

Health and Social Care Committee

Oral evidence: Healthy Ageing: physical activity in an ageing society, HC 1180

Wednesday 29 October 2025

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Dr Beccy Cooper; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Alex McIntyre; Joe Robertson; Gregory Stafford.

Questions 1-70

Witnesses

[I](#): Professor Whitty, Chief Medical Officer, DHSC.

[II](#): Dr Carole Easton, Chief Executive, Centre for Ageing Better, Dr Lis Boulton, Health and Care Policy Manager, Age UK, and Sir Muir Gray, Director of the Optimal Ageing Programme, Live Longer Better.

Examination of witness

Witness: Professor Chris Whitty.

Chair: Good morning and thank you all for joining us. This is the first session in our new inquiry, “Healthy Ageing: physical activity in an ageing society”. As the UK’s population continues to grow older, it is essential to explore how to help people stay active, healthy and independent for as long as possible. In this inquiry, over three evidence sessions in addition to considering the hundreds of pieces of written evidence that have already come in, we will look at the vital role that physical activity plays in preventing ill health, reducing frailty and supporting wellbeing in later life.

We start that exploration today, and who better to start it with than a man who needs no introduction? Professor Chris Whitty, thank you so much for joining us today. Josh Fenton-Glynn will start the questions.

Q1 **Josh Fenton-Glynn:** Sir Chris, in 2023 you produced your annual report on ageing. What did you hope to achieve by focusing on that topic?

Professor Whitty: As the Chair rightly pointed out, the population has aged very substantially since the NHS was founded, and it is going to age for the rest of our lives. The number of older people is going up very significantly; it has more than tripled since the NHS was founded and, as I say, it will go up quite substantially until at least 2066. Those are not guesses; all these people are already alive. So the first point is that this is a growing issue.

As everybody around this table will recognise, people tend to have less good health in older age. However, if you look at the people who live the longest, who are the healthiest people, in the more affluent areas, in general, despite the fact that they live longer, they have over a decade less ill health than people who live in the most deprived areas. That is largely due to preventable factors that we know about and can do something about. That was the principal reason for the report.

The final thing, which has not been fully internalised by many of our policy colleagues, is that the areas with the fastest growing population of older people are the rural, coastal and less populated areas. There are parts of rural England, for example, where 30% of the population are over 65. They will not move back into the towns, so those areas will get steadily older and the towns stay forever young, because people come in usually at 18, and leave, usually before or around retirement. So the people in places like London, Manchester and Newcastle do not see this, but the rest of the country is ageing extremely rapidly and we need to respond to that.

Q2 **Josh Fenton-Glynn:** I think that is particularly an issue in places people dream of retiring to—Devon, Cornwall, Yorkshire and so on. A particular issue for older people is dementia, which is the largest killer of women now. In your report you say that at the current rate there will be 1.4 million cases by 2040. You also say that 40% of dementia cases are preventable. What should we do in earlier life to prevent dementia?



Professor Whitty: There was a very good review that came out in *The Lancet* about six months ago—I may have got the timing wrong. It showed that there was a very large number of factors, each one of which contributed 2% or 3%, and some of which are the same things we do for heart disease. Exercise is definitely one of them, which we are talking about today; also things like lowering your blood pressure, stopping smoking and a variety of the things we know about. Some are more specific to dementia: for example, hearing loss in middle age that people do not use hearing aids for speeds up dementia, probably because it leads to social isolation.

There are a lot of different things, and if you stack them all together, you can reduce the prevalence of dementia or delay dementia very significantly. If we could delay dementia in the UK by about five years, we would halve the number of people who have dementia. That is quite a remarkable difference. I think people see this as an unchangeable trajectory, and that is not correct.

Q3 **Josh Fenton-Glynn:** So if you say it is an unchangeable trajectory—

Professor Whitty: It is not an unchangeable trajectory.

Josh Fenton-Glynn: I beg your pardon—it is not an unchangeable trajectory. In other words, you can have an impact on it. Would you consider dementia a natural conclusion of ageing or a disease?

Professor Whitty: Dementia is a group of diseases. In the UK these days, three dominate: Alzheimer's disease; vascular dementia, which has a lot of risk factors in common with other cardiovascular diseases—heart disease and stroke; and something called dementia with Lewy bodies, which is usually associated with Parkinson's disease. Historically, there have been many other forms of dementia. For example, 100 years ago, a very large number of people in the UK had dementia due to syphilis, which is now gone. I make that point because there are many causes of dementia we have simply got rid of. HIV dementia was a big problem 20 years ago.

In my view, we can take a very significant chunk out of the ones that remain. We may not be able to cure them completely, but we can slow them right down, and many of the things we can do to slow them right down are relatively simple interventions, of which exercise, which you are talking about today, is very firmly one. If we all lived to 250, almost all of us would probably get dementia, but we are not going to. The aim of this is to delay dementia enough that you die before you would have got dementia, so you live a full life up to the last point, and you die—we're all going to die—free of dementia. That is really what we want to aim for.

Q4 **Josh Fenton-Glynn:** That will be a huge win if we get this right: a society without dementia. In your report, you talk about increasing the number of years lived in good health over increasing life expectancy. What would focusing on quality of years mean for how health and social care services are structured?



Professor Whitty: In terms of the extraordinary difference between the people who live the shortest lives in areas of deprivation and the longest lives in areas of affluence, if we could make the period of ill health of the people in the poorer, more deprived areas the same as those in the more affluent ones, it would reduce the pressure on NHS and social care services substantially—not just a bit. The difference, as I say, is a more than a decade of ill health. Trying to shrink that is, in my view, in the long term, one of the most important things we can do to maintain the sustainability of the NHS.

Many of the other things we are doing are actually much less important. They tend to be a bit more headline-grabbing, but the kind of things we are talking about in this Committee—for example, increasing exercise—will have material effects by shrinking the period of time that people are unwell and therefore the time they need health and social care support.

- Q5 **Josh Fenton-Glynn:** Just to make it clear, life expectancy for women in the most deprived decile is 77.6 years, with 50.5 years spent in good health, compared with the least deprived decile, which is 86 years, with 70 years spent in good health. Similarly, for men it is 72.5 years, with 50 years in good health. Meanwhile, preventable mortality in the most deprived local authority is 374.2 per 100,000 and 131.9 in the least. Those differences indicate a huge social determinant of people's health outcomes, but some people are ageing well. What do we do to close that gap?

Professor Whitty: Like most things in medicine, it is large numbers of things, each of which contribute a few percent. There is no single thing you can do, but if we did all those things the gap would be narrowed significantly. We know what those things are: exercise is firmly one of them, smoking is a major one, and air pollution is another. That would be a huge benefit to individuals, their families and wider society, so there is an enormous win if we can get this right. We know what to do; it is simply a matter of having the will to do it.

- Q6 **Josh Fenton-Glynn:** We are talking a lot in healthcare about the three shifts. How would you make those three shifts work, in terms of shifts to prevention and to communities? What are the basic interventions into health that will help people to age better?

Professor Whitty: I will concentrate on the shift into prevention, because I do not want to go down too deep a rabbit hole on this. In that, there are five issues, which, if we dealt seriously with all of them, would significantly reduce that gap, albeit they would not take it away completely—housing and a variety of other things are also important.

The first is cigarettes and smoking more widely. That is absolutely catastrophic for people's life course, and we could stop that. I am hoping that the Bill to make a smoke-free generation will get through the House of Lords reasonably unscathed, because that is such an important intervention. Then there is air pollution, which has been going down in most places, but there is still a way to go. We know how to do it, but it is



HOUSE OF COMMONS

a matter of whether we do it. Then there is reducing the number of people who have high and risky levels of alcohol use, so that they use it for social purposes in moderation, but not in large amounts. Then we move on to exercise, which we are talking about today. That has an enormous impact on the way people are going to be.

Q7 **Josh Fenton-Glynn:** What kind of exercise would you recommend?

Professor Whitty: I think we are going to go through this probably in detail, but in broad terms, people need three things as they grow older. One is the overall amount of exercise they do. The good news is that studies that show benefit just keep rolling in. I wanted to highlight one study, because it makes it so clear. It came out literally last month—it is from the US, but the data here is similar and it is from women, which is important because a lot of the previous data has been from men. After 10 years of following up a large number of women, they found a 26% reduction in mortality if people took 4,000 steps—that is less than 2 miles—just once to twice a week, and if they did that more than three times a week, it was a 40% reduction. Those are big numbers. That is an association study, so you have to allow for the fact that causation is not the same as association, but if you had a drug that did even half of that, the drug company would make huge sums because of the extraordinary impact it could have.

Once you have the infrastructure right for most people, and it is largely free, it does not just improve mortality and cardiovascular disease, but it has big impacts on cancer, and impacts on diabetes, dementia and mental health issues—it has multiple hits. It is very important. That is why I was absolutely delighted that this Committee was highlighting this. The combination of an older population and the extraordinary impact you can have by improving access to exercise and other physical activity is important to address.

Q8 **Chair:** Can I pick up on a couple of things? You said the rural and coastal dimension to this has not been internalised by policy makers. Why do you think that is?

Professor Whitty: I think there are several reasons. There is a certain amount of “out of sight, out of mind”, because centres of political power and big hospitals are always in the conurbations. People might visit relatives in the rural and coastal areas, and MPs know this because they represent the whole country, but many people simply do not see it.

The second reason, to be honest, is that quite a lot of people think, “Well, yes, this is going to be a problem in 15 or 20 years, but we have crises now; let’s solve those now.” If these problems had been taken seriously 15 years ago, many of them would not be problems now. A responsible Government, a responsible political entity, civil society, the civil service and political leaders—all of us have to tackle the problems of 15 to 20 years hence, because it is much easier and cheaper to do it now, with a proper run-up, than to wait until the completely predictable car crash hits



HOUSE OF COMMONS

us and say, "Why didn't we do it previously?", when all the signs are there. There is nothing magic about this; the data here are really clear.

- Q9 **Chair:** You spoke about sustainability of the NHS being affected by the ageing population. Has the Department done any quantification of how much it might save, or not save, by doing or not doing interventions in this space?

Professor Whitty: The maths on this is relatively simple. Most people assume is that as you grow older you will grow sicker, and the longer people live the more time they will spend in ill health. The point I have made with the data, and which I will make again because it is so central, is that the oldest cohort of people in the UK, the people who live in the affluent areas, have by far the shortest period in ill health, at roughly half that of others. The question is how far can we get toward that higher rate. As time goes on, the people at the top end in terms of having the best health will probably get even healthier, because plenty of things are happening the whole time to improve that, so the target is moving further away. The danger is that people in affluent areas will get healthier and healthier, experiencing shorter and shorter periods of ill health, which means less impact on the NHS, but more importantly less impact on them and their families, and we leave behind everyone else. It is essential that we do not do that, but that we really push the things we know work in the areas of deprivation.

- Q10 **Dr Cooper:** You are making a really strong case, Professor Whitty, for physical activity helping people to age well. What would be the most effective public health interventions to ensure increased physical activity in older people?

Professor Whitty: Of course you know this, but I will say it anyway. If people go into older age having done a lot more physical exercise, they start off with huge amounts of money in the bank. For all of us, our muscle strength and muscle mass, our bone strength and so on decrease beyond a certain point. I am already on the slide, I regret to say, and most of you are as well. If you have a lot more as you go into older age, there is a high chance that you will reach the end of your life—hopefully a very happy and fulfilled life—with minimal impact. It is important that you take exercise all the way through life. It is never too late to start, and we will be talking about exercise in older age, but I do want to emphasise that doing exercise all the way through the life course makes an enormous difference in old age.

You know this, but I will spell it out for those watching: there are primary prevention things you can do to ensure that the whole population are able to engage in greater degrees of physical activity—in a sense, not differentiating between those who have risks and those who have not. Then there is the secondary prevention, which is where doctors, nurses, physiotherapists, and potentially even pharmacists, can help people to realise that they are at particularly increased risk, so it is particularly important they do things. The reason I am differentiating those is that quite a lot of it should be done under primary prevention. We should



simply make it easy and attractive for everybody to increase the amount of physical activity they do.

Unfortunately, some of the areas with the biggest risks have the least capacity to do this. In rural areas, for example, physical activity rates are significantly lower than in urban areas. You look around when you are in a rural area and think, "Why are people not going for a walk?" and then you realise that to get to the fantastic path network we have, you have to go along a busy A road which lacks any kind of pavement, so people get trapped in their own homes, unable to access the kind of exercise and other physical activity that people in urban areas can do. I am just giving that as an example.

Many areas where older people live have very poor access to very steady pavements, for example. The single reason that most elderly people give for not walking—way ahead of everything else—is that they are worried about uneven pavements. It is so unglamorous and people would far rather say, "Why can't they all have a digital app?", when in fact if we just levelled the pavements, a lot of people would go out walking. There is a lot of stuff we can do on the infrastructure that will help.

Sir Muir Gray, who is coming afterwards, has done a huge amount of work on this, so I will not talk about some of the work he has done, but once people get into a higher risk category, you can encourage them to take up particular forms of exercise that will be useful. As you know, there is overall exercise—cardiovascular exercise—there is strength exercise to keep your muscles going, and there is balance exercise. I would also add a fourth, which is flexibility. Those are slightly different, and you need to do different forms of exercise to achieve each, but for all of them, you need to make them fun or useful. Making exercise dull and useless is almost a guarantee that people will not do it, so it has got to be one or the other out of fun or useful.

Q11 Dr Cooper: To pick up on the theme of it being fun and useful, and not dull and useless, in public health messaging, how are we doing in terms of incentivising older people to be more active?

Professor Whitty: I think quite poorly. If you said to people, "Do you think you should do more exercise?" most people will have registered the issue, but even for that, people think that they have to walk 10 miles a day and do a whole bunch of things. The point I was making at the beginning was that really quite modest amounts of exercise, two or three times a week, make a huge difference. The biggest impact is on people who were doing nothing doing a bit, and then people who were doing a little bit doing a bit more. It is fantastic if someone in their 70s is cycling 50 miles a day—brilliant—and if they cycle 90 miles a day, it is probably even more brilliant. But the big gains are right at the beginning. That is the first thing that we get wrong.

Secondly, we do not make it clear to people that they need to do different sorts of exercise for strength and for balance. Once someone has had a fall or two, they tend to lose their confidence and not to go out, which



starts a whole chain reaction of both physical and mental decline, because people become isolated and afraid to do physical activity. It is important that we have all of those and make them very clear.

- Q12 **Dr Cooper:** What has been quite successful in terms of exercise for more sedentary people is the Couch to 5K messaging—that seems to have landed quite successfully. Do you think there might be a comparable exercise messaging package that we could consider for ageing well?

Professor Whitty: If there was a marketing person here, they would be saying that this is an absolutely classic situation, and that you should segment this market. What works for one person does not work for another; for one person it might be bhangra dancing, for another it might be bowls, and for another person it might simply be a walk to the butcher when they previously got the bus. With all of them, you want to build it around the person and build a package that they can enjoy. If they wish to be sociable they can be, but if they wish not to they don't have to. For some people, they can do it in their own homes. Very few positive things came out of covid, but one thing that did was the ability for people to, for example, do group exercise classes while staying in their own homes, or sitting in their own chair. But we need to tailor it around people.

As you know, I did a report on health in an ageing society, and within that there are many fantastic examples from around England where either volunteer groups or local authorities have initiatives that work for particular bits of the population. We just need to ensure that we do this across the whole population, rather than just for a small number. Couch to 5K is a brilliant intervention, but it doesn't work for everybody. We need to find other things that work for the people who that does not work for.

- Q13 **Dr Cooper:** I have a quick point of clarification around causality. When you talked about older people in rural areas being less likely to exercise, you referred to the lack of infrastructure to allow people to walk. Is that a clear causality, or is it related more to the fact that there are more older people there who are less likely to exercise?

Professor Whitty: Person for person, there is less exercise. In a sense, both are true. There is a much higher proportion of people who are older, and for those who are older, they are less able to access all forms of exercise. I used walking as an example, but they cannot get to gyms or swimming pools, there probably is not a local bowls club—or whatever people do for strength and balance—and it may be quite a long way to go for a dance in the evening. When you think about them, these are addressable problems. They are even easier to address if someone is in a largeish village or small town. But even in very rural areas, you can do it. Most people are in some form of community, and it is communities that tend to make this possible.

- Q14 **Andrew George:** To take an unsentimental and heartless view—not that I am suggesting that anyone in the NHS could be characterised in that way—from what you are saying, if we work at this sufficiently, people could have a shorter period of ill health at the end of their life, whenever



HOUSE OF COMMONS

that end comes, whether at 60, 70, 80, 90 or 100. Presumably, to cater for what we are beginning to refer to as the demographic timebomb that will cost the Government lots of money in years to come, we are encouraging that to happen. The shorter period of ill health at the end—with people falling off the edge of a cliff, rather than having 20 or 30 years of ill health—is clearly desirable. Has that been factored in as part of the calculations that you and the Department are working on?

Professor Whitty: First: absolutely, that is exactly what we need to do. That is not a small difference. As I said, the difference between the people who live the healthiest lives and those who live the least healthy lives—that tends to correlate with affluence and deprivation at the two ends—is over a decade-worth of ill health. That is an enormous difference, not just a small difference.

Planning is generally predicated on the assumption that things will carry on along the path they are currently on. In my view, we need to change that path. Even being cold-blooded—you started off by saying even with such a view, so let me be the most cold-blooded of all and go for a straight economic thing—looking at how much of the GNI of the country will have to be spent on health and social care by 2060 if we carry along this line, we will be in an incredibly difficult financial state. That has been laid out clearly by the OBR, which has done two reports in the past two years that are well worth reading. There are a number of ways in which to deal with that, but clearly the best way is to bend the curve so that the amount of unnecessary ill health is minimised.

The things we can do, which I have talked about, are really simple. Exercise and other activity is very firmly one of those things.

Q15 **Andrew George:** What kind of public health interventions are most effective? We talked about walking, running, swimming and so on. More importantly, how do you target the groups who would benefit most?

Professor Whitty: On the second of those, which I think leads to the first, the key thing is to find the groups where the levels of activity are lowest and to talk to them, asking, “What is the reason that you are not getting around?”

Q16 **Andrew George:** Has anyone asked?

Professor Whitty: People do do that, but what it demonstrates is that if we take everyone who is, say, 75 and has little activity, there is not a single reason. We cannot say, “That is the reason, so we should just fix that,” because there are groups of reasons. A lot of those are to do with infrastructure, or with just getting out of the house. Getting out of the house is actually one of the key first steps that can be problematic.

A lot is about fear of things, which are fixable fears: pavements I have talked about; having a seat along the path, so that if people get a bit puffed, they can sit down; or having a toilet that they can use somewhere in the vicinity, so that they don’t think they will get caught short. Those are simple things to fix. Alongside that, there are more active things we



HOUSE OF COMMONS

can do, like providing groups for what people want to do. It will be different for different people.

For example, Angela Rippon is doing a fantastic thing on getting people to dance. For some people, that is a fantastic way to get balance, to get activity, but for other people, that is the last thing they want to do in their 70s and is just not for them. Those are both perfectly appropriate responses. The key thing we need to do is to find, for every group, things that people want to do and build them into their daily lives. That is where active transport comes in.

When people talk about active transport, I think what most people have in mind is a 40-year-old guy in Lycra going too fast on a bike. I am very much in favour of cycling—I want to be clear on that—but what we are talking about here is someone getting off the bus a stop early, so that they walk a bit further. That is still built into their normal lives. It is the relatively simple things. My worry is that those get lost because they are not glamorous, and yet they are incredibly effective.

- Q17 Andrew George:** Do GP surgeries need to have life coaches? How do you ensure that the availability of activities through social prescribing or other methods is not simply taken up by the sharp-elbowed middle classes, rather than those who are the targets, who you say would benefit most?

Professor Whitty: You are absolutely right that there are many general practices and other bits of primary care that are doing a fantastic job of getting people linked up through social prescribing. We use the term “social prescribing”, but it means lots of things to lots of different people. Broadly, it is about finding a person who has a risk factor—in this case, not enough activity—and then finding a way in which they can do something. Sometimes we can find free ways to do it, like, “Were you aware there is a walking club that goes to see birds on a Saturday morning?” Sometimes it might be prescribing the ability to go to a gym, so they can get strength in various muscle groups to, for example, keep shoulder strength up. You need to make sure that it is not just a single intervention, and that it covers overall cardiovascular exercise, strength and balance, because those are three slightly different things.

- Q18 Andrew George:** We have received evidence that there is a change in commitment to physical activity at the point of retirement. How do we change that? That seems to be an opportunity, because the state knows that a person has reached that point. How do we communicate and encourage people to change that trajectory?

Professor Whitty: You are exactly right. We need to think about the points when people either step down or step up exercise. At an earlier point in life, for example, having a child can lead to people changing their exercise patterns very significantly—often for the worse—and you need to catch them and say, “Here’s a way we can do it.”

Chair: I can attest to that being true.



HOUSE OF COMMONS

Professor Whitty: The same is true as people retire or the first time someone has a fall. We all fall more as we grow older, because our ability to balance is less good—you cannot catch yourself as easily, basically. There are certain points along the way, some of which are obvious, like retirement. Some are more to do with particular interventions that have happened in people's lives, when they think, "I want to make some changes." Those are the moments to try to do it. Then there are fixed points, like new year, when you try to encourage people to do a new year's resolution or whatever.

Q19 **Andrew George:** Are there any examples around the country of local primary care and public health services getting this right or being ahead of the rest of the country?

Professor Whitty: Sir Muir Gray will have many examples of this, because he has done fantastic work on it with many other colleagues. In the annual report, one example was from Hampshire. There were two things: one was called Strong and Steady, which was about trying to do things around balance, and the second was Live Longer Better, which is one of Sir Muir's initiatives. There is another system, done a different kind of way, in Cumbria, which has a slightly different population. That probably would not work in, for example, a multi-ethnic inner-city area, where you need a different set of interventions. It is important not to say, "It works here; it will therefore inevitably work somewhere else." It will probably work in similar places, but you need to be aware that we have a very varied community.

Q20 **Chair:** On a point of clarification, I think you said that these interventions—pavements, toilets and so on—are easy, by which I assume you mean straightforward, in that they are easily identified. Many of our Members have sat on the cabinets of local authorities, and their ears will have pricked up, because it is not that easy for a council leader to do those things, rather than other things, when there are very tight constraints on money. How do we embed this? How do we get this through in such a tight fiscal environment?

Professor Whitty: First, your point is completely right. I was using terms loosely, so your clarification is absolutely right, but it is technically straightforward. The politics is the hard bit. I have not been involved in local government in the way that many of you around this table have, but I do talk to a lot of directors of public health who are very closely aligned with this. People underestimate—this is why this inquiry is so useful—how important this is, so inevitably the things I have talked about fall down the priority list. People think, "That would be nice to have, but I have—fill in the blanks—to solve first." If people realised quite how big a difference this would make to their community—that, over a 10-year period, if people could do activities or take exercise, that would make such a big difference to, for example, the number of people who need social care—that would lead to a change in the way that people prioritise. It is really about prioritisation; it is not about difficulty.

Q21 **Joe Robertson:** Can I start by thanking you, Professor Whitty, for



HOUSE OF COMMONS

highlighting the particular issues for coastal areas, as an MP who represents a coastal area? Can I take you back—or forward—to strength and balance? It has been identified—it is not controversial to say—that maintaining muscle strength, balance and flexibility is important, particularly as people approach older age. Is there specific exercise that people should do to concentrate on each of those, rather than the general positives you mentioned about being healthy and active from early on in life?

Professor Whitty: Thank you. That is a really important question, and the answer is yes, definitely. There are forms of activity that are particularly good for balance—many sports are. It does not matter what the sport is. It might be tennis, walking football, bowls or dancing. Those are all very good for balance. Balance is absolutely critical, because one of the biggest reasons why people stop taking physical activity and having social lives is because they have a couple of falls, lose their confidence and get trapped in their homes. It sounds small, but it is absolutely central to people having a good quality of life in later age.

Strength is different—they are not the same. With strength, the key things you are trying to do are exercise all the different muscle groups that you use for day-to-day life, and put a bit of pressure on your bones, because that is one of the ways that you prevent osteoporosis occurring. Since I am talking about bones, can I just do a quick advertisement for people taking vitamin D during autumn and winter months? That is important. For older people who spend more time indoors, that can be particularly important. That is just an adjunct. The actual exercise for strength keeps their muscle going, means that they are less likely to have shoulder problems or other issues, and ensures that they can do the activities of daily life like getting out of a chair—it sounds simple until you cannot do it—or walking to the shops. The danger is that otherwise it becomes a downward spiral.

Those are different. If you look at both the chief medical officers' four nations report on this and what you will get from GPs and others, they make it clear that there are things you do for cardiovascular health—they are largely to get your heart and lungs going—things you do for balance, and things you do for strength. Some things do all of those—dancing is quite a good example—but many of them do just one.

- Q22 **Joe Robertson:** Earlier, you said that, perhaps surprisingly, people in rural areas are less likely to exercise, when it would seem that they had more casual opportunity to do so. Where do you think the balance is between ensuring that there are facilities and opportunities locally for organised healthy activity, and encouraging casual activity and just trying to factor exercise into one's daily routine? You have touched on it already, but I wonder whether there is a misconception that this has to be particularly organised activity, rather than building it into daily life.

Professor Whitty: That is exactly right. For some people, organised activity is the best way to do it, because it combines sociability, and maybe doing a sport that they have always enjoyed doing, with the



exercise—terrific. For other people, that will not be the right thing to do or something they want to do, and there are many alternatives. You can go all the way through to people doing exercises in their chairs with large rubber bands, while someone does it with them on a Teams or Zoom call. There are multiple routes by which people can get to the same place. The main thing is to make sure that there is a range of opportunities available, and that everybody is aware of them, so that they can realise, “This isn’t for me, but this one is.” Most people want to do at least some of these things, provided you can make them possible.

A very large amount of this is done by the voluntary sector, either in the sense of pure volunteers or members of volunteering organisations. It might be something like Age UK, but it also might be very local. Going around the country, many of the things I have seen are very local—they are specific to one town or village, and yet people love them. You get a lot of people doing them, whether it is a walking football match or walking along the seaside. These are the kinds of things that you want to build in, because it makes it an attractive offer, rather than something people are doing as a penance.

Q23 Joe Robertson: Finally, we can understand and imagine what policymakers and decision makers should do in providing activities, whether that is through local government, the Department of Health and Social Care or other ways. In encouraging people just to make healthy choices and to understand their positive impacts, such as choices around exercise, we seem to be doing that better in choices around health eating. I think people understand that it matters what they take off the shelf at a supermarket and eat. I fear that we are a little bit behind that in how people simply choose to go about their daily life. I am not even thinking about exercises in a chair per se, but choosing walking over taking the bus if you can and those sorts of things. Do you see a bigger role for the Government and local government in promoting that sort of casual, everyday healthier physical life?

Professor Whitty: I think local and national government can do two things. The first is essentially free, and it is to make clear quite how important physical activity and exercise are, and the different things you need. There is a little bit of cost to that, but it is pretty minimal compared with the gains you will get if people change. It needs to be tailored in a way that will change behaviour, rather than just saying it, but that is a really straightforward thing to do.

The second thing that the Government have to accept is that a lot of the infrastructure that acts as a barrier—infrastructure does not usually act as an attraction, but it can act as a barrier—essentially belongs to the state, or the state has the ability to make the difference, which can either be national or local government. One of the problems has been that people think of exercise and say, “It will make couple of per cent difference, and it would be very nice to have.” They do not see this as something that is really central to long-term health and the ability to shrink the period of ill health that blights the lives of older people so much, and it does not need to.



- Q24 **Alex McIntyre:** Thank you very much for your answers so far, Professor Whitty. I want to take a slightly different approach to a similar line of questioning. In healthcare settings, how can we support or incentivise healthcare professionals to start having these conversations, particularly with inactive older people, about the benefits of physical activity?

Professor Whitty: There are probably two answers to that. First, a lot of general practices—not just the GPs, but all the people who work in primary care—already do this. However, I think that secondary care doctors are much less good at it; I suspect that the average secondary care doctor does not ask, “How about some more activity?” from one week to the next, and I think that is a failing of us as a profession. Therefore, we need to make a very clear statement to the medical, nursing, physio and other professions—the physios do not need telling this, but everyone else probably does. That is the responsibility of people like me and Sir Muir, who is coming up later, as well as the colleges. That is a professional responsibility.

I also think it is important that the Government say that we are prioritising this. There is a bit of a danger that all the messages the Government give to people in healthcare professions are about prescribing in the conventional sense, or about waiting lists for operations. People might think that is all that the Government are worried about, rather than them saying, “Look, here is something that, in the long run, is going to make an enormous difference, and we really ought to be giving significant priority to this, particularly since a lot of it is relatively low cost compared with many of the interventions in medicine.”

- Q25 **Alex McIntyre:** On that secondary prevention piece, how can we get that promotion out of healthcare settings into wider communities and people’s everyday lives?

Professor Whitty: I think there are many really inspiring examples of this around the country. To be clear, I do not think that this is a wasteland of nothing happening, but we need to go to the areas where the problem is greatest and the amount of activity is lowest. Those are often places where you think, “I can see why people do not want to go outside much, and why they do not want to have much physical activity, and we need to do something about this.” Very often, it will be a relatively straightforward intervention that makes the difference.

In my view, a lot of this starts with the simplest end of transport, such as people’s ability to walk to the places they want in a reasonably safe way, with good lighting, and with a chair somewhere on the way that they can use to sit down. A lot of people would much rather talk about the latest drug you use in stage 3 cancer, forgetting the fact that if you put in a park bench five years ago, the cancer might not have happened in the first place. That strikes me as us not having got our prioritisation right. We really have to say, “Look, this really will make a big difference over the long term.”

- Q26 **Alex McIntyre:** I guess part of the challenge is various different



HOUSE OF COMMONS

Departments of Government working together. What do we need to see from Government to support cross-departmental working on this area?

Professor Whitty: You are absolutely right. The Department of Health and Social Care does not control the roads, pavements or a whole bunch of things that are critical. DCMS does a lot of great work on support, but it tends to be on the sport end of it. They do some of the things I have talked about already, such as walking football matches, which are fantastic if you have seen them. People may not be able to run but they can sure get a ball into a net, just as well as when they were in their 20s. It is very good to watch, to take that as an example.

Local government has a major role to play, as does the Department for Transport. It is important that this is seen as a cross-Government issue. One thing I was most encouraged by in Government was the approach of mission-based Government, where you say, "Let's solve a problem," irrespective of which Government Department is doing this. It is easy to say and hard to do in a Whitehall setting.

In my experience, it is a bit easier in local government, because people tend to be a corridor apart. The director of public health and the director of planning services can have a coffee together and try to work it out. We need to do this as a joined-up thing because no one Government Department can pull all the levers needed to achieve this.

- Q27 **Alex McIntyre:** When you are thinking of inserting this into people's everyday lives, cross-departmental work is really important. My colleague, Ben Coleman, passed me a couple of suggestions. For example, everybody gets written to about their state pension by the Department for Work and Pensions. Is it possible to insert health messaging around physical activity and send out public health info with that, where we are already communicating with this group? Or for example, having a centralised telephone number for people to phone and find out where their local activity is, as well as get other information they might need to access.

Professor Whitty: Both of those strike me as good things to test out. We have to be evidence-based about this. Lots of things that seem to be good ideas don't work when you test them out, and vice versa. The right thing is to test them out. If that leads to an increase in people doing physical activity, then roll it out more widely. We should do a lot more testing of that kind of interventions, to see what they do in terms of subsequent behaviour. If they change behaviour, that is a huge win, and then you do it more widely.

- Q28 **Chair:** Is there a willingness in Government to do that? For example, if you asked DWP to test out that idea, do you generally find people would say, "Let's do it and test it"? Or, do you find a bit of resistance?

Professor Whitty: Somewhere between the two. If you have a very complicated system like the pension system and you ask to make it even more complicated, the first thing will not be, "Yes, let's do it." What people will be keen to do is to ask, "Can you prove this will be useful and can it



be done in a way that runs with the grain of what we are trying to achieve?"

That is why we need to pilot these things, but with a proper evaluation. Because at the end you can say either, "This idea made a big enough difference that the cost—maybe not financial but in terms of complexity—is justified." Alternatively, it could be, "This is a good idea but it hasn't worked." That is the key—to prove it—and then Government can make decisions on a relatively firm evidential basis.

Q29 Gregory Stafford: What do you see as the opportunities of a neighbourhood health service to support the shift to prevention and address inequalities in healthy life expectancy? Specifically, how will it need to approach service delivery and workforce planning to support those shifts?

Professor Whitty: The more you look at it, one thing that is incredibly striking is how hyper-local a lot of ill health and problems are. The way we analyse data for Government is, in my view, at too high a level. All of you will know that in most of your constituencies there will be some bits where there are significant degrees of deprivation and difficulty in doing things. They will be physically quite close to other bits where it is relatively straightforward to do.

The first thing we need to do is have better granular data, where you can say this is not a problem across the whole patch, but it is a big problem in particular areas. When you get very local maps of somewhere like Blackpool, which often gets used as an example because the outcomes are very poor, the really poor outcomes are actually in two or three wards. There are some moderately problematic areas and some areas of affluence and good outcomes. We have not been putting our efforts into the two or three wards where really problematic things are happening, and saying, "What can we do to fix the problem of low activity in those wards first?" If we can fix it in the worst places first, that makes the problem much more boundable and, to go back to previous points, it will cost less money because you are doing it in the places where the problem is greatest, rather than across the whole of the area of responsibility. I think that would lead to a much bigger, faster forward movement. If we tried to do everything absolutely everywhere, the cost benefit would probably be much less in some areas.

Q30 Gregory Stafford: Following on from that, are there things from a neighbourhood health perspective that are not being delivered or commissioned, or for which the workforce isn't there yet, that would need to happen in order to achieve some of that?

Professor Whitty: I think that if we can make neighbourhood health services work, what they should be doing is, first, at an individual level, helping an individual to find their way because, they will understand their locality and what is available; and, secondly, pointing out the bits of the locality where we can do most to intervene to increase levels of physical activity.



HOUSE OF COMMONS

- Q31 **Gregory Stafford:** Okay, thank you. You have touched on this slightly already in answers to other questions. In written evidence, the Department said it is working with NHS and other Departments to bring a “joined-up, life-course approach” to promoting physical activity. How successful is this joint working so far? Are there other areas where you would like to see improvements?

Professor Whitty: It is a classic example of where there are some outstandingly good examples and some areas where we are not making any progress at all. It is a huge spectrum, unfortunately.

- Q32 **Gregory Stafford:** If I can press you, let’s hear the examples where it is not working at all.

Professor Whitty: They tend to be in highly concentrated areas where the gap between what people can do and what we would like them to be able to do is greatest. It is much easier to make Richmond upon Thames and Harrogate a bit better for activity than it is to go into some of the more deprived areas of an inner city, but the return on investment is so much greater. To go back to my very first point, what people often forget is that a really quite small increase in activity for someone who is doing none can be transformational, whereas getting someone who is already doing a fair amount to do a lot more is a good thing, but you will get much less return on investment. We should really be using this localisation and saying, “Yes, these are the hardest places to do it, and it may even cost more in pounds, shillings and pence, but the return on investment will be so much greater that this is a really worthwhile thing to do.”

- Q33 **Gregory Stafford:** I might come on to that money point in a second. To go back to the departmental level of this, are there exemplar Departments out there that really get this and are doing things to get it? Are there ones that really don’t see this as a whole-Government approach, and really don’t follow up on the stuff that you are talking about?

Professor Whitty: In every Government Department there are people who are passionate about doing this better. At the top of each Department, you have a Secretary of State who has to balance 1,001 priorities, and the question is how far this goes up their priorities list. All of them would say, “Yes, we would like to do this.” To be clear, this is successive Governments; it is not this Government specifically.

Let’s take transport. How much time is spent debating how to get people in deprived areas to walk a bit more, compared with how much time is spent debating HS2? I am very confident that more time is spent on HS2. That would have been done under the last Government, and it will be done under this Government. That is just the way Governments tend to work. But there are people in the Department for Transport who are really passionate about doing this, and the more they can be empowered to do what they understand will work, the more likely we are to get forward movement.

A lot of this is done at a local level. Although central Government can do some high-level things, a very large amount of this really comes down to



HOUSE OF COMMONS

local Government, local NGOs, local volunteer groups and local enthusiasts, who are often the best people at getting things to happen.

- Q34 **Gregory Stafford:** Just to finish off, as you mentioned the money, you previously said before this Committee that one of the problems is that the cost-benefit of these things is not evenly split between Departments. One Department can spend the money, and another one can see the benefit. Do you believe that has any influence on how the Treasury funds these things? Would you like to see a different approach from the Government as a whole, and the Treasury specifically, so that Departments are not penalised for spending money that they do not see a direct return on?

Professor Whitty: I have to be very careful that I do not try to redesign Government.

Chair: We are inviting you to!

Professor Whitty: I am sure the Cabinet Secretary would phone me up afterwards if I took that invitation up. I think everyone would agree that the way Government Departments are siloed—not just for this issue, but it is definitely true for this issue—where the costs sit in one Department and the benefits sit in another, is problematic across a whole suite of areas. Prevention, including this area of prevention, is one of the areas that gets hit really badly. It is also true for air pollution, for example, where the benefits sit in Health if you get it right and the costs sit in Transport and DEFRA. This is a repeated issue. Treasury is one of the Departments that tries to help with this, but Treasury is trying to fight a thousand fires at once. The question is, does this ever reach high enough on its priority list that it thinks, “Actually, we can try to do something about this”?

One of the things we can do—and I am going to slightly break my own rule on this—is to have joint funds, where we say, “This problem is clearly between three different Departments. You can only bid into Treasury if all three Departments are prepared to put their hand up and say, ‘We’re going to do something about this,’ and you only get the money if everyone is agreed.” This is not a new idea, to be clear—I am not making it up on the hoof—but that kind of thing can help to make this point about funding imbalance between the different priorities a bit easier to manage. It does not solve it, but it makes it easier.

Gregory Stafford: Thank you very much. Hopefully the Cabinet Secretary will not be on the phone.

- Q35 **Ben Coleman:** Sir Chris, I am glad that you said there is something central Government can do, and I agree completely about local government and the opportunities there. Can this be done by the different Departments working together without a steer from the very top? Everybody shrugs off responsibility. However, if the Prime Minister says, “This has to happen,” as has happened with some work under the previous Government with disabled people, there is more likelihood of it happening. Without that, do you see any chance of three Government Departments working together in the way that they need to?



Professor Whitty: There are quite a lot of examples—not just in this area—where Government Departments work together very well on issues, but there is absolutely no doubt that if the Prime Minister and No. 10 say, “We would like this to happen,” the probability that it is going to happen shoots up compared with if the Prime Minister does not say that. Of course, the Prime Minister cannot have a thousand priorities, but my view is that a relatively gentle word from No. 10 would be very powerful here, because it is a boundable problem. It is not politically unpopular; I do not think there is any party arguing that we should have less activity or exercise. It is not an area that gets into tricky politics, or big P politics, if I can put it that way, and it can make an enormous difference. I certainly think that having the centre say something positive—it does not matter if it is the Prime Minister personally—does make a big difference. It is quite possible to get on in Government and get stuff done without that; it is just a bit harder. Certainly, having central interest makes a big difference.

- Q36 **Danny Beales:** Is there any modelling about what investments practically bring in those areas? I think we would all agree on repairing pavements and having street lights switched on. My grandparents moved near the coast, and the street lights are now all switched off at night to save money, the pavements are in bad shape and the public toilets have been closed. Is there any modelling about what investments in those areas practically bring in terms of reduced slips and falls and better health outcomes? For decision makers in Government, there is modelling about a certain diabetes drug or health intervention, but when it comes to local government or Government more generally, there perhaps is not that evidence base driving those decisions

Professor Whitty: You are absolutely right. This is a perfectly modellable problem because we understand the outcomes of the intervention, and the intervention has a cost that is understood, so this is not particularly tricky to do. You would probably have to do it on every individual component of it. There is not an overarching thing you could do at a macro-Government level. It would have to be, “What would be the effect of putting five more benches on this stretch of road?”

Danny Beales: You would be doing that to guide these decisions.

Professor Whitty: If we could find a way in which we could show that modelling this is relatively straightforward—you might not get it exact, but good enough that you could see the return on investment. The key thing on this—I am going to make a rather techy point, but it is important—is that I think that a lot of the models we use in Government have far too severe a discount rate. What that means is that they don’t appreciate the benefit of something over 20 or 30 years, so you have to have had your return on investment in two or three years. With these kinds of interventions the cost is up front, but the return will be over decades very often. We have to make sure that that is captured in a proper way, rather than saying, “You have got to have had it all sorted out within three years,” because you may well not get a return on investment in three years, but you are likely to, in many of these cases, if you are taking a 15-year view.



HOUSE OF COMMONS

Q37 Danny Beales: Is there a case to make those things statutory services? Usually they are not. Library provision or social care is, but none of those things is necessarily statutory.

Professor Whitty: You are tempting me into an incredibly difficult political area: what should be statutory and what should not?

Chair: I will save you because we are nearly out of time. For a very short, final question, Jen Craft.

Q38 Jen Craft: And I will ask you about an even more difficult political area. You said the Prime Minister has a bunch of competing priorities. He supposedly has five overarching missions in order to deliver a mission-led Government, and there are a lot of priorities on departmental budgets and how they are spent, particularly as the benefit is often apparent to a different Department from where the cost is. Do you think there is a potential argument for redesigning how Government spend works around a mission-led spending allocation or mission-led budget?

Professor Whitty: I think it would be a very good thing, for Governments of any political colour, if we could get mission-led government to work, because then a whole heap of problems, of which this is clearly one, which have exactly the set of issues you and others have talked about, would just fall away. If we could get that to work, quite a few problems would just fall away. It will only work if the centre—the Treasury, No. 10 or the Cabinet Office—insists that it works, because otherwise the centripetal forces are too strong. Every Cabinet Minister has a set of priorities; she or he is going to have to work down that priority list, and the danger is that this is always priority No. 7 and they have only got funding for priority No. 5.

Chair: I'm afraid that is the end of our time with Professor Sir Chris Whitty. It is always a pleasure to have you in front of us. Thank you very much.

Examination of witnesses

Witnesses: Sir Muir Gray, Dr Lis Boulton and Dr Carole Easton.

Chair: We are now spending time with three incredibly knowledgeable witnesses. We very much welcome all three of you to this session. Because there are three of you, may I get you to introduce yourselves and the organisations that you represent, starting with Dr Carole Easton, please?

Dr Easton: I am Carole Easton, chief executive of the Centre for Ageing Better.

Sir Muir Gray: I am Muir Gray, from the optimal ageing programme at Oxford. But I am not a civil servant; I am not an HM employee. I am an 81-year-old person who has been asked to come back in and lead a system development called Live Longer Better.

Dr Boulton: I am Lis Boulton, from the charity influencing division at Age UK.

Q39 **Danny Beales:** I thank our witnesses for being here today. We have already heard that many older people know that exercise is good for them. It is not that this is a foreign concept that is new information to most. But we know that few act on it, or act on it as much as they should. Beyond just telling people to exercise more, what effectively can we do to improve activity levels, in your view?

Dr Boulton: There are a lot of different influences on people and why they are physically active or not. I think it is quite useful to use health psychology in this space and look at the different levels of influence on older people. If we take a social-ecological model approach, you have the individual at the centre. There will be some people who don't see themselves as sporty, who don't believe they are capable of exercise. If you are using the language of exercise and physical activity, you will not be speaking to those people. So let's look at how we use our language to speak to them, and talk about movement, moving more and doing a little bit.

Then, around those individuals, you have social structures. Do you have people around you who are encouraging you to be active? Is somebody knocking on your door and calling for you to go out to an activity together? We also have the social element, which Chris Whitty spoke about. It needs to be fun and enjoyable, but fun and enjoyment is not the same for everybody. It might be really fun for you to go to an exercise class, have tea and coffee afterwards and meet some friends, but it also might be fun for you to go out for a walk on your own with the dogs. It has to be really personalised.

At organisational and policy levels, we can make engaging in physical activity as easy as possible for people. If we are putting on classes, let us have them near a bus stop and a car park. Let us also make sure that there is somebody welcoming them, or that there is somebody they can phone beforehand, so that there is a familiar face when they get there. Accessibility is not just about the physical environment, but about the social environment.

I used to work in local government, in Calderdale actually—small world. We noticed that if we left community groups on their own to run activities as older people for other older people, they were very vulnerable, because the older person running it might become ill or take on more caring responsibilities. We absolutely must have some paid support for those community organisations to make sure that they can run, and the structure to support people to be active sustainably.

Sir Muir Gray: Let me tell you a little bit about what we are doing in the Live Longer Better programme. First, I said to the Chair that we have discovered the elixir of life in Oxford—it is called knowledge, and it is acquired through learning. Everybody at retirement needs to be getting a learning programme about what is happening to them. Ageing is not the



problem; it is loss of fitness, preventable disease and social problems—ageism and deprivation.

People need to think that this is a radical new approach. It is you who are responsible for this. If you want to reach your 90s in good nick, then there are things you can do, one of which is exercise. Now, we have started a learning programme at retirement, and we would very much like you to get the DWP in here, so that every pension provider must become a knowledge provider. We have changed the word retirement to renaissance, so at the time of renaissance, you need a learning programme. I have not managed yet to get the NHS business authority or the civil service—every month they are communicating, but we are not using those opportunities. We need education at the time of retirement. We are also introducing a plan. We use AI, but we also use A4—very high tech. You need to make a plan. The NHS is there, but we are not the most important player.

Finally, to pick up the point that Mr George made, we are introducing, at neighbourhood level, digital prescribing. It is going to launch in Hertfordshire—

Danny Beales: We are going to come back to digital prescribing.

Sir Muir Gray: Okay. The elixir of life is knowledge consumed by learning. Exercise is a key message in there.

Q40 **Danny Beales:** That is helpful. Picking up on your point, Lis, about the importance of social interaction as driving activity, do you think there is a relationship between increasing rates of social isolation and people living alone, perhaps with less contact with family and friends, and increasing inactivity?

Dr Boulton: Absolutely. We run some annual research into older people's health and care at Age UK. We started it during the pandemic, and we are carrying on doing it every year now. We ask about how physically active people are, but we also ask about their health and decline or changes in health. We are still seeing that there are people who are still not going back out and doing the things that they were doing before covid. That might be because those activity sessions just did not start back up again, or because they are still worried or feel vulnerable. There is absolutely a link between isolation and inactivity. Then you get into this vicious cycle, because you are not using your muscles and don't have your fitness any more, so you get more reluctant about going out, joining in with activities and meeting other people, and you accelerate the decline.

Q41 **Danny Beales:** You stressed the value of talking about movement rather than exercise, but do you think the sector has moved in the opposite way? There has been a professionalism of exercise, if anything. The ways you can exercise are more and more professionalised; there are more gyms and more specialised exercise classes, but people's daily routines have become less active. People used to go to lunch clubs or social clubs to move, but now, for example, people can have their shopping delivered to



their home via an app. We have become much more focused on hyper-professionalised exercise.

Dr Easton: That really touches on the ageism agenda. The research we have done at the centre says that as many as 24% of people over 50 would self-limit. You say that people know “movement”, which is my favourite word, rather than exercise. We should encourage people to move, not to exercise. “Exercise” already has all sorts of connotations for people, particularly older people. We see that they are limiting themselves or that other people are limiting them, such as by saying, “Why are you doing that at your age?” “At your age”: think how often that phrase is used. There is a perception about gyms, as you say. I go to one myself—reluctantly, I have to say—and it is limiting even to people with some level of disability. Are we encouraging those people, as Sir Chris said, who are least likely to be able to move? Often the leisure industry has quite a way to go to encourage older people.

We have been running a campaign at the Centre for Ageing Better called “Age Without Limits” to start challenging some of those ageist assumptions that people have of themselves as well as those they experience from others. We limit ourselves by thinking, “What can I expect at my age?” That is still very strong in our culture.

The other huge barriers that Sir Chris touched on are environmental barriers, and poverty and deprivation. There are so many things we can do, as he touched on, to encourage transport. It is difficult for some people even to get in and out of their own front door, because so many of our homes are inaccessible. If you want to encourage physical activity in older people, you have to look in the round at how we are responding to an ageing population, the demands of that and the opportunities it offers.

Sir Muir Gray: Promoting walking is a simple approach. We have launched a campaign called Let’s Walk More, and we are aiming it at people who are in dangerous occupations—people like yourselves. We should regard the chair as something like radiation; we are not genetically designed to sit all the time. Perhaps as a Committee you could all make a commitment to do 30 minutes of brisk walking a day using the NHS Active 10 app. I wrote a book called “Dr Gray’s Walking Cure”, and I will send you all a copy with the evidence. I am a member of a gym myself—mostly for strength—but ageism is an issue. That is where we are looking at churches, mosques and other groups and thinking, how could we get groups of older people doing sponsored walking for the local primary school?

Again, as you have shown, the key thing is not to see older people as dependent but as contributing. I hope you all will now make a commitment to walk briskly for 30 minutes a day.

Chair: I am happy to, but I cannot speak for others.

Q42 **Danny Beales:** My question is on the role of public information campaigns. Lis mentioned the Take Five to Age Well campaign. What is



HOUSE OF COMMONS

your sense about the contribution they make and the opportunities to integrate them better in the health system?

Dr Boulton: Your question links really strongly with what we were saying before about gyms. Take Five to Age Well and the Act Now, Age Better campaign from Age UK are all about trying to educate people that it is not just about going to a gym; it is about movement and about small changes that you can make.

Take Five to Age Well is a health literacy project and programme. People get information about why making particular small changes in their lives can have a big impact. That is not just about physical activity; that is around nutrition, hydration and everything else related to healthy ageing. If we can give people bite-size information so they have the knowledge to make small, incremental changes, we move away from thinking, "I have to go to the gym." I also have a gym membership, and I also go for strength, but we know all this stuff and it is important to us. There are millions of people who are not going to be attracted by that.

Danny Beales: Was it the most inactive who made those changes, or was it the already active being a bit more active?

Dr Easton: Could I add something?

Chair: I am afraid that we need to move on to the following questions. We are straying across loads of people's questions.

Ben Coleman: I hope that you will get the chance to say everything you want to say.

Chair: I am sure she will.

Ben Coleman: To reassure you, I do not know whether you have spent any time in this citadel, but we all do thousands of steps. I do far more walking than I ever used to do before I was an MP—well over 6,000 a day.

Sir Muir Gray: Is it brisk walking?

Ben Coleman: Yes it is, because we have a lot of meetings, and we rush from A to B, so "Gray's Brisk Walking Guide"—I think we are doing that already.

Chair: Brisk questions—go on!

Q43 **Ben Coleman:** I am going to ask a question now; thank you, Chair—you see how briskly we are kept in order. A lot of interesting data has been shared with us. Age UK is running a health coaching programme. Can you tell us a bit more about that? I am particularly interested in the inequalities aspect, and why it was particularly beneficial for people in deprived areas.

Dr Boulton: Sure. This comes back to what I was saying at the beginning about the need for a personalised approach. The health coaching programme, which is commissioned and run by Age UK Norwich, looks at



people as a whole. It might be that somebody wants to be more physically active, but because this is delivered in the voluntary sector, and because the staff at Age UK have the skills and broader knowledge, they can start to ask about housing. "Why is it that you are not being physically active?" Well, they might live on the eighth floor and the lift only works up to the fifth floor, so they cannot get out. "Why can't you get the bus somewhere? Why can't you join a gym?" Well, they might be in a serious amount of debt.

The health coaching programme can look at broader things that impact people's health, but it can also provide opportunities to be physically active. If you are at a high risk of falls, it might bring you into a 12-week or 24-week falls prevention programme that is evidence-based and will reduce your risk of falls, or somebody can go with you to community activities where tai chi or something else is going on. The programme can do the assessment, but it can also do the delivery.

Q44 Ben Coleman: Some of what you are saying—lifts breaking down and so on—depends on other people: landlords, local authorities and so on. Do you work differently with them as well? Do they buy into your programme from the beginning?

Dr Boulton: Some of the health coaches are co-located in primary care, and they also work with different housing departments and housing associations. In one of the most successful locations, Citizens Advice was co-located with them as well. It is about making use of the voluntary sector and businesses. The problems that stop people being physically active are rarely just about the motivation to be active; all sorts of other things in people's lives impact their ability to be active.

Q45 Ben Coleman: If you were to recommend the programme elsewhere, what would you say are its particular benefits or outcomes?

Dr Boulton: If Dan Skipper was here—he is the chief executive—he would be able to answer that question much better than I can. They have seen huge differences in terms of people being able to get out and about in the community, in health service use and in quality of life. They did the EQ-5D quality of life scores and found massive changes. I put some stats in my written evidence, so if you don't mind, I will refer you back to that, because I don't have them in my head.

Sir Muir Gray: My panellists have led a cultural revolution. This is why we see the need to change the way people think. I will send you a copy of my book "Sod 70!" for your mum or dad. To hell with it! We are in our 70s, 80s and 90s—we have to do things. What we are hearing is that partly we need structural change in a national Government network, so that all Government Departments are working together, and we also need leadership from people like you to bring about this cultural revolution.

Q46 Ben Coleman: We need lots of people to come together. Locally, you have councils and the NHS working together on these things—in theory. We have community and voluntary organisations that can do extraordinary things, but they need to be commissioned often. They do not have that



HOUSE OF COMMONS

much money, particularly these days. What needs to happen to NHS commissioning to support the voluntary sector?

Dr Boulton: Absolutely. That is something that Dan was talking to me about this week. He was saying that we actually need a commissioning strategy for this kind of thing, full stop.

Q47 **Ben Coleman:** Carole, do you agree with that?

Dr Easton: I do. There is also an issue about commissioning in the longer term. A lot of commissioning is very short term with immediate outcomes, rather than longer term commitments so that organisations can have security of delivery over a long period of time.

Q48 **Ben Coleman:** When you say a long period, do you mean three years, one year or 30 years?

Dr Easton: I would prefer 10 or 15 years.

Ben Coleman: You'd be lucky.

Dr Easton: I know. There is another mechanism that I would like to refer to, which are the age-friendly communities. They are a partnership between local authorities, businesses and voluntary organisations to get the more joined-up approach, and to be able to get into the more deprived communities that you were talking about, because you are then talking to people from those communities about how best to respond to their lack of ability to move.

Q49 **Ben Coleman:** Where are the best ones that you are aware of?

Dr Easton: I won't tell you the best one. I have two or three examples of age-friendly communities that are not about movement programmes. For example, in Barnsley the age-friendly community has worked together to create Take a Seat, which, to come back to what Sir Chris was talking about, means that people can go out their front door and feel reassured about the distances they are going to have to move before they can sit down. There are some in your area as well.

Ben Coleman: Take a Seat?

Dr Easton: I will show you where they are. In Cardiff they have a local toilet strategy. The age-friendly communities have come together to make their communities more age friendly. This is not just about older people; it also benefits people with disabilities and people with families. This mechanism for addressing the fact that we have an ageing population in this country is growing, and, in my view, it needs more support from central Government.

Sir Muir Gray: I certainly agree with the strategic objectives of Live Longer Better, which range from mitigating the effects of deprivation to promoting activity. If we were in the Ministry of Defence, and the Committee agreed on one set of strategic objectives, and I circulated not more than 10, then what the military say is that the local operational commanders take into account history, geography and politics. We all feel



HOUSE OF COMMONS

that we need the leadership that could come from here. We are not getting it from any single Department. The NHS is important, but it is not the major player in all of this. If you imagine that you were going to war, we need strategic objectives that were owned by this Committee.

- Q50 **Ben Coleman:** This Committee, sadly, does not have the power to effect change, but it has the power to influence change. Carole, on that point, you have talked about a commissioner for older people and ageing—somebody who could drag things across Government. How do you see that working and what difference would it make in ensuring that local commissioners had the information they need to target resources to where they are needed most?

Dr Easton: As you say, we are very much in favour of the creation of the role of a commissioner for older people—and ageing. I think that is really important. We have an ageing population in this country. I would ideally like to see a Government mission on ageing population. It needs to be taken as seriously as climate change and other major challenges that we have as a society, because if we do not grab it sooner, it will get harder and harder to manage. I hope that the creation of a commissioner would mean that there would be a cross-Government mission to address ageing, of which physical movement or exercise is only a part—although a crucial part.

- Q51 **Ben Coleman:** Where would you put this commissioner? Would you put them in the Department or in the Cabinet Office?

Dr Easton: In the Cabinet Office, with a commitment across housing, health and the environment. As we have heard from Sir Chris Whitty, all these factors intersect to create better lives for our population as they get older, which will add to our growth. People will be able to work longer, so they will contribute to our economy. We will reduce the cost on health and social care services, so this is an economic benefit to our whole country, not just to older people today, but to everyone around this table, because everyone wants to age better. Everyone wants to be optimistic about their old age. At the moment I am worried we cannot offer that to our young people.

Ben Coleman: Thank you. I look forward to getting the book.

- Q52 **Jen Craft:** Health is not entirely up to the NHS to solve on its own, but how can ICBs—integrated care boards—create successful cross-sector partnerships with the voluntary and community sector to deliver these positive ageing communities?

Sir Muir Gray: Oliver Williamson won the Nobel prize for economics in 2009 and said that some problems are too complex for either bureaucracies or markets or both together. You need what he called a “complex adaptive system”. Elinor Ostrom was also a prize winner, but for managing pooled resources. So if we had the commissioner, the key thing is a single set of strategic objectives with clear criteria to measure. How do you measure increased activity or decreased deprivation?



HOUSE OF COMMONS

I have had 20 reorganisations of the NHS, most of which have made no difference at all. But if we had a set of strategic objectives and a population-based approach, the ICBs is one population. They are now talking about integrated health organisations, which I think is the old DGH and the catchment. People have referred to the same DGHs for the last 100 years, never mind since the NHS, and then there is the concept of neighbourhoods or smaller populations. It needs the commission approach that we have been talking about. Give them clear strategic objectives and ask them to produce an annual report against a defined set of criteria. How they do it—this is the military—is up to the local operational commanders. With ICBs, integrated health organisations and neighbourhoods, we need to get the objectives clear—not just NHS objectives, but whole population objectives.

Q53 Jen Craft: They have to take a wider approach to commissioning. So you are looking at bringing in the voluntary and community sector, and potentially even other Government Departments.

Sir Muir Gray: Ten per cent of all the drugs prescribed do no good. I am trying to change drug budgets to therapy budgets to let the GP shift money. At the moment they cannot shift any money. They are not motivated to make savings in the drug budget. "What is the point?", they say; "It goes into a black hole." But if they could shift it to an Age UK local initiative, we would start to see change happening.

Q54 Jen Craft: I probably know the answer to this already, but do voluntary and community organisations receive enough funding to do the vital role that they do?

Dr Boulton: Absolutely not, and that money is disappearing at a rate of knots. Public health budgets have been cut, so we receive less money. The better care fund locally is often used for very specific things. We are seeing Age UKs really struggling across the country. There are about 118 local Age UKs. They are all independent charities dependent on grant funding or contract funding. They are really struggling, yet they are faced with increasing demand from a population that is ageing and struggling.

Sir Muir Gray: Fifteen per cent of all NHS money does no good. In the other half of my life I run a thing called Better Value Healthcare.

Ben Coleman: If only you could identify which it was.

Chair: I know this rabbit hole; I think we can go down it another time.

Dr Easton: This was touched on before. Millions of people live in homes that are not safe for their health and wellbeing, so they are less likely to move to get exercise because they are suffering with damp or mould or whatever it is. If we invested money in homes, that would save money for the NHS. I am no expert on central Government, but is it beyond the wit of man or woman to sort out the fact that if we invest through homes, for example—in the control of one Department—we will save considerable money for Health and Social Care?



Chair: Our predecessor Committee did a report on exactly that just before the last election, so yes, absolutely.

Q55 **Jen Craft:** If we look at, say, VCS organisations that provide that vital social prescribing role—a GP might point someone in the direction of Age UK or, at a lower level, even to knitting groups and stuff, which can be really helpful social interactions—how do we make that sustainable? How do we make sure of that? Is it a case of the money following the person?

Dr Boulton: Absolutely. I would mandate GPs not to recruit social prescribers from within their own teams. I would have a voluntary sector organisation in there doing the social prescribing, because not only will they have the knowledge of what is available in the community, but they will not just be signposting. They will be able to say, “Right, we have these services. We can give you information and advice about your debts”, or whatever. “We have a falls prevention service”, or, “We have a walking football group.” We have that person already, rather than them just being given a leaflet and signposted out to somewhere which might not have the funding any more to deliver those services, because their budgets have been cut.

Sir Muir Gray: We also have the digital programme starting where, by the time the GP has typed “metf” for metformin, the technology—which has been approved and introduced—will be looking at the Age UK database, the Get Berkshire Active database and the Let’s Dance database, and it will produce an activity prescription even if the GP does not know anything about what is happening locally

Q56 **Jen Craft:** Is there concern about digital literacy and access?

Sir Muir Gray: Yes, but Age UK is doing great work on digital access.

Dr Boulton: Yes, absolutely. That is a massive concern for us. There will always be people who are digitally excluded. Even of those of us around the table now, at some point something could happen and we could lose our digital skills or the ability to pay our smartphone contract bill. We will never get everyone online, but I think it is an important item on the menu of how we engage with people and how we encourage people to be active and socially connected. It is never going to be the answer for everyone, but as Muir said, we are doing some good work across the country in teaching people digital skills, having the drop-in clinics and trying to make sure that it is not just about someone coming in to ask, “Can you do this for me?”, but about building those skills for the longer term, so that if they can, they can actually connect digitally.

Q57 **Jen Craft:** To tie this to some of our early years discussion on proportionate universality, is there something about how we target the hard-to-reach groups, such as people who already have existing health inequalities and live in deprived areas? I am also thinking of disabled people whose conditions might be exacerbated by the effects of age, or people who have a limited ability, potentially, to access their outdoor area or some of the activities that are provided by the voluntary and community centre. Is there a way to encourage people to take an



approach that targets those who are more at risk of not ageing well?

Sir Muir Gray: In my personal experience, we just have to give people knowledge. In the 12 years since my myocardial infarction, I have had 400 boxes of pills from the NHS, but not one word about diet or exercise. The first three months were terrific, when I was at the gym in Blackbird Leys and everything, but in the 12 years since, I have had letters about where to park my car or where to go for clinics and that sort of thing, but not one word on that. Knowledge does not solve everything, but at the moment what we are doing is hopeless. We need to provide a national knowledge service as well as a national health service.

Dr Boulton: In our latest polling of older people, or people aged over 50, 57% said that their GP had never spoken to them about physical activity. That is huge—quite a large number of people. Yes, I think education is absolutely key. That is one of the things that Take Five to Age Well does—it does it in bite-size amounts. There is also the Act Now, Age Better campaign of Age UK. This is all about giving people the information in a way that speaks to them. When you have someone in front of you, it is about making that conversation personalised: “What’s important to you?”, or, “How can we support you to move more, to help you sort out the things that stop that from happening?”

Q58 **Jen Craft:** Connecting into relevant community-based organisations will very much help with that conversation.

Dr Boulton: Yes.

Dr Easton: We cannot overstate who delivers the message and how either, and whether it is reaching those who most need it, as you say. There is also that partnership with local community organisations that know their communities and will literally be let in the front door if necessary. That is absolutely crucial.

Some of the big campaigns that I was going to mention before—you may have all seen the This Girl Can campaign, for example—had to do a real pivot because the message was not reaching the people who needed it most. What they learned from that is that any advice needs to mesh with people’s real lives and be delivered in a way that makes sense to people. That relationship with local communities, local deliverers and people who represent the communities that we are trying to reach is absolutely—we know that from other areas where we have tried.

We have just done some work on trying to give people advice about how to make their homes safe. Some minoritised groups do not trust the advice they are given by housing services, for example. They would trust one of their local community organisations more, so engaging with those is really important if we are trying to deliver messages to people and have them trust that.

Sir Muir Gray: We are planning a major strength campaign, particularly for women over 60. There are four aspects of fitness: strength, stamina, suppleness and skills. Strength has been the most ignored, but we are



HOUSE OF COMMONS

looking now at getting a set of weights in every church, every mosque, every bridge club and every bowls club. There are now weights that you can use with a little prompt programme on the phone—again, it is technology but there is always someone there who could do it—and we are starting to see different things. But you have to start off with the organisations that people trust. Certainly, when we looked at Wycombe, I think 11% of the population has type 2 diabetes. We have to relate to the mosques and the organisations reaching those communities. Again, that is where Age UK is so good because it is very sensitive to local cultures in that way and in a way that the NHS is not and probably never will be. We need to have much more sensitive organisations, such as Age UK, doing that.

Q59 **Chair:** That tees me up very nicely for my strength and balance questions, so thank you very much, and then I want to come back to the retirement pre-planning stuff. Carole, you created a report, “Raising the bar on strength and balance”—I see what you did there—that argues that there is disparity in commissioning and in approach to strength and balance programmes throughout England. I think, from what you just said, that it is more ignored. Why?

Dr Easton: Lis, did you write that report?

Dr Boulton: I did write that report, yes.

Dr Easton: Although, yes, it is the Centre for Ageing Better, it would be arrogant for me to speak on Lis’s behalf, so I will not do that.

Q60 **Chair:** Why do you think that is? Why is that part the most ignored?

Dr Boulton: For a start, it is quite resource-intensive to deliver those evidence-based strength and balance programmes. There is a lack of understanding about the gains that that investment will give you. The return on investment for delivering an evidence-based strength and balance programme such as Otago or FaME—that stands for falls management exercise—is huge. You are talking about up to a 125% return on investment because not only have you improved somebody’s physical capability—their strength and their balance—but you have given them the confidence back to get out there and get back involved in community life and to be connected and reduce social isolation. In the report, if you look at it online, there are some links to some videos with participant stories about just how transformational it has been for them to engage in those activities, which must be evidence-based. But it is expensive to commission that up front, and it is back to the issue that you, as the commissioning budget holder, might not be the one who sees the benefits of that. Those benefits will be in the hospitals because you will get people who are not being admitted.

Q61 **Chair:** We know people are working within a finite financial envelope. Are there other services that you think frankly aren’t good value for money? Do we need to start shifting money away from some things and towards this? If so, what would it be?

Sir Muir Gray: Prescribing.

Chair: Prescribing medicines—pills.

Dr Boulton: There are some NIHR research studies going on at the moment that are looking at reducing polypharmacy. I know we said that we were not going to fall into the trap of saying what you should decommission—

Sir Muir Gray: I am on seven pills a day, so I have nothing against cost-effective medication, but you have to look at the evidence. The Department of Health and Social Care's own evidence shows that 10% of all drugs do no good, and 20% of hospital admissions of older people involve a side effect in some way.

Dr Boulton: If, instead of paying for that prescription—paying for those drugs—you could create a pathway whereby you are using that money to pay for the evidence-based strength and balance programmes, that would be a good way of transferring that money, if it were technically possible.

Q62 **Chair:** I am sure the Committee will explore that very interesting thought further. Sir Muir, your sheet of A4 on pre-retirement planning—

Sir Muir Gray: Pre-renaissance planning.

Chair: Pre-renaissance planning—forgive me. Just talk us through the practicalities. How does that work? How would you see that working? Is it working somewhere?

Sir Muir Gray: At the moment, it is working in a very patchy way. I am going to see the NHS Retirement Fellowship on Monday, and the university fellowship in two weeks' time. They are all getting letters, and many of them are going to courses to do with the financial side. It is very, very important to give people help with financial planning. The Committee should see education and learning as a key issue. Now, not everyone is on a pension scheme, of course, but we give state pensions to people. We should see knowledge as a resource, like money, taking into account people's different language and learning abilities and the like.

The Committee should recommend learning as a key intervention for living longer better. There are agencies all over the place sending communications to people. We could use the pension industry, the insurance industry, and the networks that are there, including retired public servants. Trade unions have very good links, and Age UK has very good resources too. If we could get the lead from here about the need to give people knowledge and learning, taking into account all the other factors, of course, that would be very helpful.

Q63 **Chair:** Do you feel that the pension providers want us to live longer? The incentive for them, versus the risk-reward—

Sir Muir Gray: I tried to influence the actuaries and they said, "Muir, we don't really care. We just change the formula if the expectation changes."



HOUSE OF COMMONS

But I think the Government needs to bloody well tell them that this is their job.

Q64 **Chair:** Okay, so the point is that they will not do it themselves; they need influencing.

Sir Muir Gray: Yes.

Dr Easton: It is not just the pension providers—I will not comment on the question of whether they are incentivised or not. They certainly would be incentivised to make us live longer, better, because it would cost them less.

We run an age-friendly employer pledge, and we now have about 550 organisations signed up to that. We encourage mid-life MOTs—whatever language you want to use for that—which sometimes have a financial or a career focus, and they could incorporate health.

What is really important—again, this relates to the issue of joined-up government and delivery at a local level—is that one of the ways employers can enable their staff to move more is not gym provision but flexibility in the workplace. It is allowing people to say, “I can go between 3 and 4, because that is when it would be cheaper for me to get to the gym or go for a walk.” If we all go at the same time, it is not practical.

There are the associated things of greater flexibility in the workplace and encouraging employers. In the more affluent firms, you will be given free healthcare, free gym membership or whatever it is. That is all very well if you work for one of the big five, but the smaller companies will not be able to manage that. There are things that they can do.

Q65 **Chair:** Are there examples of specific employers that are doing this well and that are smaller companies?

Dr Easton: I can give you some, but I do not have them to hand.

Chair: I would be delighted to see them, so that we can understand more.

Sir Muir Gray: The front page of the business section of *The Sunday Times* had walking to reduce stress on it. I have never seen that in the business news before. So the message is getting through. Almost everything that we are doing for those in their 60s, 70s or 80s is equally relevant to those in their 20s, 30s or 40s.

For the Live Longer Better programme in Hertfordshire, we are involved with the DWP and with the nurses in hospital, because what is called sickness absence, with 7 million people getting antidepressants, requires new approaches, and not just more people going to the GP. The health service is not a wellbeing service; it is a disease service, which is very important. There are other things too, and the work that Carole has been doing with employers is of terrific importance. There is also a very quick return for employers in doing these things.

Q66 **Chair:** Has the work you have done in Hertfordshire been quantified?



HOUSE OF COMMONS

Where is the money flowing? Obviously, there is the issue that whoever is incentivised to spend the money does not always recoup it at the end. Have you been able to manage the flows?

Sir Muir Gray: What we are doing now—this is the other half of my life—is that we are reintroducing programme budgeting. In Somerset, for example, we are spending £68.4 million on respiratory disease. We then say to the respiratory community, “Ladies and gentlemen, you are responsible for this. Let’s think about respiratory rehabilitation and exercise.” The doctors, the physios and others will then rise to that.

We did away with programme budgeting in 2008. In Oxford, if you look at the annual accounts of the John Radcliffe, all you can see is that we spent £796,310,000 on staff. Whether those staff were dealing with cancer, respiratory or whatever, we haven’t a clue. Working with the healthcare finance managers, we are reintroducing programme budgeting, and you can then start to put in activities for every programme to find resources. The doctors will do that—they will know how to do it—but the present budget structure of primary and secondary doesn’t make that possible.

Q67 **Paulette Hamilton:** Good morning, all. Sir Muir and Dr Boulton, the 10-year plan talks about the Government’s plan to move from analogue to digital. For some reason, we seem to be moving to digital by default—we are going to get there in the end—but what does that mean for people who are trying to get physically active? How can we ensure that we use that digital front door to make sure that people become more active?

Sir Muir Gray: It is a fundamental issue. I believe that everyone aged 18 should be given an NHS contract that sets out their responsibilities, as well as their rights. In the work we are doing with the Live Longer Better campaign, we are working with the 42 neighbourhoods that are being launched. We are starting to call people partners, not patients. We in the NHS can do certain things and offer you certain things, but self-care and care by community are more important for living well with a long-term condition and for prevention. The NHS will diagnose acute care and start the right treatment.

I think it is about a cultural change. This may be beyond the role of this Committee, but I do not think it is. If you see what Age UK is doing in places, you realise that we need to think in a different way. Older people have a contribution to make and we should be looking to them. For example, on the age distribution of volunteers, the majority are probably over 60. The NHS needs to rethink its relationship with the people called patients.

Dr Boulton: Thinking about the app in particular, I have already outlined my concerns about digital exclusion, so I will not go over those again, but there are some really good examples of apps that are already out there and have been certified, and they are recommended through the NHS. The We Are Undefeatable campaign, which I hope you will have seen on TV screens, is aimed at people with long-term conditions, helping them to be more physically active to manage their condition. There is an app that you



HOUSE OF COMMONS

can now download from the App Store or Google Play. That is a person-centred way of encouraging people to be physically active.

Our concern at Age UK is that the NHS app, as the digital front door, is going to be doing a lot of heavy lifting. Would any physical activity support inside that app get lost? How do we make sure it is linked into other parts of the app, like appointments, reviews or medications? If it is just a discrete bit by itself, I can imagine that it could get a little bit lost.

Sir Muir Gray: The one we are launching—I am hopeless at these things, but I have very good people—will work with the NHS app. It has all been signed off. It is called WISH, and it would mean that by the time the GP had finished typing a drug or a diagnosis, it has looked at your postcode and the various databases, of which Age UK would be a key one, as well as health walks from the county council database, and Angela Rippon has put all her dance studios up. It is completely integrated with the NHS app. The NHS app could be better—there is no doubt about it—but it is a start. There are so many locum GPs, and they just do not have the local knowledge. If you could get more Age UK people in health centres, that would make a difference, but we have discussed that problem.

Q68 Paulette Hamilton: I am going to press a bit further, and I will bring Dr Easton in at this point. As you have said, there are issues with digital inclusion, but everything you guys have said is quite middle class and about people whose first language is English, and they can understand these things because they have very professional children or what have you. When you come from the heart of somewhere like Handsworth in Birmingham, lots of people's first language is not English, and lots of the people we are working with are not just digitally excluded: they are in a digital desert, so they cannot access any of what you guys are talking about. Explain to me how we can work with them.

In the area where I am an MP, between my street in Erdington and across the road, there is nearly a 10-year difference in life span because of many of the issues I have just highlighted, but people cannot access what you are talking about. What do you think we can do to help those people? Because of the time, I just want an example of some kind. Many of the people out there switch off when we talk, because they are nowhere near where we are at this moment in time.

Dr Easton: I cannot give you an example of health. I referred before to some work we have done recently on housing and the fact that people in very deprived areas and in minoritised groups are not trusting and not engaging with the information or the services that are theoretically available. The recommendations coming out of that report are about local engagement, working with local voluntary organisations, face-to-face contact and having people from communities involved in planning and funding decisions—there is a whole range. The movement is only one part of this bigger picture of communities who are isolated and marginalised.

Sir Chris Whitty touched on the fact that if we can focus investment in those areas more, the return can be even greater. If we just go in and



say, "You need to move more," the response will be, "Well, whoopee. I'm working from 9 o'clock in the morning till 9 o'clock at night, and then I've got to feed the kids." It has to be in the context of people's real lives. As you say, relying on digital will work for some people—they love it—but we know that movement is a social thing, too, so it is also about engaging with people and investing in those particular places, and in partnership. That is the real thing, because otherwise it is imposed and not trusted.

Dr Boulton: I can give you an example from the Take Five to Age Well campaign that Age UK has been developing with the Open University. We use a community champion approach, so that we can get into those communities that are not engaging with health literacy or public health information. The learning disability community came up with this phrase a few decades ago: "Nothing about us without us." That is how we need to go about this. We need to involve the target populations in developing any interventions, any tech and any app. Let's not do things to people; let's develop interventions with people. That way, you will get that greater engagement.

Sir Muir Gray: In my view, the NHS should recognise that it is a national disease service. We have got to get it right for diagnosis, acute care and starting the right treatment. We do run some preventive services, such as screening—I have set up screening and immunisation programmes—but for prevention, and for people living longer better, the NHS is not the main player.

For living longer with long-term conditions—remember, that is 60% of 60-year-olds and 70% of 70-year-olds and so on—we have to think in a different way. That is where it is about looking at the population and the neighbourhood. It is a good move that we are now saying in the NHS, "Don't just think about joint committees; look at the neighbourhood and understand and listen to the neighbourhood." If we can reduce the waste of time of people like me using the NHS, by communicating better with them, it leaves the clinicians with more time to communicate with the people who need face-to-face communication.

Paulette Hamilton: That is a good place to end. Thank you .

Q69 **Ben Coleman:** This is a really interesting session and I appreciate everything you have said. To come back to the importance of national Government giving a steer, and what happens at local level, it occurs to me that you are very effective proselytisers. Again, I am looking forward to reading the book. Have you considered sitting down, for example, with the health and wellbeing board chairs network in London, which meets regularly under the auspices of London Councils? They discuss different issues regularly, and I am sure they would be interested if you wanted to go along, Sir Muir, and make a presentation to them. They are the people who are leading the public health work, so it might be interesting. The same is true in Manchester and other parts of the country where they have those groups.



HOUSE OF COMMONS

Sir Muir Gray: Manchester is terrifically well organised. I will finish my contribution with a point about national level. I have probably spoken too much, as usual. The Japanese would ask each permanent secretary to identify two young people in the Department—the leaders of 2035 or 2045. Those two young people would still carry on in the Department three days a week, but they would join two other young people from the Department for Work and Pensions, the Ministry of Defence and every Government Department. That would be set up as a network. The Japanese call it a hypertext organisation. It floats beside the bureaucracies.

From this work, we could have something more joined up. There is no point in just the perm secs meeting once every three months. They have got to get a team. The Japanese say, "In the west, you do things like a relay race: the top of the office gives the baton to the middle, who give it to the front. We do things like a rugby team: we get people together." That maybe something, Chair, that we could recommend when we need something for population ageing. You would obviously then get really well-informed people to join that team. You get a team of departmental people with the next generation of leaders and get them involved.

Q70 **Chair:** We have two minutes left, so I am going to allow you to be Prime Minister for 30 seconds. You are allowed to make one change—what would it be?

Dr Easton: A commissioner for older people and ageing, with a cross-cutting national strategy to address the opportunities and challenges facing an ageing population in this country.

Sir Muir Gray: I would give everyone from 60 up—those in their 70s, 80s, 90s as well, because we didn't do it 30 years ago—the opportunity to learn how they can make an even bigger contribution to society and to their own wellbeing, and introduce a learning opportunity for everyone.

Dr Boulton: I would mandate voluntary sector involvement in primary care.

Chair: Very interesting. Thank you all so much for your contributions today, and thank you Members.