People's Health Trust's evidence to the Health and Social Committee's inquiry on Healthy Ageing

About People's Health Trust

People's Health Trust believes in a world without health inequalities. People are dying too young because of where they live or who they are.

Since 2011 People's Health Trust has partnered with a vibrant network of over 3000 community organisations across Great Britain, supporting them with funding at a grassroots level to find vital and timely solutions to tackle the causes of poor health. Our approach is collaborative and innovative. We listen closely to communities to build funding programmes, develop campaigning and policy work and connect decision- makers with communities with lived experience of poor health and shortened lives.
We partner with universities and researchers to understand the effectiveness of different approaches to improving people's quality of life and health. We share these findings with communities impacted and with people who have the power to change practice on the ground. We also support national campaigns to help influence the agenda on health inequalities.

We are pleased to submit evidence to this inquiry. Our response is limited and to avoid duplication we have grouped our responses to questions.

2a What interventions would have the most impact in reducing the gap in healthy life expectancy between older people living in the most and least deprived regions?

3. What are the key barriers to older people increasing their physical activity and how can they be encouraged and supported to do more?

People in the poorest areas of the country are not only living shorter lives overall but also living fewer years in good health. Women and men in the most deprived parts of England will spend only about two thirds of their lives in good health - notably less than people in wealthier areas where and the least since 2013–15. In 2020-2022, healthy life expectancy (HLE) in the most deprived areas of England was 51.1 years for males and 50.5 years for females. In the least deprived areas, HLE was 70.1 years for males and 70.2 years for females – a gap of 19.1 and 20.2 years respectively. This is a fall in both life expectancy and healthy life expectancy compared to previous years, as well as a widening of inequality.

This has implications for how we think about ageing. In order to reduce the gap in healthy life expectancy it is vital to address the wider social and economic determinants of health, such as poverty, housing, and social isolation and designing services and allocating resources accordingly.

While physical activity is an important contributor to healthy ageing, a wide range of the evidence shows that social and economic conditions often have a greater influence on

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whether people age well, especially in deprived areas. Income security and housing quality, access to outside and green space, social connection and control over life, as well as access to preventative health care.

Evaluation of our long-running programmes over a decade show that participation in community-led activities, including walking groups, dance, gardening, and adapted sports, improves physical activity levels while also strengthening social connections and mental wellbeing. For older people, the combination of physical and social engagement is especially important in preventing health decline, reducing loneliness, and building resilience. These outcomes both support and encourage physical activity.
However, if an older person in a deprived area has poor housing, insufficient income, and is socially isolated, increasing physical activity will have limited impact unless these barriers are also addressed. For the biggest gains in healthy life expectancy, and therefore the greatest impact on reducing the gap between people living in the most and least deprived areas, physical activity needs to be delivered alongside measures that tackle poverty, housing, and social connection.

Personal and behavioural change programmes that encourage older people to do more can be effective when embedded within trusted, culturally competent, and non-clinical community settings, but are far less effective when delivered in isolation from the broader conditions affecting health. Older people's ability to be physically active is shaped as much by social and environmental conditions as by individual motivation. In the most deprived areas barriers are often multiple and reinforcing - inaccessible transport, poor housing, lack of safe or suitable space, digital exclusion, stigma, and poverty can limit physical and other activity. Older age groups provide the highest hours of unpaid care per week and caring also has its own health impact as well as being a barrier to participating in physical activity. Interventions that remove these barriers while embedding physical activity into daily life, delivered by trusted local organisations, address both the causes and symptoms of the inequality.

One example of a community partner we've worked with to successfully support health among older people is The Young Again project, run by the Pakistan Association Huddersfield, based in one of the most deprived areas of the England. There are physical and financial barriers preventing people from getting out and meeting each other and being active: lack of suitable space, cost transport or local activities means many older people in this area simply cannot afford to participate. The Young Again project organises free day trips and activities designed to keep older people connected and active and aims to offer the opportunity to as many people as possible.

Programmes that are peer-led and combine practical support with health-focused activities tend to achieve better and more sustained participation among older adults than short-term or individually focused initiatives. This is because they address multiple barriers at once — not just the physical activity itself. Peer-led programmes and those designed in consultation with their intended participants also help to address other protected characteristics, particularly sex, sexuality, race, religion and disability, as well as class and cultural and regional differences in experience.
Peer leadership builds trust, making it more likely that participants will attend regularly and feel a sense of ownership over the activity. Practical support such as transport, lunch clubs or help with benefits forms, combined with activities that also support wellbeing, such as group exercise, community gardening, or cultural outings, helps participants form strong social bonds, which contributes to improved health outcomes. It also helps sustain engagement: Public Health England found that participants are more likely to continue attending activities where barriers are addressed and evaluation of People's Health Trust

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programmes have found friendships and mutual support contribute to engagement and adherence.

4. How can health services work with social care, the third sector, businesses and local government to support older people to be more physically active and address existing health inequalities?

Our long-term Active Communities and Local Conversations programmes show that community-led activities such as walking groups, gardening, dance sessions, and culturally specific exercise classes, particularly those co-designed with older residents, significantly improve both physical and mental wellbeing. The two programmes engaged residents who faced significant health-related challenges, and endured sharper health inequalities than had been anticipated.

Local Conversations was a long-term funding programme that worked with the same communities across Great Britain for over a decade. Alongside multi-year funding for vital local organisations, steering groups of local people worked with the Trust to set priorities, design activity and allocate local grants.

Case study

Residents in Merstham chose parks and green spaces; activities for local people, including older people; digital inclusion; and mental health as their main priority areas to tackle health inequalities. Activities included a Repair Café, allotment, community cash box small grants panel and a parks and greens conservation group. Residents set up a peer lead mental health support group and created a toolkit on improving wellbeing and accessing support services.

Through our Active Communities programme, have supported many hundreds of grassroots projects working with older people, genuinely designed and run by local people across England, Scotland and Wales. Partner organisations came up with their own locally determined ideas to strengthen social connections and encourage greater collective control. The programme enabled participants to take the lead by putting processes in place to address issues that are important to them.

Case study

The Healthy Active Lives project, based in Derby, was aimed at older people from black and minority ethnic communities, particularly people aged over 50, carers and people who were socially isolated. Activities included Tai Chi, Chair Yoga, Over 50s, games evenings, dominoes, darts, film evenings and a carers' support group. The project built stronger connections within the community, enabling friendships between the members and helping them to develop improved social networks. Members who met at a Tai Chi class set up a rambling group and participants reported increased confidence to seek out ways to improve their own health and that of others in their community. It also created an environment where members were receptive to health awareness messages delivered through community-led events. Participants reported a reduction in their sense of isolation and improved their physical and mental health and wellbeing.
The final report of the evaluation of these two long-term programmes showed that our approach of supporting local projects, led by residents, improved health and wellbeing by strengthening social ties, growing local networks and increasing community power in neighbourhoods. The findings highlights that, amid pressures such as the cost-of-living crisis and lasting impacts of the pandemic, small charities are vital to promoting physical

activity. By boosting confidence, strengthening social ties and improving access to tailored advice, these grassroots groups tackle health inequalities from the ground up.

Building on these lessons, People's Health Trust is continuing to support local projects to tackle health inequalities in communities facing the highest levels of disadvantage and marginalisation through our Health Justice Fund programme areas. These have been developed in partnership with communities and focus on people's priorities - from increasing access to advice, to improving mental health through nature, establishing pathways to good work for young people, and tackling discrimination, we are supporting communities at the sharp end of health inequalities and who are frequently furthest from statutory health services.

6. What should the Government prioritise in funding allocations for delivering services to support older people to become more active?

7. What could the Government learn from examples of best practice that exist in local authorities, the third sector, NHS Trusts, or internationally?

Examples from NHS Trusts and integrated care systems demonstrate that collaboration between health services, social care, local government, and voluntary and community organisations creates more joined-up and effective provision and reaches those people furthest from statutory services and most in need. Commissioning should also account for intersectional needs – including protected characteristics in addition to age, class and regional differences in experience. Funding allocations should require and resource partnership working, beginning with close consultation with local delivery partners and starting in areas with the greatest health inequalities. Funding criteria should prioritise grassroots and community delivery and be accessible to these organisations, with proportionate application processes and core cost support, recognising their central role in delivering effective and culturally relevant programmes that meet the intersecting needs of older people, including older people in the criminal justice system.

In allocating funding, Government should consider programmes that combine opportunities for physical activity with measures to address the underlying social determinants of health. Peer-led initiatives that combine health-focused activities with practical help such as transport, meal provision, and benefits advice have proven effective in both encouraging initial uptake and sustaining long-term engagement. Government should allocate funding to models that address these practical needs alongside promoting physical activity.

Best practice from local authorities and the third sector shows that multi-year, locally designed programmes, co-produced intended participants and delivered by trusted organisations, achieve higher participation and better health outcomes. Funding models should reflect this by supporting continuity rather than short-term projects or focusing solely on innovation.

Sustained partnership working with grassroots organisations also creates an opportunity for meaningful consultation on policy development and service design. People's Health Trust maintains a network of grassroots expert organisations that we currently or have recently funded, who we engage with regularly including on programme development and influencing work. Their contribution and expertise, working every day on the front line of health inequality in the country's most disadvantaged neighbourhoods, is invaluable.

In 2024, People's Health Trust consulted our network on the planned changes to the Winter Fuel Payment and the reactions of older people to the changes that were announced. More

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than 30 organisations responded to our call; between them, these organisations work with thousands of older people each year (generally between the ages of 55 and 100, with most older than 65). Many also work with particular groups of older people, such as those from racially minoritised communities, carers, those with dementia, those with learning disabilities, survivors of stroke, and older people living with a diagnosed mental health condition such as bipolar disorder. Maintaining our trusted relationship with grassroots organisations gives us significant reach into communities while enabling us to provide current and meaningful evidence to decision makers.

In the case of the Winter Fuel Payment changes, we heard direct testimony from older people describing the negative health impact the announcements had already had (worsening their mental health, stress, anxiety, exacerbating existing physical health conditions), as well as the expected impact once the changes took effect. Our recommendations based on this testimony including calling for a reversal to the announcements (which has now largely happened). Based also on the fact that the impact of the policy on the health of older people had not been sufficiently considered, we recommended that any new policies like this must undergo an equalities impact assessment (under the Public Sector Equality Duty), which must pay serious attention to means testing with regards to ensuring health equity, alongside a consultation process to understand the impact on older people and older disabled people.

Along with others in the third sector, we have called for 'A Health in All Policies approach', to ensure that there is cross-departmental responsibility for improving population health and reducing inequalities. This approach recognises that factors shaping health outcomes - such as housing, transport, employment, and the environment - lie outside the health sector and calls for health considerations to be systematically integrated into the policymaking of all government departments. This requires aligning wider government policies, including those on income security, such as the Winter Fuel Payment — with health goals, as measures that protect older people from fuel poverty also reduce excess winter deaths and help maintain independence and wellbeing. Embedding a Health in All Policies approach supports the ambitions of the Department of Health and Social Care 10-Year Plan for Health and Social Care to improve healthy life expectancy, narrow inequalities, and create a more preventative, joined-up system.