the leisure review

an independent view for the leisure industry

Physical activity: *The Leisure Review* round table

With physical activity prominent in so many discussions relating to the pressures on the health service and the sport and leisure sector, *The Leisure Review* brought together a number of senior practitioners representative of both sides of the health-leisure fence to discuss the current situation and what may become of physical activity promotion in the future.

When circumstances brought a number of thoughtfully opinionated leisure professionals to the city of Oxford at the same time *The Leisure Review* made a virtue of necessity and invited them to sit round the same table to discuss physical activity, its impact and its promotion and the extent to which it offers solutions, challenges and options for both health and leisure. Joining us at Zappi's Café, a coffee shop that is located within the Bikezone bike shop and bears the name of former professional cyclist and Oxford celebrity Flavio Zappi, were: **Ian Brooke**, head of leisure services with Oxford City Council; **Carl Bennett**, a senior health improvement specialist in the Directorate of Public Health, NHS Stoke on Trent, and a regular contributor to *The Leisure Review*; **Ian Mitchell**, business development director with MyTime Active, a leisure contractor specialising in health projects; and **Mick Owen**, managing editor of *The Leisure Review,* a highly experienced sports coach and director of WellFit Health & Wellbeing CIC. **Jonathan Ives**, editor of *The Leisure Review,* was on hand to hold the tape recorder and fetch the drinks.

"In terms of the debate between leisure and health it is interesting that health and leisure don't talk to each other at all. There's very little health in leisure and although leisure operators try to do health they don't really deal with health fully in terms of commissioning."

Jonathan Ives (JI): Ian, as contractor with a leisure background and working with clients in health, how do you see physical activity as common ground between leisure and health?

Ian Mitchell (IM): In terms of the debate between leisure and health it is interesting that health and leisure don't talk to each other at all. There's very little health in leisure and although leisure operators try to do health they don't really deal with health fully in terms of commissioning. About four years ago we chose to say, 'We know the market is going to be in health so let's set up a health division to do that.'

JI: But leisure has always traditionally told health that it has a major role to play in health promotion.

Mick Owen (MO): Not always. Historically I believe the interest of leisure in health came soon after Sue Campbell managed to get all that money from education. Her mission was to get education money to pay for leisure. She said as much in Nottingham [the National Sports Development Seminar] and also said that there were other agendas with funding. So we all scuttled off – I was in sports development at the time – and chased education money, health and crime money. It worked in education and now it is beginning to happen in health but not in the other sectors.

Carl Bennett (CB): Where did the industry come from? It started with wash houses in the Victorian age. That's where health started in leisure, the sanitation phase of public health. It made a huge

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difference to the health of the population that didn't have a bath at home. We're only just starting to revisit that.

MO: We haven't moved miles away from that. Leisure had become about lifestyle. I was surprised by the £3.70 cost of an exercise class in my local leisure centre but was told it was the cheapest in the area.

CB: From my perspective within public health that type of pricing structure prices out my target groups, those that are affected by inequality.

MO: I need to declare an interest. Our company, a community interest company, delivers local physical activity and we've been talking to Carl about how we can deliver it for people who cannot afford to pay a fiver for an exercise class. It's about people who get out of the house to get active to save their lives.

Ian Brooke (IB): The story of the public ethos and the shift of the industry is a fascinating one. I worked in private leisure for quite a while, which was a million miles from that [public ethos] but that ethos is still there. I think the price issue is fascinating. For me personally, the £3.70 wouldn't be an issue; I can afford it and it's not a barrier. Compare that with the cost of a cup of coffee. What a lot of operators try to do is balance that, so the people who can afford it are charged that amount and then they try to remove the barrier for the people who can't afford it. The Oxford example is that we offer free swimming – and we continued that, although there's a lot of debate about the value free swimming – but we invested additional money into targeted free swimming. We've also got a good concession scheme. That's about trying to get the balance but a key point is how you communicate that and join it up; how do get people to value that offer and come along to something that might be part of a real lifestyle change. That's the huge challenge we've got. I personally think the only way to do that is through a joined-up message, working with people like yourselves in health locally and nationally to knit that together. I sit down with GPs in the city and I'm constantly trying to make the case that, as you've pointed out, was made 100 years ago but when you're having to compare it with short-term intervention it is quite a challenge.

MO: Carl, do you go back into health as an advocate of physical activity?

CB: Yes, that's part of the role. I was at a UK Active conference a couple of weeks ago and Dr William Bird[1] was saying that he surveyed 100 GPs in London and only seven of them knew what the current message was for physical activity. So there's a lot of work there to raise the potential value of using GPs and others as the vehicle to communicate some of those messages. And they're not the most effective individuals. Somehow you've got to take it out of there, allowing them to focus on their clinical interventions, otherwise physical activity becomes a clinical offer; and it's not a clinical offer. You can't measure the output of physical activity intervention in the same way as a pill. You don't want to 'clinicalise' this because it becomes a barrier.

IM: If you make it clinical people won't want it.

CB: The populations I engage with are already the ones that don't go to the GP. And males over 45 just don't go to the GP. We need to look at new ways to engage these people.

IM: But in terms of the leisure operator, isn't it about measuring the value of what they do? They are generally poor at measuring data.

CB: They are good at collecting data but poor in understanding what it means.

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IM: Going back to your point, Ian, about funding and opportunities, it's not sustainable if it comes and goes. It is only in projects that are sustained through time that you can show true value. You need to get leisure operators to show value and then you can sustain a level of funding. Pricing is always going to be a barrier.

CB: Pricing is a barrier in terms of the various contracts that providers have. Many providers are set up to achieve a deficit and as long as they achieve it they don't have to do anything else. It's only the good, positive providers that will do something else for added value to the contract.

IM: Are there many of those?

CB: I'd say that there aren't.

IM: I'd agree and it's getting harder to in the leisure industry, even in the local authority-run leisure centres. With such tight margins and ageing stock, why would they focus on health? They are going to focus on the gym and swimming lessons. They could do that at the same time of measuring and assessing value but they are never going to put their prices down because they are going to lose money; and, again, the margins are so tight.

IB: Unless the local authority says, 'Actually we are happy to subsidise this because it's important to us.'

IM: But is that sustainable, given the pressures that local authorities are under to reduce your bottom line?

IB: I think the only way it can be is in understanding the value of leisure in its broadest sense and understanding what it does to our wider outcomes. Most local authorities are bothered about communities, how they work. The context of traditional leisure is now so changed, so different. Local authorities are different, between the John Lewis authority and the EasyJet authority, so that conversation is very challenging. I can sit down with someone doing a similar job to me in another authority but the roles will be fundamentally different. Here we're in a fortunate position that we've done a lot of work on making the case. We've used the DCMS research. We've used the education research in relation to what Sport England have put out – if you engage in physical activity your numeracy scores are higher – and local health profiles, where we know that the local cost of inactivity in Oxford is £3 million a year. You can always unpick those things round the edges but it helps to make the case. And if you can make the case with key people you can influence the contract. When we sat down with Fusion [Oxford City's leisure trust], we said that the two things we want you to do more of this year are health and wellbeing, and carbon. These are things we're passionate about but the only reason I'm able to have that conversation is because we put a lot of work into making the case and pulling together the evidence base that is there. Without working closely with local colleagues that is far more difficult. But politics changes and key people change.

IM: There are very few heads of leisure or people in your position around the UK. Someone as passionate as yourself in that position can see that change and you have time to spend with Fusion. Across the UK there is probably not much of that but it needs that engagement to make a difference. It is still going to be tough to get funding for health interventions in leisure centres. I don't see much of it. Leisure operators are not focusing on health so much because physical activity is only one part of it. If they can focus on some other parts of that puzzle they would start seeing benefits.

IB: That's a valid point but then you start looking at a local health offer.

You've got leisure centres where there is a barrier, so you start coming back to parks. What is the price barrier of a park?

IM: We use parks a lot in our health interventions, for healthy walk, cycle rides…

CB: It's interesting. Organisations such as the boot camp people have all identified the value of outdoor space and suddenly someone has come up with the idea of a licence fee to use outdoor space. It's happening in London and it's ridiculous. They are increasing the barriers still further.

MO: But isn't it robbing the rich to pay for the poor? It's charging, say, British Military Fitness for a facility they want to use that belongs to the community. They are using it for free but if the council can levy a fee then I think it's fair because the boot camp companies are making money on it and the people that turn up for the sessions can afford it.

CB: But you wouldn't like to think that your WellFit group is going to be charged for going round their park.

MO: Yes but by the same token if I were making money out of it I wouldn't mind so much. I'd make the case to the council. We do the sitting down fitness thing in a pub because the space is big enough, it's on the estate and the landlord lets us use it for nothing. If he said that he was going to have to charge us I'd have to pay. And I'd recognise that this is part of the process. As soon as anyone is making any money it's a commercial operation.

CB: At the same time, when we start looking at the key assets of the community we find people beginning to attach a financial value to them rather than a social value. If they charge anyone that raises the prospect of having to charge everyone, including the community we need to be working with

MO: But we were talking earlier about health inequalities and segmenting the market. You can segment the market. There is Well-Fit's version of walking round the park but if a boot camp company wants to run a session for 30 people who can afford to pay a premium price I don't see why the local authority can't charge that company. You can have free swimming for some and not for others.

CB: And that comes down to understanding the marketplace and understanding what those individuals require. Many leisure providers haven't caught up with that yet. They are too busy segmenting the market that is using the facilities.

IB: Non-user data is not as strong as you would want it.

CB: That's a huge miss. You can only get so much resource out of the 20% of the population that has the choice and the income to spend and invest. The others are where the hard work has to be done, to bring those people along rather than expecting them to come.

IB: I think that's a shift in roles for many local authorities, to become an enabler and within the centres they own manage that offer, charging people who can afford it a bit more to enable people who can't to get in a bit more. This is exactly the same principle I think with a licence for people like British Military Fitness: you charge some people a bit more but as long as that money is going back into something like a trim trail around the park you get that balance. Therefore, as a local authority, you're asking whether you can do more to coordinate a local offer. Can we do more with our centres and our community centres? Can we talk to the private sector? Can we be a bit more creative than we have been before?

CB: It's going to take a very strong local authority to turn round and say, 'We should be helping our private sector colleagues engage the people that they are best at engaging so that we can focus on the people that we need to focus on.' That would allow a progressional pathway so you could have starter activities in parks, then go into a community centre, then into a leisure centre and then, if it becomes part of your life and you can afford it, you can go into the private sector.

MO: But that is social engineering. In the case of WellFit, you start on the local estate, which is where the people on that estate want to go, which is why we go there. Are we then to say to these people who have lived on this estate for generations that if they want to get fitter they are going to have to become part of the social class that goes to the DC Leisure facility?

CB: No, no. You need to be putting in, for want of a better term, a bus stop so that an individual can get off at any point and stay there. To enable that person to progress they need to be directed to more formal support if that's what they want. At this moment in time people are just being directed into a formal environment and they don't even have a choice.

MO: I must admit that I've got a thing about Lycra fascists. You can follow lots of people on Twitter who will tell you how they've smashed this or that bike ride. Well, no, that's not for me and I'm not going to do that. You're in danger of sounding a bit like the Fitness Industry Association…

CB: No, definitely not! It is all about a choice mechanism to enable people to make an informed choice because what we have at the moment is an awfully high percentage of the population that have already made a choice: 'It's not for me.'

MO: But there are an awful lot of people who spend an awful lot of time saying: 'It's not for you.' In 1983 I was interviewed for a facility manager's position and I described the centre as 'a middle-class mausoleum'. The guy interviewing me said, 'Well done, you've got the job. Now change it.' We tried very hard to change it but now that centre has gone back to being a middle-class enclave. In leisure we now say again: 'It's not for you.'

IM: If you say 'leisure centre' to a lot of people in the community they think 'Lycra and gym' and 'I do not want to go there'. It's a massive barrier and getting people to the door is the hardest thing. Once you get people into a leisure centre you will be able to keep them. Part of the issue is getting them into activity and enjoying it, and then try to get them to try a leisure centre.

CB: But that's the only option that a lot of people have. We have lost some of that community development that we used to have, when it was about participation in the community to maximise the use of the big built facilities but we just don't have that reach now. There are some elements returning but we're still driven by the big contracts and the big facilities. Some of these contracts run for 15 years.

MO: So if that's the case, and we're agreed that in too many cases that is the case, why do people in your position still insist on commissioning GP referral schemes? And perhaps the more important questions will come in April next year when public health moves into local authorities. Are we going to see the local authority saying, 'This contractor is running our leisure centre for us. We'll give them the job'?

IM: The local authority won't be able to deliver generic health interventions on their sites; they are not skilled enough and they haven't got the expertise, the knowledge or the experience to do it.

MO: They will tell you they have.

IM: Of course they will. We've been doing the commissioning trail for about three years now since we've set up [a health division] but there are no leisure operators in competition with us. No other leisure operator is doing what we are doing and I'm surprised by that. But [leisure contractors] do need to get those experienced people in to make a difference. They have the facilities, the centres, the areas, the communities and the money but they are not getting into the health commissioning world; and I'm surprised that they are not.

IB: We had one of our health workshops with lots of different local providers and my leisure colleagues could paint that picture of all the good stuff they are doing. It seems as though we are almost there but your assessment of the gap between where we are and where we need to be is apt. The huge challenge we have is that there are lots of things going on and I think most places have a pretty decent offer but it's that choice aspect – how do people know what the offer is and what the choice is? I think you need the standards of leisure facilities to be very high so that if people want to pay a bit more for whatever reason they can do but I don't think we should be offering lower quality than the private sector. I think the aspiration for public leisure has to be high-quality with excellent customer service but inclusive. And if that's not the aspiration for public leisure then something is going wrong.

MO: But shiny chrome is putting people off. The operator of the local authority-owned leisure centre has turned that facility into a shiny, chrome, six-quid-to-get-in-the-door facility. I think it is wrong that local authorities are allowing that to happen with a community facility and if we want to reach people with little physical activity sophistication and who are anti-Lycra why don't we have not quite so shiny centres? There's a place in Derbyshire where they have opened up a shop as a health facility. It's not called a gym but it is really: a place to go and exercise with a particular emphasis on being sociable.

IB: But isn't what you're describing a budget, low-cost opportunity to get into leisure? Whether it's a private budget gym, a local authority low-cost gym or a local authority gym with concessions, if you get that offer right I don't think that goes against having high-quality leisure facilities. Clearly leisure operators deliver a contract so what we do is have inclusive targets for areas of deprivation, targets for health, targets for working with schools and, of course, that whole schools offer is a huge issue. The local authority has a huge role in setting up that contract and setting it up in the right way. If it's set up in the wrong way, turning that round is a massive job.

CB: And a costly job as well.

IM: But a lot of contracts are going through KPI [key performance indicators] and PayMech so the operator's core funding payment is only given if they achieve certain KPIs. A lot of them are health-oriented now so that drives leisure operators. It's not the best way but it does push them.

IB: It is a way, though.

IM: Oh yes. But for me the only way leisure operators should be doing it is by using their staff to get out of their centres and into their communities to bring people back in. This is done well by some operators, who can then pull people back into the centres once people are comfortable. But unless it's in the contract, a lot of leisure operators don't see that as a sales tool. Taking your point, Mick, about who is going to pay for leisure centres if you don't charge those prices, I think we'll see leisure centres closing. All the subsidies in local

authorities are being stripped, the stock is getting worse so the operators are having to hike their prices to support lower subsidies from the authority and service older buildings. There has to be a pinch point and it's a question of where that pinch point is. I think they need to be contracted into health interventions, both in and out of centres, and then you'll see some difference. But how? A lot of contracts are for 15 years and you can't change them.

MO: Is a new breed of health commissioners going to be capable of doing that?

CB: Let's not forget why public health is going back to local authorities. The whole point of going back is to ensure that a local authority becomes a public health organisation. Unless you're lucky enough to work up north, the historical heartland of public health, the public health responsibilities, or perhaps the public health ethos, have been lost. One on the purposes of bring public health back into that environment is to make sure that my town planning officer also considers public health, that my school dinner services consider public health. I see my role, and our role in the future, to be influencing and pulling levers to provide and shape services that will be targeting individuals who don't have any other choice. Leisure will be part of that package but it has to be a systems-approach. Leisure will be a beneficiary of that but they also have to respond to the education agenda and, say, the food agenda. Some of the crap that is sold in leisure centres!

IM: But it comes back to affordability…

CB: It comes down to contracts.

IM: A lot of the centres have done the healthy food option, especially in dual-use sites where they had to take all the vending machines away, but they don't sell, and someone will sell it down the road.

CB: Just take them out. We all know that secondary spend gives a nice little extra but it's a hugely competitive market so let them go somewhere else. That's what public health is about. It's not just about getting people active: it's the whole package, the whole environment, like the carbon argument.

IB: There are parallels between obesity and CO_2: they are multi-faceted, complex and knit so many things together.

CB: These are the arguments that we need to be getting over to leisure providers. Leisure activity is one part but we could do so much more. Why aren't we offering smoking cessation sessions? Gyms are perfectly placed. Let's do an alcohol assessment. We don't do it even though people are perfectly placed to do it and collect the data. Often they will collect the data and not analyse it.

IB: Why do you think that is?

CB: I don't think we invest enough in the data that we have available. It becomes a simple output and people can't see the value. It has to be a holistic approach. All I hear when I listen to the leisure sector is: 'We do health.' No you don't. You reach 20%, a very small proportion of the population.

IM: And the people you reach are advocates. We need to reach the people who don't want to use leisure centres, those people with barriers to engagement.

CB: I was at a UK Active [the erstwhile Fitness Industry Association] event a few weeks ago and someone stood up and said, 'How are you going to help me? We've delivered GP interventions to 500 people this

year.' My reaction is: 500? Talk to me when you've done 5,000. They think that's a success but it has to be numbers.

IM: GP referral has pretty much been the only thing delivered and they see that as their model.

CB: It doesn't work.

MO: Why does it have to be about numbers?

CB: Because for the NHS the problem is that big. We're talking about 87,000 people at high risk of CPD [cardiopulmonary disease] in Stoke-on-Trent. Therefore we need to target 87,000 people a year and we're doing that at a rate of 3,000 or 4,000 a year, so we're only slowly chipping away.

MO: But if they're not quality interventions then you're wasting your time.

CB: It's about quality and an evidence base. This can mean changing what you do and that's a slow journey in any environment.

IM: But why would a leisure operator look at a health intervention if there was no incentive for them to do it?

CB: Because that 20% market is becoming less and less.

IM: But a lot of operators will be focusing harder on that 20%.

IB: It poses the question: what is the purpose of public leisure?

IM: Exactly.

CB: It's a very small marketplace now and some people do it better. Maybe we need to go back to some of our basic principles.

IM: But that goes back to the wrong types of contract, operators paying a lot of money to local authorities, having to hit targets. How do they do that if they have highly deprived areas with hard-to-reach groups? It costs money to do that.

IB: So a local authority contract is up for renewal and, with the comprehensive spending review on the horizon, the operators are challenged to see how can they achieve another 'x million'. How do they get that value and how does that sit with those financial figures? The only way to do that is to demonstrate the value not just for the local authority but for the partners. You could argue for a real partnership approach in the contract might mean a financial input from health. Wouldn't that be a good thing to do in the context of the whole contract debate? It would shift the focus of this fundamentally.

CB: I believe that this is what that public health could bring to the table for negotiation.

IB: That would be a tipping point.

CB: Of course. Health has the ability to shape those future contracts and that is where health can bring value and also support, along with some of the resources for change management.

IB: And other bodies – Sport England, Arts Council, other national bodies – could be involved in those conversations in some form.

CB: As we said earlier, Sport England think it's good to give £5 million to help. £5 million? How many local authorities has that got to help?

IM: Public Health England have got to have a voice.

CB: But they've got no resource.

IM: They have staff…

CB: But they have no influence on what I will be investing in. Their role is around public protection, things like that. And another key thing is that what suits Oxford doesn't suit Stoke; what suits Birmingham doesn't suit Liverpool. Health is a local issue. People look at the great examples of Birmingham Be Active or Liverpool Lifestyles but you can't replicate that.

IB: I totally agree.

CB: My population group has totally different needs. You can't lift what you have already done elsewhere and think it's going to be replicable. It comes down to understanding local needs and I don't think a lot of people who write leisure contracts understand that.

IB: Not at any level of detail.

IM: There are a lot of standardised contracts now.

MO: But the contractors know so much more about it. They are the experts and you are going to listen to them.

IM: We now get into a competitive dialogue these days and dialogue is a good way of doing things, and not just for leisure. I think health needs to look at it when you are doing commissioning. Even in market testing when you speak to leisure operators all the way through the process they are adapting the specification to suit local conditions. Health commissions are very much inclined to say, 'Here's the tender', which is where leisure contracts were ten years ago; that's because it's the easiest way to do it. There are a lot of front-end costs on contracts and what leisure operator is going to put in that front-end investment to win a commission if in a year's time the commission is going to change? Public health organisations have got to look at their length of contracts.

CB: A lot of contracts are going out now for a three-year period and the reason for that is because people are unsure what the situation will be in three years' time in terms of the resources available.

IM: When I was contracting in leisure a five-year contract was not a bad contract but now it's like 10-, 15- or 27-year contracts because of the capital injection. Health has a five-year standard contract with a benchmark or review after three years. But for a commissioner a longer contract would enable the contractor to put capital in there. Health will need capital but some are one-year contracts. We've had them and by the time you get in it's time to retender. They can be extended but I think if you want leisure operators to sit up and listen they may not listen to one- or three-year contracts. They haven't got the understanding, the experience and the staff expertise, so they will have to employ people and they then have contract and human resources issues, so it's a hard market for leisure to get into. I'd love to see more of the DC Leisures, the Fusions, the GLLs doing commissioning because there is enough work out there for everyone and they have the resources to do it.

IB: As you said, there is an opportunity to have closer links with public health. That's more difficult in two-tier places like Oxford. The flip side is that local authorities are shrinking so in five years' time what is the world going to look like and how are we going to make sure the expertise is there? You can buy someone in with the expertise but that will be an increasing challenge. People in my role are picking up far

more things [to deal with] and then the leisure expertise gets watered down. The question then becomes: have we got the confidence of in the contractor so that the local authority gets out of the process what it could get out of it? That's quite a challenge.

IM: It is – particularly if it is still to be affordable. Anything is possible at a cost and it won't be the operator that takes that cost, it will be the local authority.

IB: A local authority does it perhaps once a decade but an operator does it five or six times a year. There's a skill difference there. In comparison to health, a district local authority is not highly skilled in commissioning. But there is a real opportunity with some real health challenges out there. Of year-six students in Oxford, 20% are obese.

CB: And the evidence tells us that if the child is obese they are likely to be an obese adult. But how many of those kids can afford to go to our facilities?

IM: The NHS is prepared to take a bit of a longer view but when you go into the world of local authorities they are asking about what they can get in six months' time. How can you get short-term value on health projects? It's almost impossible but I know that it is coming.

CB: But it is pretty strong as long as it is an evidence-based intervention. There is a lot of information out there to build your offer on.

IM: But pharmaceutical reductions won't kick in until later on.

IB: The chief medical officer's report includes advocacy for sport, physical activity and health. It's there but for some reason it does not transfer.

With this debate showing little sign of flagging, time was reluctantly called by the invigilator who had noticed that trains had to be caught and day jobs had to be pursued if they were to be retained. The Leisure Review *will be continuing the debate regarding the promotion and delivery of physical activity throughout 2013. We would welcome any thoughts, comments or suggestios readers may have in response to this discussion. Please email the editor at editor@theleisurereview.co.uk*

Notes:

1 *The Leisure Review* reported on Dr William Bird's presentation to the Sport and Recreation Alliance conference in the July 2011 issue. http://www.theleisurereview.co.uk/articles11/williambird.html

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