



An exploration of physical activity and related opportunities for older people in Staffordshire

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Contents

Acknowledgements.....	2
Contents.....	3
Executive Summary.....	4
1. Introduction	6
2. Aim	8
3. Objectives.....	8
4. Outline of the approach.....	8
4.1. Community workshops	8
4.2. Stakeholder interviews	9
4.3. Situational Analysis	9
4.3.1. Social world maps	9
4.3.2. Positional maps.....	9
5. Findings	10
5.1. Community workshops	10
5.2. Stakeholder interviews	10
5.3. Situational Analysis	10
5.3.1. Current situation (post-COVID) based on a system thinking approach.....	10
5.3.2. Role of, and processes in Situational Analysis	12
5.3.3. Positional maps.....	13
6. Implications and recommendations	21
7. Reference list	23
Appendices.....	25
Appendix 1. Common themes from report of community workshops by VAST	25
Appendix 2. Common themes from report of community workshops by Support Staffordshire	26
Appendix 3. Social worlds map from Situational Analysis	29

Executive Summary

Aim

To support scaling up healthier ageing initiatives through understanding the impact of COVID-19 on physical activity participation of the population >55 years of age in Staffordshire & Stoke on Trent, and identify needs, opportunities, and solutions for community and systems level approaches.

Approach

Data were collected through eight workshops with community members (total n=83) and interviews with stakeholders (n=15) who represented relevant organisations in Stoke-on-Trent and Staffordshire. Written materials were requested from the local authorities to provide relevant policy and strategic context. All data fed into Situational Analysis, a flexible, data-driven, qualitative methodology used to understand systems. In this case, the situation was the **system of community-level supports for physical activity in Staffordshire**.

Main findings

How COVID-19 affected physical activity levels and related opportunities in older people

- The impact of COVID-19 on physical activity and opportunities (at individual and community levels) had been profound and persisted. Illness and/or caring responsibilities had limited physical activity, lockdowns had set a new normal of not *going out*, and many groups or physical activity sessions had not yet restarted.
- A key limiting factor was the reduction in volunteers during COVID (which had not recovered). Some older people had been volunteers and were negatively affected through losing this as a means of social and physical activity, while others lost access to programmes that relied on volunteers (a population disproportionately comprised of older people).
- Failure to *get out* remains a key impediment to physical activity; many older people are still staying in, avoiding crowds, and have a prohibitive perception of the risks of interacting with others. The reduced social contact, in turn, has additional negative consequences (e.g., social anxiety, mental health problems, low confidence, social isolation).

Older people's experiences, needs, priorities and solutions to physical activity participation

- Individual-level facilitators for physical activity were primarily social (social ties, social belonging, desire for company).
- Individual level barriers were often practical (cost, transport, lack of time) or related to existing health problems (e.g., poor mobility, fear relating to misunderstandings of the risks of physical activity). This highlighted a need to maintain existing/offer more opportunities and subsidies for physical activity in older people.
- Organisational-level facilitators were maximising the VCS offer and to address the gap left through reduced volunteer support.

- Organisational-level barriers included cost of service delivery, some offers not accommodating older people (unconscious ageism), and lack of coordination between services (silo working). The latter is made difficult when services or programmes are short-term funded and do not specify a need for collaborative working.
- At the system-level (and related to the above), the wider economic climate (cost of living crisis) was a pervasive, negative influence (placing financial pressures in individuals, service providers, and local authorities). The abundant natural environment in Staffordshire was recognised as a physical activity resource (e.g., for walking, outdoor recreation), but the related physical activity offer was considered *ad hoc*, needing a more joined up and coherent approach. Relatedly, limited opportunities for physical activity among rural communities were another barrier.

Role and acceptability of social prescribing and other interventions to increase physical activity

- Social prescribing was generally regarded as having a growing role in physical activity, but needed: social prescribers to have a broader than exercise referral (i.e., helping to connect older people with communities); more active roles for GPs; to address reluctance among referrers.
- Key limiting factors here were the medicalisation of physical activity and risk aversion, and unconscious ageism.

Recommendations

Overall goals for the local system should be to:

- i) Eliminate any barrier to access resulting from intentional/unintentional forms of ageism.
- ii) Set clear long-term goals that all local key partners sign up to, supporting the idea that ‘doing something is better than doing nothing’.

Four limiting factors in the system that offer leverage points to help systems change:

- i) Getting old people out (breaking the post-COVID norm)
- ii) Reviving volunteering by any means necessary
- iii) Promote/campaign for physical activity to older people that is more specific to them, and promote basic physical activities of daily life that can easily be adopted
- iv) Promote physical activity message to ‘do something’ is more tangible for this group (e.g., playing with children, gardening, walk with friends, etc.).

Finally, long-term, process-focused goals towards systems change require truly collaborative working between all parties (local authorities, key stakeholders, local VCS), and a move away from short-term solutions (e.g., long-term, flexible commissioning of services that encourage providers collaborate towards a common goals).

1. Introduction

Physical activity has multiple benefits for reducing the risk of noncommunicable diseases such as heart disease, stroke, diabetes, and breast and colon cancer [1], and is important in helping people to maintain health and independence into older age [2]. Increasing regular physical activity at any age is beneficial for health, particularly given the age-related increased risk of conditions including neurodegenerative disorders, rheumatoid arthritis, cardiovascular disease (CVD), macular degeneration, and diabetes [3, 4]. Such chronic or non-communicable conditions often manifest around midlife, after years of exposure to unhealthy behaviours, like smoking, excessive alcohol, poor diet and physical inactivity [4].

Age-related increases in disease risk are compounded by commonly observed age-related reductions in physical activity. For example, data from the Health Survey for England in 2018 estimated that the proportion of those meeting the recommended 30 minutes per day of moderate-vigorous intensity physical activity reduces to steadily from midlife, with a marked reduction in the over-75s levels (Figure 1). Although the absolute figure is based on self-report and might overestimate the proportion achieving 30+ minutes/day, the decline with increasing years, /is clear.

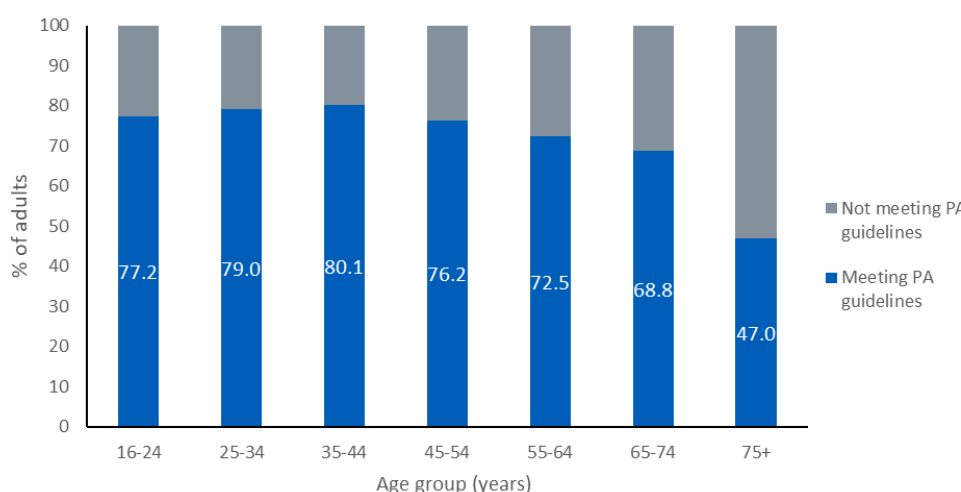


Figure 1. Age related trends in proportion of English adults meeting recommended physical activity levels (Data taken from Health Survey for England 2018 [5])

COVID-19 exacerbated this problem, with global reductions in physical activity among older people [6]. In the UK, there was an overall population physical activity decline as a result of lockdowns and social distancing, which was most severe in the youngest and oldest age groups (Figure 2 [7]).

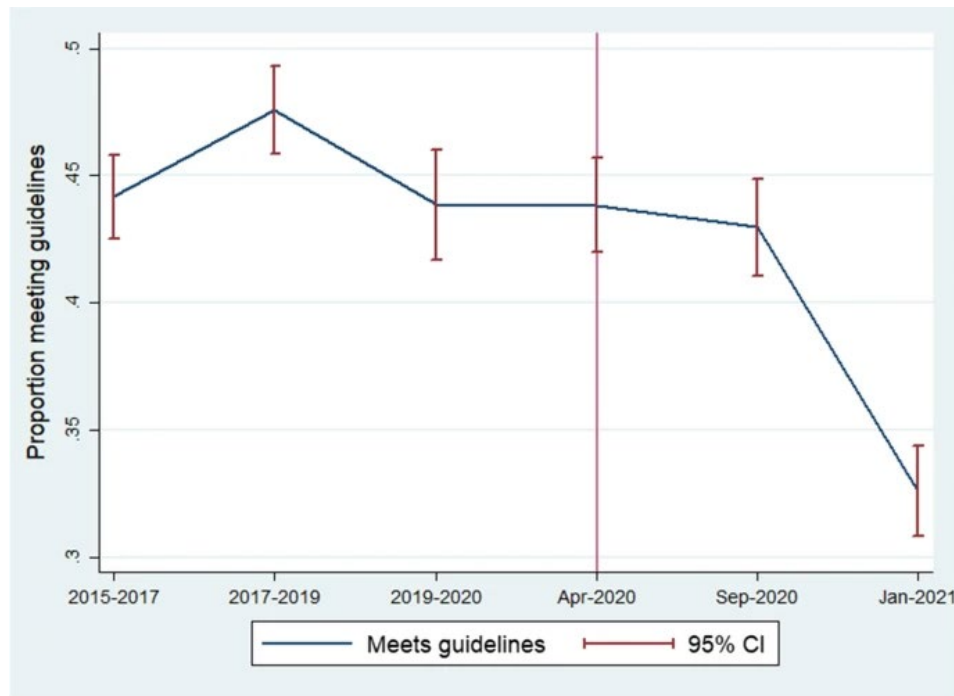


Figure 2. Proportion of over-65s meeting physical activity guidelines over time (red vertical line indicates the introduction of the first UK lockdown) (Taken from Elliot et al. 2022 [8])

This project was commissioned to feed into the Staffordshire Health Ageing Strategy. Physical activity is clearly an important consideration, which demands even more attention in the wake of COVID-19-related disruptions to people's behaviours, habits, and possible, related opportunities. To that end, we sought to explore the barriers, facilitators and possible approaches to increasing activity as part of a wider healthy ageing strategy in Staffordshire. In recognition of the need to shift emphasis to prevention of age-related decline in physical activity and greater risk of health problems that follow, we focused on the **over-55s**.

It was also important to include a community focus, which links to the NHS Long Term plan aspiration to '*dissolve the historic divide between primary and community health services*' [9, p17]. There is growing recognition among public health researchers and professionals of asset-based approaches to improving community health and well-being [10].

The complexity of studying health or physical activity impacts of community assets and networks, meant that traditional research methods used to simplify and measure linear relationships were unsuitable [11]. We, therefore, took a multifaceted qualitative approach, drawing on *Situational Analysis*, a three-phase approach [12], that was well-suited to this project for several reasons [13, 14]:

- Data can be gathered using various methods
- It is iterative and data driven (based on Grounded Theory), rather than looking to confirm a pre-existing hypothesis
- Context is at the heart of the inquiry in seeking to understand the mechanism of action.

2. Aim

To support scaling up healthier ageing initiatives through understanding the impact of COVID-19 on physical activity participation of the population >55 years of age in Staffordshire & Stoke on Trent, and identify needs, opportunities, and solutions for community and systems level approaches.

3. Objectives

The overarching aim was addressed through a series of objectives, speaking with members of the public (aged 55+ years) and relevant stakeholders in Staffordshire, to:

1. Understand how COVID-19 has affected physical activity levels and related opportunities in older people.
2. Explore older people's experiences, needs, priorities and solutions to physical activity participation.
3. Explore perceptions about the role and acceptability of social prescribing and other interventions as a means of increasing physical activity.
4. Identify some goals and leverage points for systems change to increase activity in older people in Staffordshire.

4. Outline of the approach

The overall approach drew on two major data sources, workshops with community members and interviews with stakeholders who represented relevant organisations in Stoke-on-Trent and Staffordshire. Written materials were also requested from the local authorities to provide relevant policy and strategic context.

4.1. Community workshops

To gather insights from community members, eight workshops were conducted in October-November 2022 by our voluntary and community sector (VCS) partners. **In Stoke-on-Trent**, Voluntary Action Stoke-on-Trent (VAST) ran four workshops, one in each of Bentilee, Blurton, Burslem and Shelton. **In Staffordshire**, Support Staffordshire ran two workshops in each of Lichfield and Stafford. Collectively, these offered diversity in area socio-economic and urban/rural composition.

A Staffordshire University researcher observed all sessions and made detailed notes to supplement reports from the workshop organisers. The workshops were organised around a small number of questions developed with VAST and Support Staffordshire to generate discussion relevant to the overarching aims and objectives:

- How did you stay active before / during the COVID Pandemic? How are you keeping active as we return to normality?
- Have you / are you a member of any clubs / groups? How does this help you stay active?
- What stops you being more active?
- Do you have any ideas of what's needed to help you be more active?

In the context of the literature and routinely reported physical activity data discussed above, community workshops were used to further explore changes in physical activity levels in older people as a result of COVID-19 in Staffordshire. Indeed, this emerged as a major consideration.

4.2. Stakeholder interviews

Semi-structured, one-to-one interviews were undertaken with stakeholders from organisations linked with health and physical activity provision in Staffordshire. Project partners (MPFT, VAST, Support Staffordshire, local authority) were asked to distribute initial email invitations to potential participants, who were then followed up by the research team. For those interested and available, interviews were arranged. All interviews took place over MS Teams and were audio-recorded and transcribed *verbatim* for analysis.

4.3. Situational Analysis

All data fed into Situational Analysis. This is an iterative, bottom-up, and data driven methodology that analyses the system under investigation. In this case, the situation was the ***system of community-level supports for physical activity in Staffordshire***. We have used Situational Analysis elsewhere to evaluate a city-wide system change intervention for people experiencing multiple disadvantage [15, 16] and are applying it to a longitudinal study of a similar city-level implementation of the national programme [17].

Typically, Situational Analysis uses cartographic approaches to produce three different types of map [12, 18]. Given the extent and type of data available, we focused on two types of map for the present study: social world arenas and positional maps.

4.3.1. Social world maps

Data from community workshops and interviews were used to produce a social worlds map. This represents the key social active players (social worlds), and the field (arena) in which they interact; for example, how the social worlds of local voluntary and public sector organisations interact within the arena of physical activity provision for older people in Staffordshire. In the map, social worlds that are similar are positioned adjacent to each other, and those with conflicting or opposing relationships are positioned opposite. The depth of intersections indicates the extent of their single or cooperative involvement with the situation.

In this sense, social worlds are comprised by various social entities and institutions, all with their own perspective and collective identity at the present time, within the situation of inquiry, and are dynamic, potentially changing over time [18].

4.3.2. Positional maps

The final outputs of Situational Analysis are the positional maps. These set out the major discourses or issues to emerge from the data, the various positions that are held about that issue, and help to identify key areas for attention and action.

5. Findings

5.1. Community workshops

Table 1 summarises the composition of delegates attending the eight workshops. In total, 83 individuals attended, including 14 in community volunteer or organiser roles. The remainder were individual community members or members of a community group. More women than men attended (68.7 vs. 31.3%), with the majority aged between 65 and 84 years (68.7%).

Table 1. Summary of participants of community workshops

		Stoke-on-Trent	Staffordshire	Total
Total		29	54	83
Gender				
	Male	8	18	26
	Female	21	36	57
Role				
	Volunteer/Organiser	8	6	14
	Community group member or individual	22	46	68
Age (years)				
	age <55	0	3	3
	age 55-64	1	7	8
	age 65-74	13	12	25
	age 75-84	10	22	32
	age 85+	4	8	12
	Missing	1	3	4

Reports of main themes recorded by the workshop facilitators are presented in Appendix 1 and 2. These reports, supplemented by observer field notes were used as data sources for Situational Analysis, findings from which are presented below (5.3).

5.2. Stakeholder interviews

Semi-structured interviews were completed with 15 stakeholders across Staffordshire and Stoke-on-Trent, representing local authority (n=6), voluntary and community sector (n=8) and other types of organisation (n=2). Similar to community workshop data, interview transcripts were analysed as part of the Situational Analysis, findings from which are presented below (see 5.3).

5.3. Situational Analysis

5.3.1. Current situation (post-COVID) based on a system thinking approach

Before presenting the outcomes (or 'positions') from Situational Analysis (see 5.3.3), this section aims to orientate the reader to the system thinking approach adopted here [19] and consider the *situation* under investigation in the wake of COVID-19 and related disruptions.

To understand the situation, we must conceptually focus on our target population. In system thinking each tangible and quantifiable element is called a **Stock**. For this investigation, the stock of interest is that of **physically active older population in Staffordshire**. Each stock has various inflows and outflows that counterbalance its quantity (i.e., the number of active older people in the county). These could

be active older people moving into/out of the area, people reaching old age/dying, people increasing/reducing activities levels, and so on.

Within this mini-system, **feedback loops** are the mechanisms whereby persistent behaviours *counterbalance* the system (i.e., keep the population of active older people relatively stable). The importance about the understanding of feedback loops is that the dominance of one feedback loop over another, results in the persistence of its related behaviour within the system. For the present study, on one side there are the goal-oriented **balancing feedback loops** - factors that promote continuity and maintain a stable population of active older people. On the other side are the **reinforcing feedback loops** – influences that amplify disturbance of stock, which can be beneficial (e.g., drastic increases in the population of active older people) or destructive (e.g., drastically reducing the active older population). To better understand how the system behaves, we need to keep in mind that the main characteristic of these reinforcing feedback loops is their exponential effect; whenever there is a long-term dominance of a reinforcing over balancing feedback loops, the effect can be profound. As discussed above, in the context of overall population physical activity, COVID-19 lockdowns had a sudden, dramatic effect on physical activity behaviours that impacted the ‘stock’ of people who were physical activity people, nationally. As discussed below, this was evident in the local population of older people. **COVID can be considered as an external force that suddenly and dramatically disturbed the local system of support that focused on promoting and keeping active the local older population. This led to a reduction in activity levels of local older population, in turn, reducing the ‘stock’ of active older people in Staffordshire.**

Longer term, *balancing feedback loops* eventually kick start again; for example, venues or groups for physical activity reopen, social networks re-establish, and individuals resume previous activity behaviours. However, delay to reinstatement of balancing feedback loops is a critical determinant of system behaviour and the rate of change (or return to previous state). With COVID-19, the re-opening of society followed a relatively specific time schedule and, as such, the system adjusted with a slower rate of change regarding the number of people re-engaging with physical activity.

A key issue of all complex systems, including the one under investigation, is its *self-organisation*: the ability to regenerate by adding, changing, and evolving its structures. In our case, the local infrastructure to support physical activity in older people was profoundly damaged by COVID-19 (e.g., community organisations stopping their activity, venues closing, exercise classes not running, social groups not meeting). As discussed below, this was compounded by reliance of **many local older people on the VCS for physical and social activities**, and the **VCS’ reliance on volunteers of older age**. This generation gap in volunteering cost the system valuable resources when they were most needed (during COVID-19). Many older age volunteers suffered the consequences of COVID (personal infection, caring for family members) or were shielding through elevated risk of serious COVID-19 outcomes. In the absence of a balancing feedback loop to mitigate this effect, the entire system experienced a shock. Therefore, the **reestablishment of volunteering in the local population is a priority**. Figure 3 offers a simple schematic of these processes.

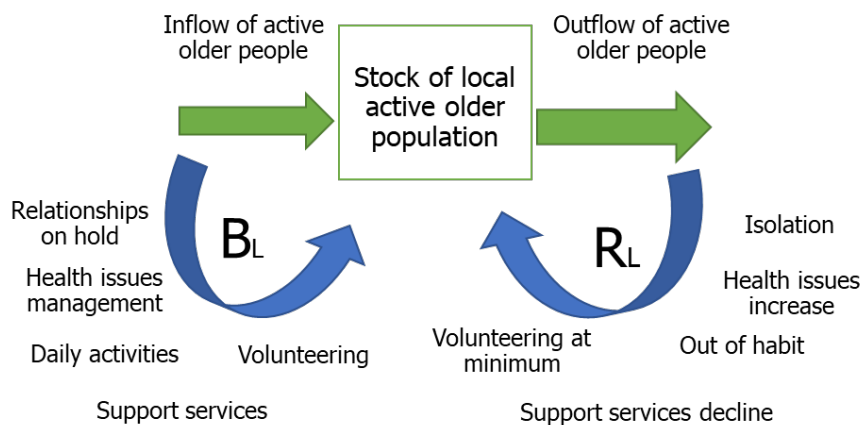


Figure 3. System influences on the post-COVID situation of physically active older people in Staffordshire
(B_L – balancing feedback loops, R_L – reinforcing feedback loops)

5.3.2. Role of, and processes in Situational Analysis

Situational Analysis allowed us to explore all these parameters. The outcome of Situational Analysis (see 5.3.3) is a *thick analysis* of the interrelations between the system structure (stock, flows, feedbacks loops) and behaviour (the performance of system overtime) through identifying the *positions* of human and non-human elements, and discourses (or issues) of the situation. These *positions* allow us to identify a higher-level explanation of the system complexity, which can be linked with the system's purpose. In turn, we can identify the best leverage points for sustainable system change; i.e., where to prioritise action for the greatest and most sustainable effect on the system of support for physical activity in older people in Staffordshire.

As noted in section 4.3, a social worlds map was produced (Appendix 3). It identified five social worlds that surround the situation of interest. In our case this has been defined as the **system of community-level supports for physical activity in Staffordshire**. The social worlds map not only illustrates the complexity of situation, but also the key social active players that contribute towards the overarching system goal (in this case, promoting health and physical activity in Staffordshire older people).

The five social worlds identified include the two local authorities, the voluntary sector, the health sector, and the private sector. As noted previously, social worlds that are similar are positioned adjacent to each other, and those with conflicting aims or have opposing relationships, are positioned opposite. The depth of intersections indicates the extent of their single or cooperative involvement with the situation. Specifically, there was no close alignment of the two local authorities, indicating scope to integrate services under a common long-term goal for the local older population (in Stoke-on-Trent and Staffordshire), while the relative opposition of healthcare and private sector indicate their relative contribution to the subject matter. The inclination of voluntary sector shows its need to collaborate but also its interdependence with all social worlds, as it works to address unmet needs across sectors. Groups or organisations that appeared important (from the data) regarding the success (or not) of achieving the system goal (i.e., increasing physical activity in older people), but that did not form any collective action toward it, are shown in the map without a surrounding circle (e.g., public transport, hospitals, community transport, mental health services). For example, the importance of public transportation was commonly noted in terms of inconsistency of routes, limited range, or cost. Community transportation, though important, appeared more in the context of travel to medical appointments and cannot cover the needs for physical activity of the local older population.

5.3.3. Positional maps

The positional maps presented here show the positions taken/not taken on main issues in the situation. Visually, two-dimensional axes (vertical/horizontal) form the spatial area of discourses where the emergent positions are displayed. This presents an anonymous, abstract proposal in which specific people, groups, and organisations are not named. There are no good/bad, positive/negative, expected/unexpected positions because groups and people can simultaneously hold contradictory positions.

Through this, Situational Analysis serves two major systematic goals. First, by presenting the range of views, assumptions, actions, and contradictions, Situational Analysis gives equal prominence to all positions (including those often not heard, silent and/or taken for granted). Second, it facilitates the abduction process (i.e., creative process to create new theories), which is critical for the implementation of system change.

The positions are presented that relate to the three overall objectives (section 3).

Positional maps for objective 1: To understand how COVID-19 has affected physical activity levels and related opportunities in older people

Three positional maps indicated the impact of COVID at individual, community level and the 'aftermath' of pandemic (Figures 4-6).

Figure 4 illustrates some key positions regarding individual level impact of COVID on activity levels in older people. There was evidence that physical activity levels had been greatly impacted, particularly in light of the greater risks of COVID for older people, and the other aspects of life that were affected. For example, combinations of personal experiences of being ill with COVID-19, in addition to caring for their partners/family members, whilst opportunities for usual activities were reduced (or stopped) because of lock downs, had profound impacts on their typical activities, including physical activity.

An opposing opinion was that COVID created opportunities for activity through active travel or more walking, but this was challenged as myth or 'rhetoric', not necessarily based on data or evidence.

I think it was, there was kind of rhetoric going on that people were being more physically active, so they were just spending more time at home, they were going out for walks, they would enjoy, you know, going cycling and enjoying the outdoors (Stakeholder 5)

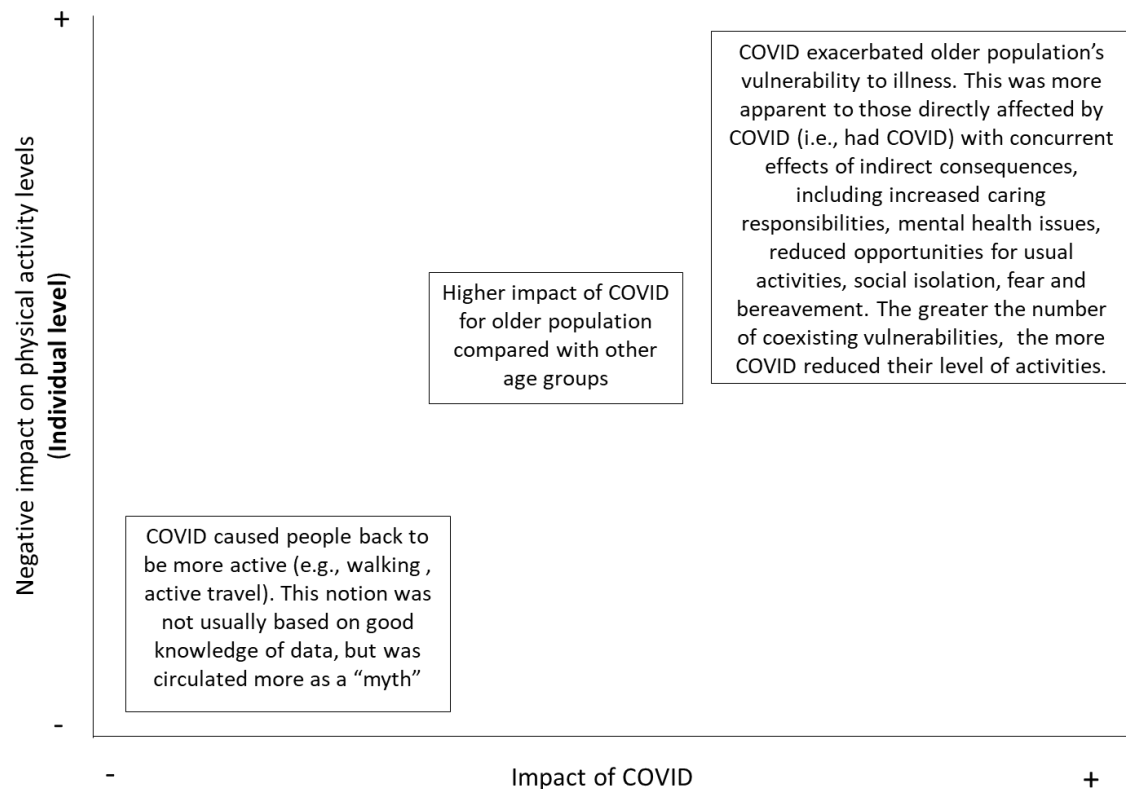


Figure 4. Positional map for impact of COVID-19 (individual level)

Figure 5 presents the same issue at the community level. Here, the data highlighted that local infrastructure for older people's physical activity had been severely disrupted through COVID. At the heart of much of this disruption was volunteering: groups and programmes for older people led by the VCS were heavily reliant on volunteers, who were disproportionately older people (also indicated in Figure 3). Therefore, some older people were negatively affected through losing their social and physical activity as a result of cessation of the opportunity to volunteer, while others lost access to programmes that relied on volunteers.

In terms of clubs and groups and things like say a lot of them disappeared, or really had to cut back on what they were able to provide, we've been able to support a lot of them, but there will still be ones that have gone under and like I said, particularly those more informal ones that are very volunteer led, have disappeared (Stakeholder 7)

There had been efforts to adapt to challenges of the COVID-19 situation, including trying to shift towards and upskilling around digital services, but the success had not necessarily been evaluated, and the risk of digital exclusion remains, especially among older adults.

there's also virtual options, there's options where you can do by yourself, or you can do it led. That's what we've tried to do is actually make it more accessible to them. And I think a lot of the older generation now they've been using Zoom a little bit more with family and friends. They've been more inclined to 'yeah, yeah, I'll do the virtual option because I'm at home, I'm in my safe space' (Stakeholder 10)

...we're very aware of digital poverty... but even if the people you're targeting aren't online, more than likely people who know them will be, or it will make it easier (Stakeholder 7)

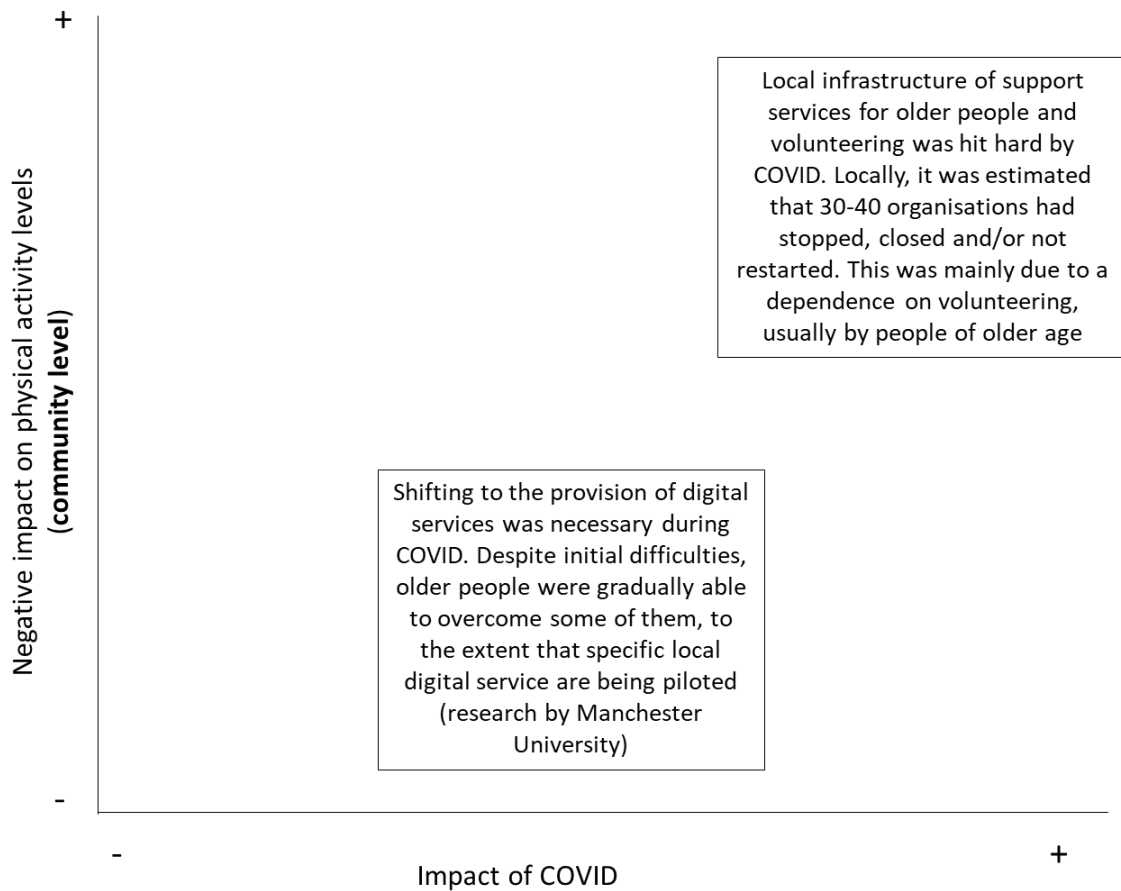


Figure 5. Positional map for impact of COVID-19 (community level)

Figure 6 shows positions related to the situation for physical activity in older people in a period after the COVID-19 emergency response and lockdown (or 'aftermath'), when much of society had returned to pre-pandemic functioning, or a modified 'new normal'.

There was evidence of a lasting negative impact on physical activity in older people through them not *going out*. COVID-19 appeared to have set a new normal of staying in, avoiding crowds, and general aversion to the perceived risks of interacting with others. This reduction in social contact has negative impacts, in terms of social anxiety, mental health problems and low confidence, and the resulting social isolation has further negative consequences. This failure to *get out* remains the prominent issue for many older people and a key impediment to physical activity.

We've seen people not return back to this (physical activity) project since COVID. Because during lockdown, unfortunately, people got very isolated, they got very anxious, and they also got very unwell. Me and my colleagues tried to do... well-being calls, phone calls. But I'd say it took a good six to eight months post-lockdown to get most of our participants back... some haven't returned because of that anxiety... Going out the house can still be quite daunting (Stakeholder 23)

There was evidence that some had returned to physical activity (or even increased it), but this was a minority view. Long-COVID was also a barrier, with those affected being unable to be physically activity as a result of their health problems.

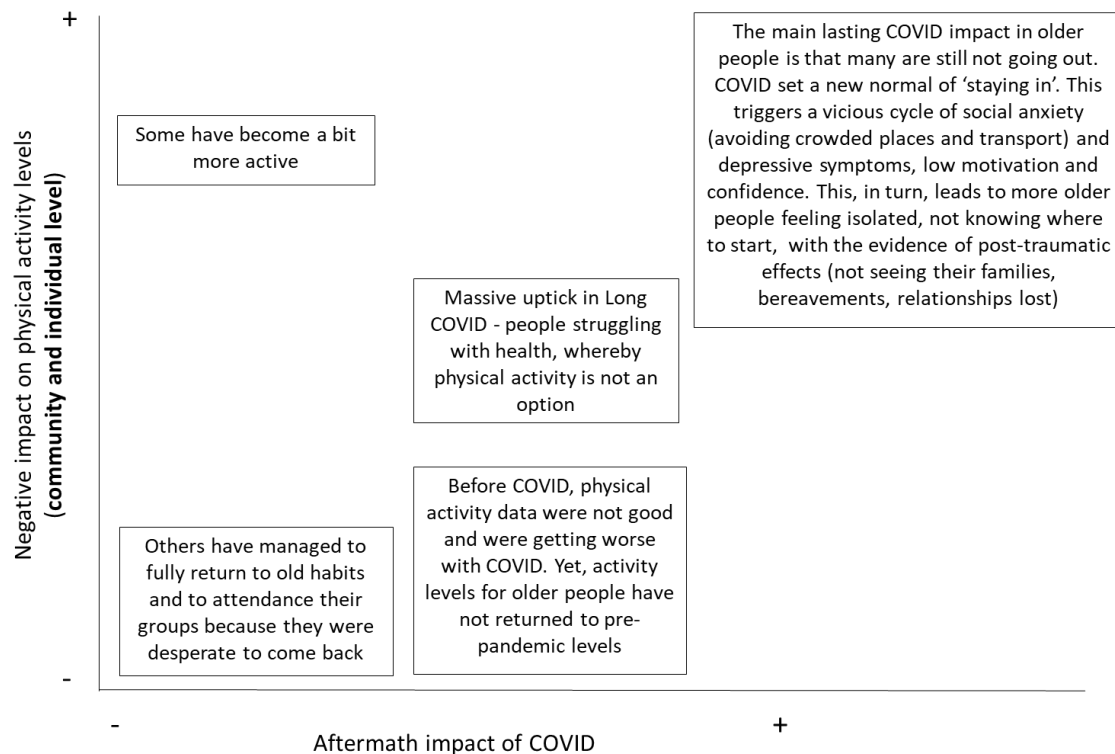


Figure 6. Positional map for **aftermath** of COVID-19 (community and individual levels)

Positional maps for objective 2: Explore older people's experiences, needs, priorities and solutions to physical activity participation.

Three positional maps show the grounded evidence regarding barriers and facilitators to physical activity in older people from the individual, organisational and system perspectives (Figures 7-9).

Individual level facilitators for physical activity in older people were primarily social – social ties, social belonging and the desire for company through physical activity, in addition to the benefits around increasing stamina and fitness (Figure 7).

... we have to take it out of context for older people, it's the socialisation... that's what works. That's what keeps them going [to physical activity groups] (Stakeholder 22)

... the main reason I got to exercise classes, because I actually like to meet people. I know I can do a lot of those exercises on my own. But for me, there's that added belief of being in a group (Stakeholder 6)

In opposition were the barriers, many of which were practical, relating the cost of physical activity or barriers to access, such as transport or lack of time (especially in those of working age) (Figure 7).

Personal barriers included existing health and mobility issues that prevented engagement. There was also evidence of misplaced fears surrounding the risks of physical activity for those with health problems, and others who were deterred through poorly communicated health messages (i.e., misunderstanding of physical activity requirements led them to misunderstand personal levels of physical activity).

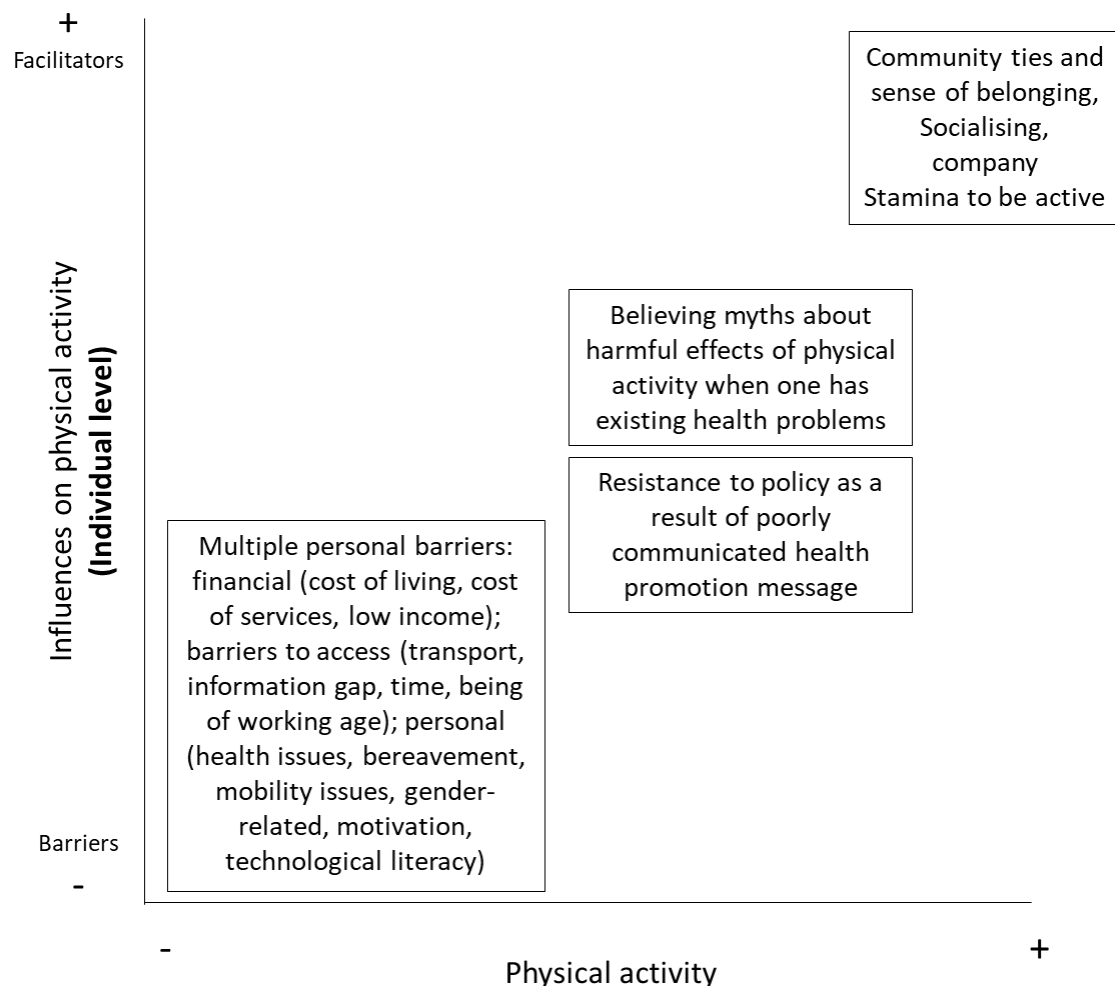


Figure 7. Positional map for barriers and facilitators of physical activity (individual level)

Organisational facilitators to physical activity included maximising the offer from VCS (Figure 8), although this was opposed by the limitation that many such programmes rely on volunteers, a valuable human resource that had not recovered from the COVID-19 disruption. Other barriers included the cost of services, opportunities that were not accommodating to older people (i.e., opportunities undermined by unconscious ageism), and lack of coordination between services. Such silo working is a common system weakness that limits the ability to work towards a common goal. Finally, it is suggested that existing incentives to encourage older people to be active (e.g., subsidise gym membership, older people-only sessions) should be retained, even if uptake had not recovered after COVID, as their removal would further limit future opportunities for those trying to change their behaviour.

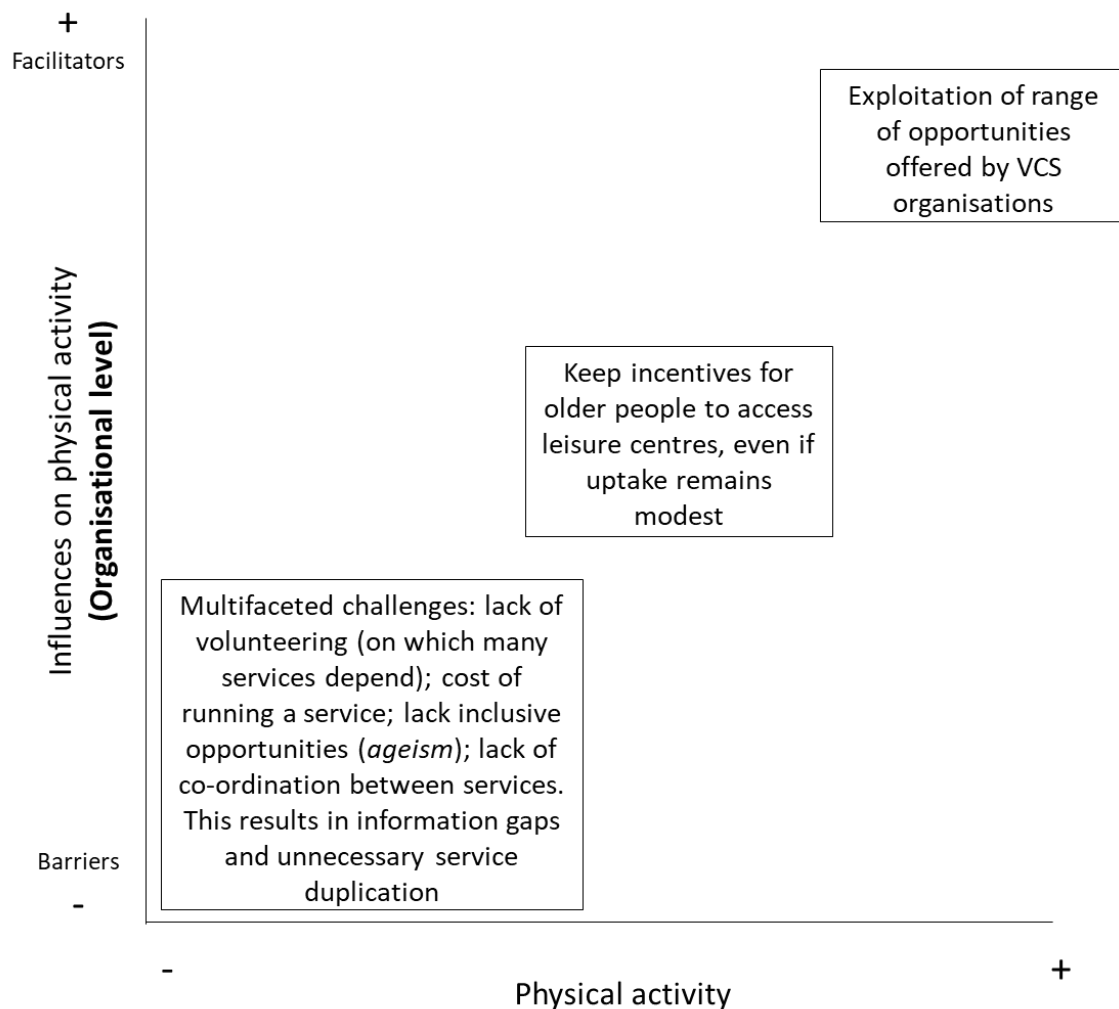


Figure 8. Positional map for barriers and facilitators of physical activity (organisational level)

System-level facilitators of physical activity in older people covered maximising the natural assets (green spaces, parks) to encourage walking, given the abundance of natural environments in Staffordshire (Figure 9). However, there was recognition of the need to do so in a more consistent and joined up manner (i.e., the physical resources are available, but there is inefficiency and inconsistency in the related physical activity offer).

...one of the advantages we've got in Staffordshire is actually the local environment... on most people's doorsteps, there is really good sort of access to open space (Stakeholder 6)

I believe there is work going on in [location]... to improve things around active travel and use of green spaces. There's not as much as I would like to see. But there are there are things that happen again. It tends to be more sporadic and ad hoc, it's not somethings that's got a lot of cohesion behind it (Stakeholder 7)

The role of the VCS was, again, clear. As was apparent through the above lost physical activity through reduced volunteering, the VCS is a major source of physical activity opportunities that 'fill the gaps' in the system (Stakeholder 11).

... they [voluntary sector] are a major provider of opportunity to, to be active and take part in all sorts of things, sport leisure, for sure. I think sports clubs, probably a huge part of the voluntary sector in Staffordshire, and Stoke, but other stuff as well. Just things which get people out (Stakeholder 9).

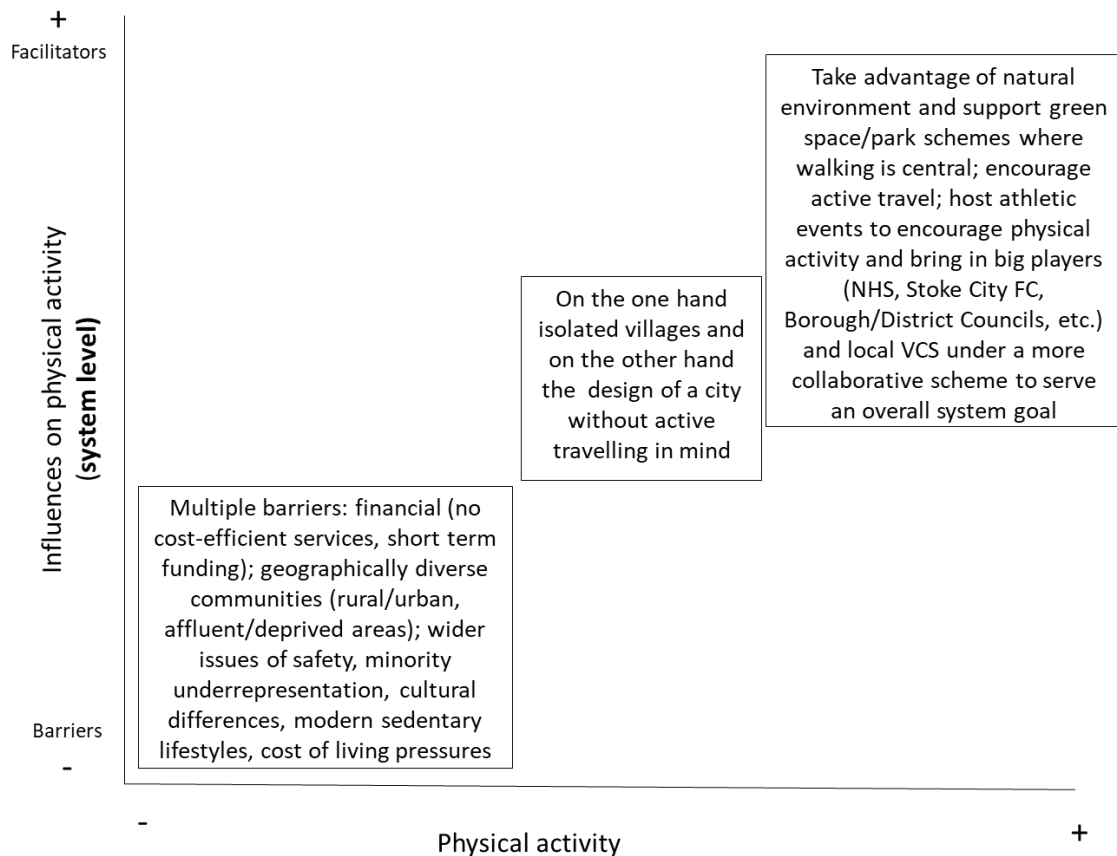


Figure 9. Positional map for barriers and facilitators of physical activity (system level)

Barriers, again, were often practical. They related to the economic climate and funding for service provision, and the challenges of meeting the needs of diverse communities. The abundance of natural environments brings with it challenges of meeting the needs of rural communities, whose access to services and public transport links are more limited than those in urban areas. The urban areas have challenges around active travel, whereas rural communities are isolated from other opportunities.

The wider economic climate is limiting physical activity, through restraints on individuals' abilities to pay for physical activity:

... it's cost of living. It often costs money to do some of these things at least. It's expensive to go for a swim. It's expensive to play sport really, depending on sort of level of income. And those incomes have been really hammered (Stakeholder 9)

And through financial pressures on service providers:

... most of this does come down to [funding] as well. It's like funding resources. You know, it is a big issue. You'd love to be running more programmes, but getting the funding to pay for, you know, venues and delivery staff is difficult (Stakeholder 15)

This indicates a need to look upstream to commissioning of services to pursue more reliable, long-term, collaborative commissioning. Short-term, project-specific service commissioning creates uncertainty and pressure that ultimately limits the service offer.

Positional maps for objective 3. Explore perceptions about the role and acceptability of social prescribing and other interventions as a means of increasing physical activity

Several positions were evident in relation to social prescribing (Figure 10). There was some scepticism regarding effectiveness.

I'm not quite sure whether that in the long term, they really work... There's quite a lot of research sort of coming out to say that actually, they haven't really made that much difference (Stakeholder 22)

The majority opinion was of a growing role for social prescribing, which required the social prescriber to be broader than exercise referral; that helped to connect older people with their communities.

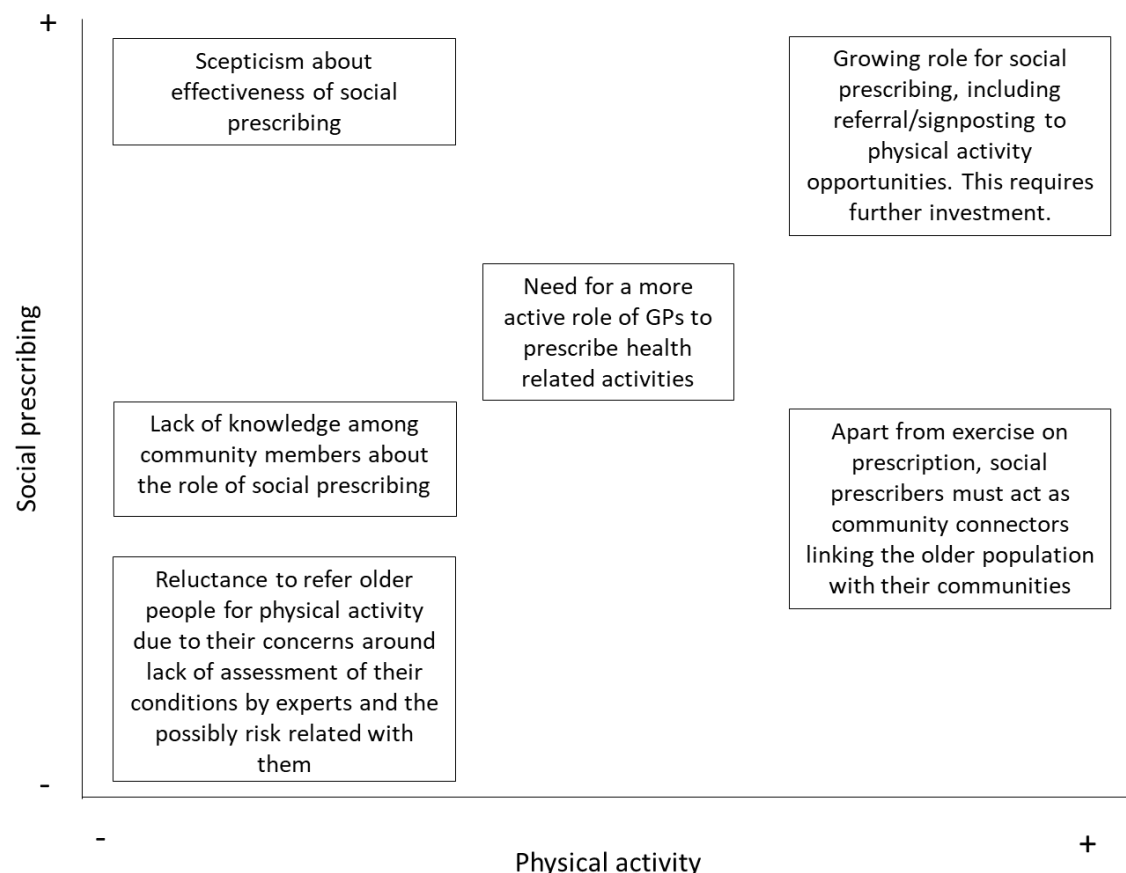


Figure 10. Positional map for social prescribing and physical activity

There was a position that this greater role required investment and a more active role for GPs. Other barriers that limit implementation of social prescribing and its potential for physical activity promotion were lack of knowledge among community members. Perhaps more important, was the apparent reluctance among referrers to send older people for physical activity programmes that was not familiar to them. This speaks to two issues: the medicalisation of physical activity and risk aversion

regarding medico-legal responsibilities; unconscious ageism. The result is marginalisation of older people from potentially beneficial physical activity opportunities.

They're really nervous about saying, 'well go along to the village hall and do the Pilates class', because they're worried that they go along, and then they get a further injury or something, and they get blamed for it...

The biggest... barrier really... reluctance to signpost and refer and support people into [programme] that they haven't risk assessed, isn't regulated, and that they're nervous of
(Stakeholder 8)

6. Implications and recommendations

Implications and recommendations are summarised and presented in the form of an overall positional map of the current position and overall system goals for physical activity in older people in Staffordshire (Figure 11).

Based on data from community members and stakeholders representing local authority, VCS and other, overall goals for the local system should be to:

- iii) To eliminate any possible barrier to access resulting from intentional/unintentional forms of ageism. This includes addressing risk perceptions that serve to exclude older people from certain physical activity opportunities (including social prescribing options)
- iv) To set clear long-term goals that all local key partners sign up to, supporting the idea that 'doing something is better than doing nothing'.

We have identified four limiting factors in the system that offer leverage points to help systems change:

- v) Getting old people out (breaking the post-COVID norm)
- vi) Reviving volunteering by any means necessary, which links with the above need to encourage people to re-engage with previous activities (including volunteering)
- vii) Promote/campaign for physical activity to older people that is more specific to them, and promote basic physical activities of daily life that can easily be adopted, regardless of external groups, facility-based or organised physical activity opportunities (e.g., walking and chair-based exercise)
- viii) Convey the physical activity message to 'do something' is more tangible for this group (e.g., playing with children, gardening, walk with friends, etc.).

In line with holistic, long-term, process-focused goals towards systems change, there is need for truly collaborative working between local authorities, key stakeholders and local VCS to act jointly towards physical activity older population. A move away from short-term solutions could require a revised approach to commissioning (e.g., long-term, flexible contracts for providers to work collaboratively towards a common goals).

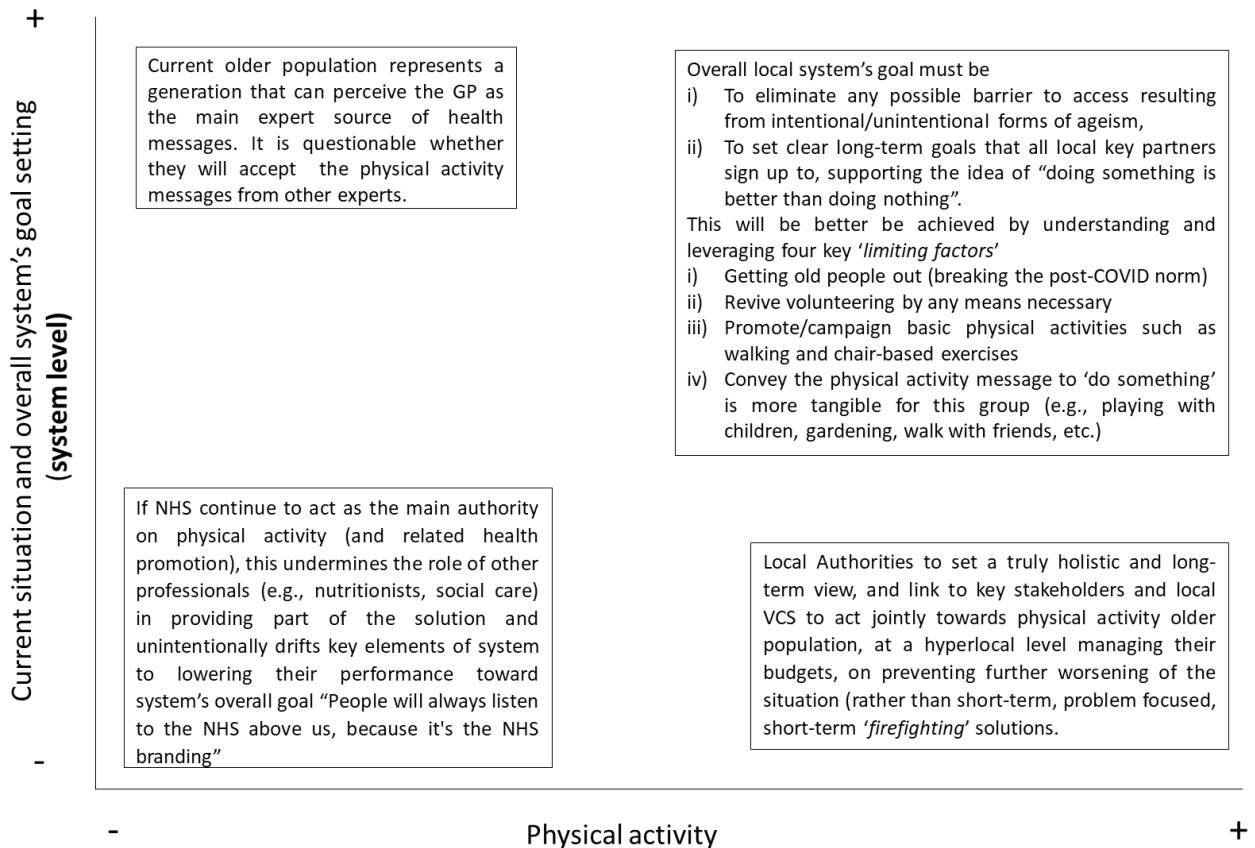


Figure 11. Positional map of the current situation and overall system goal setting (system level)

It's about trying to increase the know-how and the cross collaboration between different organisations to better the community

(Stakeholder 23)

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Appendices

Appendix 1. Common themes from report of community workshops by VAST

How did you stay active before / during the COVID Pandemic? and How are you keeping active as we return to normality?

People gave examples of part time work, volunteering, day trips, classes, and clubs they used to take part in. These have returned in some instances, but not all and not all to the same extent. Some activities shut down and haven't returned as their momentum was lost. Those that have returned are running with less participation.

People mentioned walking in their local area more now as they got more familiar with routes during the pandemic. Also some groups were back in action and people were able to spend time with friends and family again now.

Have you / are you a member of any clubs / groups? How does this help you stay active?

Many of the people were back to a level of activity. The participants of the sessions were there due to their participation in other activities and so could be considered as being motivated. Many different clubs, activities and sessions were specifically mentioned. The participants often spoke about feeling the need to stay active and not stop, doing what they can as much as possible and getting out of the house, even if that was only into their own garden.

People often mentioned the use of technology to stay connected as well as the physical connection of being in the same locality as others and being able to see each other around the local area.

What stops you being more active?

Responses to this question highlighted the “state of the streets” and perceptions of unsafe streets, with people saying they are too scared to go out or have been warned by family and friends not to go out. Also mentioned was a lack of visible policing.

Also cited was a perceived lack of shops and facilities, meaning there were less reasons and less motivation to get into towns or into the city centre.

Many mentioned a lack of transport and a lack of easy access to buses and poor routes or inaccessible bus stops and poor timetables as a barrier. Also mentioned were changes in eligibility for the bus pass and lack of longer routes for days out now.

Other barriers frequently mentioned across the workshops was a lack of money and poor finances, lack of time due to other commitments at home such as caring or being busy in other ways, physical and mental health issues and feeling a general loss of confidence and increased anxiety after COVID and COVID restrictions.

Do you have any ideas of what's needed to help you be more active?

Community featured prominently in the responses in terms of involvement, keeping activities local (and so walkable) as well as encouraging people to take part in things that are going on. Using local assets such as parks, halls, and churches so that people can easily see what is going on and feel like they can be involved and welcomed.

A key part of this was using the knowledge, interests, and skills of local people. Also marketing and advertising what is going on, asking people what they want to see and building a strong network and connecting groups together.

Appendix 2. Common themes from report of community workshops by Support Staffordshire

A number of themes were identified from the sessions. Most of the themes were represented in both locations (Lichfield and Stafford) so we have combined our results throughout this report. Where a topic was unique or a particular issue for the one of the areas this has been identified.

Impact of Covid-19

Covid-19 had a very real impact on this age group. It has affected their mental and physical wellbeing. The session at Wade Street Church, Lichfield was particularly emotional when the pandemic was discussed.

- Most participants in these groups followed the guidance during lockdown. Many appreciated the feeling that the country was “all in this together”.
- Some people reported that they did more physical activity during lockdown as they took advantage of a daily walk. Some have continued to do this. Most have not.
- Those who were active prior to the pandemic felt that they were not doing as much exercise as before the pandemic.
- Several people reported reduced fitness levels since the pandemic and an increase in the pain that they experience.
- Social isolation had a huge impact on this age group’s mental health. One participant in Lichfield saying she had lost all her friendships and had contemplated taking her own life. Some members of the group at Wade Street have felt worse since activities have opened up due to the risks associated with socialisation and understanding the expectations of others.
- One participant in Lichfield reported that the social distancing meant that she could no longer hold her friend’s arm when they went walking and that had made her decide to purchase mobility equipment (walking frame) which she had resisted before due to stigma. This activity has increased her independence.
- There was a real anxiety about returning to group activities. People reported needing encouragement to return to their previous activities.
- Those with caring responsibilities described specific challenges during pandemic such as lacking support, exhaustion, and no time for themselves, but also told how this gave focus and direction during periods of lockdown.

Healthy Lifestyles and Keeping Active

It is important to note that members of the groups that we attended were already involved in their communities and therefore keeping active at varying levels. We noted during all the sessions that this population is more concerned about mental decline than physical decline.

- As stated, the groups were more concerned about mental decline than physical decline. Dementia is a particular worry. It was hard for members to separate between cognitive and physical activities, for example one participant in Stafford reported that he goes on a 4 hour group walk every week which will benefit his health, but for him the social aspects of the walk were the draw.
- Some members took on online fitness sessions during pandemic, but most were concerned that they might find technology too difficult to use, for example one lady felt uncomfortable returning to face-to-face activity sessions as didn’t feel her fitness level was as it was beforehand, and weight felt like an issue; however, she has carried on with online classes.
- Majority of the groups felt that they now have health issues which hinders returning to normal activities. One gentleman said he was doing the same amount of activity just at a slower speed.

- There is no one size fits all to activities that support healthy ageing. In another example, two group members found that the support of a women's only gym was helpful, whereas another person in the group found the intensity of support offered at this gym was intimidating.
- Variety was felt to be important. Several participants in Stafford remarked that they liked having several different activities to join in. This helped to keep their interest up.

Access to services

- There has been a reduction in support in the community. A number of groups that participants previously attended have closed following the pandemic or participants have not returned so groups are smaller than they were.
- Several members of the groups reported that they had lost previous volunteer placements with charities as they were no longer running or had changed how they operate.
- Costs of equipment can be prohibitive. One participant described how the cost of the clothing to exercise was a barrier.
- One participant attended the archery club in Lichfield which is well attended and popular, but she was not comfortable going in the evenings as a lone woman due to the isolated location of the club.
- Riverside leisure centre in Stafford does not offer discounts for older people.
- The leisure centre in Lichfield is not on a bus route and is up a hill to get there.
- Groups of young people on public transport could be intimidating for this population
- Relying on friends for transport was not felt to be sustainable. People felt uncomfortable asking friends and family for support to activities.
- Trust in the health service has been eroded by the pandemic. Participants reported that it was harder to access their GP than before. This may be in part a reluctance to seek support due to concerns, following the pandemic, for example being a burden to stretched health services or perceived infection risk of going to a health service. Some services are restricting face to face consultations and as a result participants now feel it is too difficult to access their GP which may limit access to services that support healthy ageing such as social prescribing
- Participants were not aware of the social prescribing service and how that it could benefit them.

Confidence

- The population's confidence has been dented as a result of the pandemic. Extended periods of social isolation have increased worries and concerns about getting involved in activities. One of the participants in Lichfield described her struggle to return to her social activities and the support she needed from friends to get back to activities.
- One of the participants was bereaved during the pandemic as a result of Covid-19. There was limited support for her during this time.
- Pets were frequently cited as support, companionship, and encouragement to be physically active for this age group.
- People were concerned about making their physical health worse by not having appropriate supervision when undertaking physical activities.

Low Knowledge of Physical Activity Guidance

The UK Chief Medical Officers' Guidelines recommend each week adults do at least 150 minutes moderate intensity activity

- Every group's awareness of the recommended guidance around physical activity was low. Participants questioned the guidance as they felt some activities that they participate in for their health, such as yoga would not count as it doesn't raise their heart rate.

- Participants felt that guidance based on tasks would be easier to understand.
- One participant (aged over 85) described how she felt her heart rate increased changing her bedding, but felt that this wouldn't count.

Opportunities to support healthy ageing from participants

- Majority felt that if they could get free sports / gym membership it would help/encourage them to do more.
- 1 person felt that there should be classes targeted towards her age group so that she wouldn't feel uncomfortable going to a class
- Free fitness tests (or reduced price)
- Many were interested in going to Social Prescriber via doctors to help with activity.
- Any support offered needs to be hyper-local. Offering an activity in central Stafford may not be accessible to someone in Rising Brook for example. Using local community facilities was thought to be important.
- Support from a physiotherapist or specialist personal trainer / exercise professional would ease concerns about joining an activity.
- Consider ways to promote physical activity guidance in ways that places emphasis on activities and social opportunities and cognitive benefits of exercise.
- Support to access physical activities needs to be factored in as it is not always possible to rely on friends and family.

Appendix 3. Social worlds map from Situational Analysis

