeling independent and in control Preparing for an active retirement Changes such as moving home or a new job that makes distances shorter	Distances too great (especially in rural areas) Lack of motivation/lack of priority Weather Personal safety or feeling unsafe Lack of an active travel habit Declining health and/or disability

In addition, the following cycling-specific motivators, enablers and barriers were identified:

Active travel – cycling-specific	
Motivators and enablers	**Barriers**
Having cycled earlier in life Feeling an identity as a cyclist and part of the cycling community Understanding and valuing the tangible benefits of cycling, such as predictable journey times and no traffic jams Developing resilience and coping strategies to overcome unsupportive cycling environments	Fear of motorised traffic Lack of confidence Poor cycle infrastructure Prevailing car culture, including poor driver behaviour

Ageing Better has identified three characteristics of places where levels of active travel are high which speaks about the changing attitudes towards walking and cycling post-pandemic:

- **Supportive infrastructure** - Supportive infrastructure means continuous routes for the duration of a journey, whether on foot or by bicycle. This infrastructure needs to address and reassure pedestrians and cyclists about the perceived and real danger posed by motorised traffic and other risks and obstructions. This usually means walking and cycling paths that are physically separated from motorised traffic. Good street lighting is also important.
- **Connected street networks** Connected street networks create shorter and more direct routes to key local destinations by walking or cycling compared with driving. Features include having a high density of intersections, crossings along junctions or along street sections that are safe and easy to use, minimal dead-ends (cul-de-sacs), and traffic calming measures such as low speed limits.
- **High population density and mixed land uses** Environments that promote active travel often feature high population density and mixed land use, meaning shops, housing, workplaces and other amenities are close together. Journey distances are short and therefore more amenable to walking and cycling (such environments have been given the name "20-minute neighbourhood" or "15-minute city").

As a result of this research, Centre for Ageing Better **recommends** the following policies to encourage more active travel and promote walking and cycling for people in later life:

- **Invest in walking and cycling infrastructure and emphasise safety:** This includes investing in and maintaining pavements, and for cyclists, improving deteriorating surfaces and making them smooth, fixing potholes and clearing debris and overhanging vegetation; investing in and maintaining cycle lanes that are physically separate from motorised traffic; installing cycle parking and pedestrian and cyclist bridges; and implementing traffic calming measures such as reduced speed limits. For cycling specifically, design and investment should be made at the town/system level as opposed to making piecemeal changes.
- Neighbourhood street networks should dove-tail with 'whole town/city' networks
- By increasing investment in aesthetic improvements such as seating, planters or community parks evidence shows there is an increase in walking.
- **Design and re-design street networks to provide connectivity and recognise the role of public transport:** Invest in street networks that start from the doorstep and are connected to key local destinations, and public transport maximising accessibility and allowing pedestrians and cyclists shorter, more direct trips than car users.

- **Aim for longer term plans to increase population and housing density:** Increased density, alongside mixed land use supporting diverse local amenities, services and facilities – consistent with the principles of the 20-minute neighbourhood (or 15-minute city) – will help to ensure that distances to be travelled are short and therefore more amenable to walking and cycling.

However, it is important to note that while environmental interventions alone have been sufficient to lead to changes that have public health benefits, combining environmental interventions with behaviour change approaches are likely to lead to even greater impact.

Is there evidence available to help our understanding of how the digital divide – both physical and social – may be excluding: - those without any or adequate broadband, preventing access to online shopping, studying, work and recreation; - those unable to afford the necessary IT equipment and monthly costs; - those lacking the knowledge/skills to use broadband/internet.

We know that currently there are 3 million are offline across the UK (ONS, 2020a) and the COVID-19 pandemic has exacerbated the digital divide among 50 to 70 years old.

In 2021, we commissioned Citizens Online to understand more about the effect of COVID-19 on digital skills and usage. The research was conducted with a range of organisations, local authorities, and people aged 50-70.The report found that the key to building digital inclusion isn't only about getting more people online, but also building skills and confidence.

It highlights the need for National and local government to recognise and promote the crucial digital support offered by local organisations to combat widening digital inequalities and the importance of recognising that many people still do not want to use the internet and want to continue using non-digital channels.

The research made the following recommendations:

- National and local government need to recognise the crucial digital support offered by the local organisations.
- Local authorities need to collaborate formally on digital inclusion projects with community organisations more.
- The Department for Digital, Culture, Media and Sport (DCMS) should create a resource bank that signposts to all the resources available to digital champions from one central place. There is a wealth of resources available for anyone providing digital training or support, but those new to providing support are often unaware of what is available.
- There is an ongoing need for devices to be made available.
- Non-digital options from both the public and private sector, such as telephone or mail, need to continue for those people who cannot or choose not to be online.
- Local authorities and digital support groups should encourage peer support through campaigns for volunteer digital champions.

Is there evidence of the effects relating to working practices adopted during the Covid pandemic: - flexible working, - hybrid working at home and in an office, - working in office hubs close to home

We know that both people aged 50 and over, and people living with LTCs and disabilities, face barriers to employment. Our report Working well? How the pandemic changed work for people with health conditions shows that in March 2020, 73% of people aged 50–64 were employed, compared with 86% of people aged 35–49 – giving an age-related employment gap of 13 percentage points.

Furthermore, in the year to September 2020, 52% of disabled people aged 16–64 were in employment, compared with 81% of non-disabled people – giving a disability employment gap of 29 percentage points and we know that the disability employment gap is largest for those aged 50–64. Although ill-health is not an inevitable part of being middle-aged as we get older, we are more likely to experience a long-term condition (or LTC). Forty-five per cent of those aged 50–64 report at least one LTC, compared to 28% of those aged 30 to 49.

In the light of this evidence and the 2019 green paper 'Health is Everyone's Business' which offered proposals for concrete changes to improve access to occupational health and incentivise good employer behaviour Centre for Ageing Better makes the following **recommendations** to employers:

- Create a culture that is explicitly anti-ableist and anti-ageist.
- Actively try to learn from the natural experiment of mass remote working
- Confront ageism and age-bias in your recruitment processes
- Continue to offer support and protection to staff who are clinically vulnerable to the virus

Flexible working is an important element in ensuring older workers are supported to remain in the workforce. Research by the Department of Work and Pensions identifies flexible working as the key factor in enabling people to work longer, but nearly a third of over 50s don't realise they have the right to request flexible working and almost a quarter aren't comfortable asking.(DWP, Attitudes of the over 50s to Fuller Working Lives, 2015) Ageing Better ran an 18-month programme with large employers and developed a toolkit for employers to implement flexible working for over 50s. The toolkit guides employers through developing clear policies and procedures around flexible working, facilitating open conversations between managers and staff, and creating a sense of shared responsibility to make flexible working arrangements work.

Health & Wellbeing (public health, social prescribing, food and exercise, health creation)

What has the Covid pandemic taught us in terms of health inequalities?

Even before the pandemic, our health inequalities in terms of years lived without disability were stark. People who live in the wealthiest areas (by Index of Multiple Deprivation decile) have almost

twice as many years of disability-free life ahead of them at age 65 as those in the poorest (6.2 and 6.4 years in the poorest areas for men and women, respectively, compared with 12.2 for men and women in the richest areas). This means that at the age of 65, men in the poorest tenth of the country can expect to spend 39% of their remaining life free of disability, compared to 58% for the those in the wealthiest (the corresponding proportions for women are 35% and 53%, respectively). It seems certain that the gap in disability-free life expectancy will have increased as a result of the impact of the pandemic. (Centre for Ageing Better, State of Ageing, 2020).

The COVID-19 pandemic has laid bare our existing health inequalities. Those with the poorest pre-existing health were more likely than those in good health to have poor outcomes, including death, from COVID-19. Of the 50,335 deaths involving COVID-19 that occurred between March and June 2020 in England and Wales, 45,859 (91.1%) of those were deaths of people who had at least one pre-existing condition, while 4,476 (8.9%) were deaths of people who had had no pre-existing conditions. The mean number of pre-existing conditions for deaths involving COVID-19 during this time was 2.1 for people aged 0 to 69 years and 2.3 for people aged 70 years and over. Our research shows that just 12% of people aged 50 to 69 who died with COVID-19 had no other pre-existing condition. The most common pre-existing condition was ischaemic heart disease, which accounted for 14% of all deaths involving COVID-19. After that chronic lower respiratory disease was present in 13% of all COVID-19 deaths and diabetes in 10% of deaths of people aged 50-59. We know from our work and others that the prevalence of these common conditions increases with increasing level of deprivation.

The consequence of this is that outcomes from COVID have been worst for the poorest in society. Working-age adults in the most deprived areas were 3.7 times more likely than those in the least deprived areas to die with COVID-19. In addition, over the period March to July 2020, there were 2.5 times more deaths per 100,000 population among Black African males aged 65 and over and 1.8 times more among Black Caribbean females 65 and over than in White males and females of the same age (Centre for Ageing Better, 2021).

The pandemic has not only exposed our existing health inequalities but has exacerbated them. So, while our own work at Ageing Better has shown that one in five 50 to 70-year-olds has seen their physical health deteriorate during the pandemic and associated lockdowns, the impact has been worst for those who are less well-off. Whereas a little over a quarter of those people aged 50-69 who are living comfortably say that the pandemic has had a very or fairly negative impact on their physical health, this increases to two-thirds (63%) of those who are finding it difficult to get by. And while 43% of those people aged 50-69 who are living comfortably say that the pandemic has had a very or fairly negative impact on their emotional health, the proportion is double – at 81%- among those who are finding it difficult to get by. (Centre for Ageing Better, 2021)

Is the Commission right to see health as the prism through which to consider the full spectrum of a city's social and public policies?

Extending the number of years we spend living in good health as we age is central to maximising our enjoyment of later life. Addressing health inequalities should be at the heart of all policy

making. This will create a more resilient society in the future and enable more people to be active economically and contribute to society. This means tackling the wider determinants of health as well as action across the life course to ensure that everybody has the same opportunities to achieve a good work, financial security, a decent home, and to develop and maintain connections to family, friends and a supportive wider community. It also means ensuring that health and social care services as we age are timely, appropriate and accessible to the whole population, irrespective of wealth or geographical location.

A lifecourse approach considers the critical stages, transitions and settings where large differences can be made in promoting or restoring health and wellbeing. This approach implies identifying opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at important life stages, from perinatal period through early childhood and adolescence, working-age, pre-conception and the family building years and into older age.

In 2019, Centre for Ageing Better and Public Health England launched the Consensus on Healthy Ageing whose purpose is make England the best place to grow old in the world as we enter the World Health Organization's Decade of Healthy Ageing 2020-2030. The Consensus has already been signed by 120 organisations across the health, housing, employment, research and voluntary sectors including Age UK, NHS England and the Department for Health and Social Care.

How can our highly centralised and illness-orientated health service be transformed to achieve more responsive, more preventative, more holistic and more personalised outcomes?

As an organisation we share the Government's goal of closing the gap in healthy life expectancy to ensure that people can enjoy at least 5 extra healthy, independent years of life by 2035, while narrowing the gap between the experience of the richest and poorest.

There are many factors contributing to this gap, as described in our Healthy Ageing Consensus Statement and strong connections with Public Health England focuses on that. As highlighted in the Consensus if we want to see more people keeping in good health for longer, we need to do more to prevent and delay ill-health in the first place.

Smoking, harmful levels of alcohol consumption, unhealthy diets and physical inactivity are some of biggest contributors to ill-health as we grow older. These risk factors are also closely linked to socioeconomic advantage – people from poorer backgrounds are more likely to live in environments and face circumstances where it is much more difficult to make healthy choices compared to richer people. For example, it is very difficult for us to make healthy choices if we live in environments where it is unsafe to walk to cycle or where unhealthy food and drink are relentlessly marketed and discounted while healthier options are harder to access.

According to ONS data from 2020, in the poorest parts of the country, a baby girl has a disability-free life expectancy of 51. That means she's currently set to spend 16 fewer years in good health

across her life than a girl born at that same time in the wealthiest parts of the country. And when you look at how these same measures apply in later life, the average man and woman aged 65 can expect just six years longer free of disability compared to the 12 years their wealthiest peers will enjoy. (ONS, 2020)

In addition, according to the same data there is a stark North/South divide. Someone aged 65-69 living in the North East can expect 8.3 more years disability-free – nearly three years less than someone living in the South East (State of Ageing, 2020).

This health-wealth gap risks becoming wider still in the wake of COVID-19. Poverty and financial insecurity, employment, our homes and the places we live all affect physical and mental health directly. They also affect behaviours like being physically active, smoking, having a poor diet and drinking too much.

Addressing smoking, alcohol, obesity and physical inactivity therefore has the potential to not only increase the number of years we spend in good health, it can also help to reduce the gap in healthy life years between the richest and the poorest.

Does the evidence suggest the most cost-effective improvements in health and wellbeing will come from encouragement of healthier lifestyles and diets, combatting obesity, inactivity and tobacco/alcohol/substance abuse?

The recent PHE report on the wider impacts of the COVID-19 on physical activity, deconditioning and falls in older adults from August 2021 highlights the importance of strength and balance activities for health. They predict that for each year that the lower levels of strength and balance activity observed during the pandemic persist, there is projected to be an additional cost to the health and social care system as a result of the change in predicted related falls of £211 million (incurred over a 2 and half year period). (PHE, 2021)

We also know that muscle strengthening and balance activities are a part of the UK Chief Medical Officers' physical activity guidelines for health. Yet many people are unaware of these guidelines and much greater emphasis is placed on the aerobic part of the physical activity guidelines than on muscle and bone strengthening and balance. It is not just the public who are unaware – these guidelines are also often overlooked or forgotten by commissioners funding physical activity programmes and services, by healthcare professionals prescribing physical activity and by physical activity providers and exercise professionals themselves.

Any promotion of physical activity needs to give equal weighting to strength and balance and aerobic activity. In addition, we need increased funding for strength and balance programmes and more local actors working together and providing programmes that are evidence-based.

The Centre for Ageing Better published a research report which presents different models of delivery, issues, barriers and innovative solutions that were found: https://www.ageing-better.org.uk/publications/raising-bar-strength-balance. For our age-cohort, we know that mid-life is crucial for maintaining activity levels as it's around this age that people start to develop long-term health conditions that need managing or preventing. From the age of 40, adults lose 8% of their muscle mass per decade. Low muscle mass is significantly associated with inability to perform activities of daily living with the prevalence of disability increasing significantly as muscle mass decreases. This is why incorporating strength and balance exercises are particularly important for those in in their 50s and 60s. (Centre for Ageing Better 2020).

Our latest report on physical activity, Keep on Moving has examined the motivators and barriers to physical activity for those in mid to later life. This comes in the context of the pandemic whereby inactivity became an increasingly urgent issue. According to the Sport England's Active Lives Adult Survey, the pandemic led to unprecedented decreases in activity levels during the initial restrictions with 1.2 million (+2.6%) more adults compared to 12 months earlier taking part in less than an average of 30 minutes a week. This increase takes the total number of inactive adults in England to 12.3 million (27.1% of the population). (Active Lives Survey, 2020).

Recommendations:

- At national level, the government should prioritise physical activity as part of the pandemic recovery, working with local government, local health systems, the fitness and leisure sector and the voluntary and community sector to fund, create and adapt approaches that enable a diverse range of people aged 50–70 to engage with physical activity.
- Local government should adopt whole systems place-based approaches to supporting people aged 50–70 to become more physically active. These will differ by location but must be grounded in an understanding of people's preferences and abilities and focused on both demand (identifying those who might benefit from physical activity interventions) and supply (improving local provision of physical activity interventions).

- Local health systems should embed physical activity in local health and social care systems, including the upcoming Integrated Care Systems (ICSs), which will be crucial to any whole systems place-based approach
- The fitness and leisure sector should create an inclusive and welcoming environment for people of all ages and ensure staff are trained to support people aged 50–70 with long-term health conditions. The sector should also ensure staff are as diverse as the populations that you offer activities to.

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