

Health and Social Care Committee

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

Wednesday 12 November 2025

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Watch the meeting

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

Questions 71 - 154

Witnesses

I: Adam Blaze, Chief Executive, Activity Alliance; Professor Martin Green OBE, Chief Executive, Care England; and Emma Hutchins, Physical Activity and Health Influencing Manager, Richmond Group of Charities.

II: Professor Elizabeth Orton, Professor of Public Health, University of Nottingham; Professor Dawn Skelton, Professor of Ageing and Health, Glasgow Caledonian University; and Professor Chris Todd, Deputy Director, NIHR Policy Research Unit in Healthy Ageing.

Examination of witnesses

Witnesses: Adam Blaze, Professor Martin Green and Emma Hutchins.

Q71 Chair: Welcome to this second session of the Health and Social Care Committee's inquiry into physical activity and its role in ageing well, and thank you very much to this panel for being with us. Can I start by asking you to please introduce yourselves and tell us what your organisations do?

Adam Blaze: Thank you. I am chief executive of the Activity Alliance; we are the leading national organisation working with and for disabled people in sport and physical activity.

Emma Hutchins: I am the senior influencing manager for the Richmond Group, a coalition of 15 health and care charities. I work on our Sport England-funded programme that supports physical activity for people with long-term conditions.

Professor Green: I am the chief executive of Care England, a representative body for care providers, which includes services for older people, people with learning disabilities and people with autism. There are also some brain injury units and mental health services in our membership.

Q72 Chair: Thank you very much for being with us again. We have been doing this work in the hope that we might all learn something about how we can better age well. Today we are focusing on people who are older, possibly with comorbidities and multimorbidity. The evidence that we have heard is that it is never too late, but for many there is a significant barrier to starting any exercise. So I will start by asking what barriers you see in your work that prevent older people and those with multimorbidities from taking on new physical exercise?

Adam Blaze: There are a significant number of barriers facing older disabled people who try to access opportunities for sport and physical activity. Some are infrastructure or environmental barriers; for instance, the transport system may be inaccessible, so that getting to and from activities is really difficult.

One of the key things that stops people getting active is that the programmes are not designed in the right way for the people who need to access them. Disabled people, and particularly older disabled people, are not actually involved in the design of programmes; well, to say they are never involved is incorrect, but they are not involved enough to help the providers understand what services people want and how they want them delivered. A key thing in our work is to create opportunities that are designed and delivered in the way that people want, as opposed to sport and activity being something that is done to them.

Professor Green: I am particularly interested in people who are in the health and care system. There is a lot of ageism, particularly when people



HOUSE OF COMMONS

are older and receiving social care; there is an expectation that they cannot do anything, and they are often not given opportunities to engage in physical activity. But there is very clear evidence that it does make a difference, not only to people's physical health but also to their mental health and wellbeing.

There are some systemic issues. For example, we do not prescribe for prevention in this country. What we tend to do is prescribe when people have a comorbidity, and we prescribe in silos. So people who have comorbidities often find themselves on high drug regimes, and that then also mitigates against their being able to take exercise.

There is also an issue about risk; we are a regulated sector, and often people think that if they engage in physical activity there is a risk of harm. Nobody takes into account the risk of harm from not doing activities, from having a sedentary lifestyle, or from not tending to your wellbeing. So there are some systemic issues that we need to address, particularly in the care sector.

We also need to make sure that different programmes are linked together. For example, there is the Enhanced Healthcare in Care Homes programme. I want to see that not only dealing with issues related to comorbidities, but progressing into the next phase, which is about preventive strategies. Rather than always focusing on mitigating health conditions, let us start thinking about how we can use physical activity to make sure people do not go into the next level of dependency.

Q73 Chair: Thank you. That was very much the focus of our first session. In fact, what you are saying is echoed by PHE, which says that, "Physical activity is as good or better than treatment with drugs for many conditions." Sir Muir Gray went as far as to say that we prescribe too much, and in fact that might be where the money comes from. Would you agree with that?

Professor Green: I would absolutely agree. We also need to remind ourselves that we want to prescribe as little as possible. To be clear, there is a need for some prescribing but, for example, a lot of people who might have sedentary lifestyles are still prescribed lots of things like blood pressure lowering drugs. So when they get up, they then fall. We need to recognise that in an exercise programme, which is highly preventive and very positive for people, there needs to be a read across from other parts of the system.

If we can reduce prescribing and introduce physical activity, there will be beneficial outcomes for the individual, but there will also be beneficial outcomes for the system, and that could be about reducing the prescribing bill. Hopefully, we could then redirect resources into a much more preventive approach where we use exercise to improve people's ability to live their lives, but also to improve their health and wellbeing.

Q74 Chair: Do we need to be looking at the NICE guidelines?



HOUSE OF COMMONS

Professor Green: Yes, and we need to look at programmes like Enhanced Healthcare in Care Homes. We need to do a horizon scan of everything that we are doing in relation to older people's health and wellbeing, make sure it is all co-ordinated, and identify the areas where there is potential to save money if we redirect resources to preventive rather than to more acute strategies.

Q75 **Chair:** Emma, you have spoken about the empathy gap, which speaks to something that was just mentioned. Do you want to tell us more about the work you have done?

Emma Hutchins: We published a public consultation last year that identified an empathy gap, as we term it. During the consultation, we spoke to people with long-term conditions and the people who support them: health professionals, professionals in sport and physical activity, and those with Government roles. What we found was that for people with long-term conditions, the biggest barriers tend to be around capability and condition-specific issues such as experiencing pain, fatigue or tiredness, fear of making a condition worse, and the unpredictability of having a long-term condition.

When the same question was asked of health professionals or sports professionals, they had a different perception of the barriers. Health professionals tended to think the barriers were more around mindset or motivation, and sports professionals mainly reported cost, location and access. That might be because this is what those professionals see in their work, but that fundamental difference between how the barriers are perceived sets us up for how we then design some solutions. This speaks to Adam's earlier point about designing services with people who have long-term conditions and lived experience, so that the barriers that are being tackled are the real barriers.

That is not to say that other barriers do not apply as well for older people or those with long-term conditions; they stack up. The more barriers you are facing, the harder it is to overcome them with a single intervention.

Q76 **Chair:** Do we need support and training in order to overcome this? What do you suggest?

Emma Hutchins: We would support more work around health professionals. For example, there are up to 100 NICE guidelines that include references to physical activity, either through treatment pathways or ways to manage conditions. The issue is that there is a lack of awareness that those guidelines are out there, and that physical activity is a part of routine care. There is a huge opportunity, especially with the upcoming workforce plan, to be thinking about the skills that health professionals in all kinds of roles need to be working with people so that they are providing personalised care and supporting people to move more in ways that work for them.

Q77 **Chair:** Turning to the issue of benefits, obviously we want people in



midlife to do more; that came out loud and clear from our first session. I should be starting my weight programme now, if I have not already, as I am in my 40s. But Adam, you have done some work that shows that many people who are on benefits worry that if they start this it is going to impact them financially. Can you tell us more about that, please?

Adam Blaze: We have completed some research and have ongoing work that absolutely demonstrates that the benefits system is preventing people from being active. With the welfare reform work that Minister Timms is doing, this is a great time to really think about physical activity for people on benefits. Getting active should be supported through that process, not punished. At the moment we have people who have had their benefits reduced because they have been seen to be active, so that is a challenge in itself, but there is also the perception issue. People on benefits often want to get active but do not because they are significantly worried that if they are seen to be active, they will be punished and lose some of their benefit income.

We also know that people rely heavily on benefits to get active. So when there is a reduction in benefits, or a concern that those things are going to be taken away, people stop being active and are then in a spiral that they do not want to get into. All the extra benefits that come through being active—reducing loneliness, reducing isolation, potentially getting into work—disappear. So we really need to think about how we can positively look at the role that physical activity can play within the benefit system and not use it to punish people.

Q78 **Chair:** Can I ask you to be slightly more specific? Which part of the process is punitive, and what should change to reverse that trend?

Adam Blaze: One example is the PIP assessment: people are judged on whether they can walk a certain distance or do a certain activity. So you might absolutely be able to get active and ride a horse, for example, but still not be able to feed and dress yourself. If you are seen to be able to ride a horse, a judgment might be made that you do not need financial support for other parts of your life, or that your support can be reduced.

The PIP assessment and the way that works—the points-based system, the gathering of evidence—and the ways in which it is being reformed, is definitely something that needs to be looked at. We do not want the PIP assessment to negatively affect people's ability to be active.

Q79 **Chair:** I will now turn to social prescribing and how that works. If we can continue with you, Adam, how do you feel that social prescribing is currently working, and could it be made better?

Adam Blaze: One of the things we need to look at to improve social prescribing is inclusive, adapted activities. What can people actually be prescribed to do, and how well are those things set up so that people can access them? There is significant evidence of solutions out there and of programmes that people can go on to, but we have to prescribe things that are inclusive and accessible and that people can actually access.



HOUSE OF COMMONS

There is a real need to look at that system and make things better, and to understand that social prescribing into physical activity is a good thing. Not everyone understands that, even though the benefits are there for us to see. The evidence shows that social prescribing of activity can really help, particularly with an ageing population. We need that population to be active, healthy and part of the community. So it is really important that we start to think about the inclusive and accessible nature of what is being prescribed.

Q80 Chair: We heard some examples in the first session, but are there examples of good practice around the country that we could look at?

Adam Blaze: Yes, there are solutions to most of the existing problems. The issue is that they are not understood or known about or delivered at scale.

Before we came into the room, we were talking about an example that I have seen of a programme being delivered in supported housing where older people are potentially living on their own. They have a social breakout area, and an activity is delivered once a week. It was the most competitive sport I have seen all year; 75 to 85-year-old women—there was only one man—playing a version of cornhole where you throw beanbags into the target. They were all shouting and cheering. It was not just about the physical activity, although they were being active, and there were walking frames and sticks all around. It was about reducing social isolation; it was about the feeling of community and a sense of belonging to that community. Accessing that service once or twice a week is making a big difference to their lives. So there are solutions out there, and there are things that can be seen to work.

Q81 Chair: Where does the money for that particular programme come from?

Adam Blaze: It is public money provided through Sport England, the arm's length body of DCMS. But there is a lack of investment and money to deliver things like this, and a lack of join-up. How does money from the sports system influence the money that is being spent in the health sector or the NHS, and how do we take the things that we know work and deliver them at scale?

Chair: Emma, I saw you nodding furiously.

Emma Hutchins: I agree with what Adam said. I would just add around the role of the voluntary sector that social prescribing, when it is working well, is really about what matters to the person sitting in front of the professional. It can be inclusive and it can be adaptive, but the offer has to be there for people to be able to pick up those opportunities. Many of those opportunities are delivered by the voluntary sector, which is where I am nodding along because there are a lot of similar issues for the sustainability of funding for initiatives in the voluntary sector, as well as in terms of the design of these services when the voluntary sector is brought in. It is vital to put lived experience at the heart of provision; the join-up between care and physical activity needs to feel frictionless and



seamless. At the moment, there are barriers to how different sectors work together on things such as data sharing. For example, a health professional can say there is a great walking group, but there is not necessarily a system where that professional can refer directly into a walking group or one of the activities that Adam described.

There definitely is good practice out there. An example of where the ARRS roles have been used really well is Leamington Primary Care Network. They run lifestyle clinics where different primary care professionals do group consultations on things such as nutrition and mental wellbeing, including physical activity. That is a really good example of where different roles are coming together and are able to provide the activities as well.

But we want to see barriers addressed more broadly across the integration of the voluntary sector and health services, and that can really enable more social prescribing and the opportunities that Adam described.

Q82 Chair: Martin, I know you have a frustration in your sector. Would you care to tell us about it?

Professor Green: One of the problems is that—particularly if you are in the social care sector—people seem to abandon you on things like prevention. Emma and Adam have given some great examples of these initiatives, and there is no reason why people who are living in care homes could not engage, but I have yet to see a proper approach to social prescribing within care services. That is something we need to do.

Also, if you look at care services, often they have public areas where you could develop really great things. You could bring in the community, which would reduce isolation and engage people from the local community with people who live in the care home. Care homes are at the centre of communities, but there is a real problem with how the NHS, in particular, supports people in care homes. There is an expectation that when you go into a care home, you have so many comorbidities that you will not be accessing a lot of the things that you should be accessing. There is very little focus on things such as the personal health budget. I would really like to see that used for the activities that both Adam and Emma have talked about, and I would like to see it used for people in care services. This would be a way of shifting the dial and making it about wellbeing as well as prevention.

If we look at the NHS plan, we are talking about things such as neighbourhoods, we are talking about being proactive and preventive; we need the system to understand that this is not just words on paper. They need to start thinking about how they engage, and they need to change how they engage so that they are much more inclusive. We will then start to see the benefits of a prevention strategy, rather than always focusing on when things go wrong.



Q83 **Chair:** On the personal health budget, why is that not happening already?

Professor Green: Very few people understand personal health budgets. People are not told about them. I have never had a professional say to me, "You have a personal health budget, and this is how you use it." A similar thing is happening right across the system. It was a good idea, but the implementation and delivery has not followed through.

I also think we need to get much better on how we use data. For example, if we have personal health budgets, why are we not seeing the data on the number of people using them? Why are we not seeing anecdotes that prove the benefits of this approach? We need data, we need the system to understand what these newish initiatives are about, and then we need a really clear communication strategy that reminds people that this is for everybody. There are no exclusions around this. Just because you are in a care service does not mean that you cannot access some initiatives that could really help improve your quality of life and your comorbidities.

Q84 **Chair:** My grandma went into a home this week, and we rallied around her as a family as best we could to make her feel safe. I completely agree that no one spoke to us at all about how we could help her manage that transition, which strikes me as something that would have been so obvious for us to have learned about. But who would have had that conversation with us? It is a moment when families come together, but whose job should it be to tell us this information?

Professor Green: The answer is that it should be everybody's job. For example, the care provider should be talking about this, and as a result of these conversations I am going to go back to my office and make sure that we are much clearer about things that people need to be communicating. The issue should also have been dealt with by your grandmother's GP. He or she might have said to you, "Look, there are some options here."

There is also a need when people are doing assessments. For example, in your grandmother's move to a care home, assessments will have been done throughout the system: primary care assessments, assessments in the care home, and perhaps if she is coming out of a hospital, assessments around discharge. This is an element that should be taken into account in those assessments, and sadly, I do not think it is. What happens is that you tend to go down the route of assessments that are all about what people cannot do. We also need to shift the dial on assessments; they should be about enabling people to do the things they can do, and then to mitigate the challenges they have when they cannot do things.

Adam, I thought your example of somebody who might have a big issue with walking but who can still ride a horse was really great. The amount of wellbeing and activity that you get from riding a horse is phenomenal.



But for many people, that would be seen as, “You couldn’t possibly do that because you can’t walk more than X number of yards.” So I would say we need to be much more open and much more positive in our focus on assessments.

Q85 Alex McIntyre: Emma, are there opportunities for us to use technology to support and motivate older people with long-term health conditions to be more active? How can we make sure that the drive to digital does not leave older communities behind?

Emma Hutchins: Two digital opportunities spring to mind as examples. Our We Are Undefeatable campaign has launched an app this year. It offers free, tailored, customisable workouts that people with long-term conditions can do at home. It has been in the wild for about six months, and we are undergoing an evaluation so that we can really understand who it is reaching and how, but the testing has shown that it is resonating with older people. The majority of users are older people, and we are reaching into the least active. The app is able to provide support for people who might not be able or might not want to get active in other ways. What is important is that it is not just an app, it is tapping into the wider We Are Undefeatable brand that we have built, which uses the power of storytelling to resonate with people with long-term conditions so that they see people like themselves being active. We have learned about the behaviour change journey as well, and how important it is not just to think about going from doing nothing to doing 30 minutes, but to go from not thinking about being active to thinking about being active. That is already a really valuable step.

There is also learning around being person-centred and putting the individual at the heart of a response. The app asks people how they are feeling that day, whether they are feeling any limitations, or if they feel like moving in a particular way. That person-centred approach is really valuable throughout. So when we look at digital solutions, they still need to channel the principles that apply across all kinds of good health and care.

Another example is the Diagnosis Connect initiative that was announced earlier this year. This is a great opportunity to connect the voluntary sector support offer with the healthcare system in a really systematic way, and an example of what I spoke about previously of linking with the voluntary sector in service design. The Richmond Group is working on that with DHSC and NHS England, and we are really pleased to be playing a part in bringing it to life.

But when it comes to physical activity specifically, we need to think about how we use that at the point of diagnosis, whether through support that is available for people diagnosed with a health condition, or through thinking about how we in the health and physical activity sector diagnose inactivity and provide some form of self-management. Again, that points to some challenges around data collection and recording how we understand levels of activity, plus the role of health professionals and



how comfortable they would feel supporting users or signposting people to the right kinds of support. So those are two examples of the digital opportunities that we have at the moment.

In the previous session, Lis from Age UK spoke about digital exclusion and how we need to be really mindful that app-based solutions, or any digital solution, is just one choice among many. There will still be people who do not want to use them or who cannot use them, and we need to make sure that we are not channelling everyone towards a digital solution that is not right.

- Q86 **Alex McIntyre:** Building on that, what do you think the Department could learn from We Are Undeatable when it is developing its NHS app or other technological interventions to ensure that they are as relevant and appealing as possible to older people?

Emma Hutchins: Those learnings I described really apply: being person-centred and putting lived experience at the heart of things. People do not want to feel like they have been told what to do. We need to tap into people's motivations, and I will say a little more about what those motivations are.

We find that for people with long-term conditions, some primary perceived benefits are around improving mood and mental wellbeing, helping to manage a condition and the symptoms associated with it, and increasing energy levels. Those are the headlines, but it is also about what those things enable. Maybe you want to improve your mood so that you are able to socialise more; maybe you want to manage your condition and its symptoms towards a goal, such as walking your daughter down the aisle. It is about tapping into those benefits, and to do that, as we have said, you need to recognise the insights that come from lived experience as part of gathering evidence and producing solutions.

- Q87 **Alex McIntyre:** Adam, what do you think the opportunities would be to expand access to physical activity for older people through personal health budgets?

Adam Blaze: It is about building on what Professor Green said earlier: helping people understand that it is an option and legitimising that spend. If people are never told that this is something they can do, we are never going to get to the point where we can age healthily. Sport and physical activity are really key for us to have an older but healthier nation.

"Sport" can be a bit of a challenging word. There is a perception of what sport is, but we are just talking about helping people to get physically active. If you have a personal health budget and you can use it for that type of thing, and if services are designed and developed in the right way, that is going to help us with the end point of a healthier, active, older nation, because we know we are becoming an older nation. But if at every turn you are not being given that advice and you do not know it is an option, you are moving further and further away from having the



HOUSE OF COMMONS

opportunity to get active. The real challenge, as was mentioned earlier, is in linking together systems, structures and sectors. I had never met Martin until today, but we have a lot of solutions for all the organisations, associations and places he is working with. The system needs to help bring people together, and then we can help health professionals to understand the offers and how they can be promoted.

The disabled people we work with tell us that health professionals are the people they trust the most. They are not going to go to anyone in sport, or from a sports club or physical activity, to get advice, but if a health professional, whether that is their physio, their prosthetist or anyone they touch on in the health world, recommends something and tells them it is a good thing to do, they are much more likely to do it.

Q88 Alex McIntyre: What is the barrier preventing health professionals from doing that at the moment? Is it a lack of understanding?

Adam Blaze: There is a lack of understanding of the role of sport and activity within their training, within the things that they can offer. But coming back to your earlier point, Layla, the solutions are there. For instance, occupational therapists tend to operate in a cold, medical environment; we work with an organisation called Sport for Confidence, whose occupational therapists deliver their therapy in a sports or leisure setting. They have moved away from medical settings; they are helping people get active almost straightaway to build that habit. As health professionals, they have understood the benefits, they have had the training, they have seen the evidence. So there is definitely something about training and supporting the workforce to help them understand the benefit of sport and activity and what can be achieved.

Much more intelligent and greater people than me have said that activity is better than prescribing drugs, and we know that is true. But how can we know that and still be in a position where we are prescribing drugs and the solution has not been to get people active?

Q89 Gregory Stafford: Professor Green, outside hospitals, how well understood are the risks of deconditioning for older people living at home or in a care setting? How can awareness of deconditioning be improved among older people and those who care for them?

Professor Green: There is a real problem, as the system does not understand the impact of deconditioning, and neither do individuals. There are countless examples of people who have a critical incident, go to hospital and find themselves in bed without any physical activity for a significant amount of time. They then get discharged to a care home. The basis of the discharge is the fact that they have no ability to do this, that or the other, or they cannot walk; but that is partly because the system has put them in that position. Instead of talking about what they cannot do, we need to be thinking about how we can retain what they can do and improve things.



It also goes to something that Emma and Adam mentioned: giving people some understanding of what their goal is and what they want to do. Sometimes it is quite small scale, but if you can actually help them do that, it raises their sights to do other things.

The whole issue of deconditioning is not well understood at all. The system only sees it in terms of what it is rather than how you prevent it and then how you reverse it. There are many times you can reverse it, but unless we are really clear that we have a strategy on how to reverse it, what happens is that it becomes part of people's decline.

The other problem we have in our system is that it is riven with ageism; our expectations of older people are so low. If you are an older person, you might have four or five health conditions, you might need care and support, but people then start to think that you have no aspirations or no potential to do other things; people do not engage with you in the way they would engage with you if you were 30 or 40. There is a lot of talk with younger people who have had major traumas and whose physical needs have changed about what they want to do, what things in life they want to achieve, what their goals are. Very seldom does that conversation happen when you are 80. We need to recognise that there is a systemic issue around ageism, not only in our health and care system but in our society, and that impacts on how people engage.

Q90 Gregory Stafford: You talked about people who had been taken into hospital and were then discharged into a care setting. I wonder if you have any further thoughts on those people who have not necessarily entered the acute system but are simply at home. Do you think that local authorities have a role to play when they are dealing with a social care setting at home or in a care home? How well is deconditioning understood within local authorities, and what can we do to improve that understanding?

Professor Green: It is not well understood. Part of our problem is that the system does not kick into gear until something awful happens. We do not have a prevention approach; we have a dealing with a crisis approach. What we need to do is get people in every bit of the system, whether it is the local authority or care providers—it might be the NHS—to start thinking about how we downstream stuff.

For example, someone living in their own home and not accessing any social care might be getting more and more isolated and disconnected. Many issues are based on fear. People think, "Oh, it's a bit cold this morning, I'm not going to go out for fear I might fall," or, "I'm not going to start this particular group because I'm frightened it might be dark when I'm coming home." That links to something Adam said about the whole system, including things like transport, and how we engage with people to live well within their communities.

What we need to do is to get this issue of deconditioning on everyone's agenda. It needs to be part of community prevention approaches. We



also need to be able to identify people who might be in danger of these things happening; GPs have a vital role through their registers. There are links to isolated people. For example, if you have a bereavement, what does that do to your social connectivity? If you were the person who never drove the car and suddenly the person who drives the car is not there anymore, then you have an issue: do you drive the car, and feel frightened? Do you then decide that you will not bother to go out? We need to identify the triggers we have data on and then think about how we can make targeted interventions to stop people going into this deconditioning cycle.

Q91 Gregory Stafford: Who do you see delivering those interventions? You have mentioned GPs. Is it a whole-system approach, or do you think there should be designated people looking at this within, say, local authorities?

Professor Green: It has to be a whole-system approach. As Emma said, we need to engage the voluntary sector within communities. There are parts of the system that have resources available, so I would expect GPs to be thinking about this. I would expect navigators in GP surgeries, who know what is available in social prescribing, to be making sure that information is readily available. Local authorities all have wonderful ways of communicating with residents: monthly newsletters and endless emails. Even an email saying, "You haven't paid your council tax" might also include some information about a range of other things. So I just think we need to connect up the system.

Emma made the point that there are silos everywhere. It is about connectivity, and to Adam's point, we are in a sector where we have mutual things we can do together, but we have never met before. We just have to create the opportunities for people to start thinking creatively, and to create a map of where people are in communities so that we can connect with each other.

Q92 Gregory Stafford: I have to say, if you guys cannot talk to one another, what hope do we have for the whole system? As far as I understand it, there are several best practice models for supporting health professionals to embed physical activity in routine healthcare. What difference would similar standards make in social care, and how would we go about doing that?

Professor Green: It would make a huge difference. One of the challenges is that we spend a lot of money doing training and development in the NHS, but that area is very neglected in social care. We need to see social care professionals as very important in enabling people to live better lives. Part of that is about training and supporting them to have those conversations with people—those encouraging conversations that might say, "If you really want to do that, let's work together to make sure you can, whether it's walking your daughter down the aisle, going to the theatre or whatever it is that really motivates you to have a good life. Let's work with everybody to get to that end."



HOUSE OF COMMONS

Unfortunately, one of the problems is that there is no systemic approach to training and development in social care. The NHS has a training budget of £100,000 a minute, but that budget is not available to social care, yet we are constantly being told that this is an integrated system. It seems to be integrated in the rhetoric but not in the reality of the practice. Let us bridge that gap.

Chair: Hear, hear!

Q93 **Gregory Stafford:** That slightly leads me on to my next question. What, if anything, does the Department of Health and Social Care need to do to ensure that people receiving social care also have access to evidence-based physical activity interventions?

A slightly leading question here: would you also like to see physical activity embedded in the Casey Commission on Adult Social Care?

Professor Green: Yes, I would love to see it embedded in the Casey Commission. The commission has a real opportunity not just to talk about how we tinker around the edges of funding, but to start shifting the paradigm and create a new vision for what health and social care can do to enable people to live well.

I hope the Casey Commission will be extremely broad, and I want Baroness Casey to deliver a vision for social care, but it needs to be a vision that is absolutely co-produced with people. People know what they want, and they know what their vision is. We also need to have a vision that downstreams support so that it prevents people from going into crisis. I really hope the Casey Commission will be broad, will create that vision, and will think about how the system works together. As well as what needs to be commissioned, I hope it will also say something about what needs to be decommissioned because it is no longer fit for purpose in the 21st century.

In terms of the role of the Department of Health and Social Care and local authorities, they need to have this on their agenda as a priority, and they need to think about how they measure its impact. One of the challenges, particularly around prevention, is that it is very difficult—at least, people think it is difficult—to measure the impact. But we need to think about qualitative measures, which are the measures that individuals say are important to them. We need to enshrine those at the absolute centre of what might be our measures of success within the system.

Then there will be some other hard measures that will really show us that we are delivering, so when we have this prevention and wellbeing approaches, we will see a reduction in the number of hospital admissions and people going into care and support services later in their lives. We will see people who are able to use physical activity not only to be more physically active but also to live better lives.

Q94 **Gregory Stafford:** I apologise for directing my questions only to Professor Green; Mr Blaze and Ms Hutchins, do you have anything to add



on those points?

Adam Blaze: When you are talking about the role of the Department and the role of major reports, the key thing for me is that physical activity is seen as a solution, not an add-on that is put in later. It has to be at the heart of what we are trying to do. If we are trying to design a healthier society, a healthier community, and to move away from the medicalisation of everything, let us think about that from the very beginning.

One of the biggest challenges we face when we try to engage with other sectors is that we are always trying to retrofit or fix something that was not thought about at the very beginning. We need to take the point that was made earlier, that physical activity is as good as, or in some cases better than, prescribing drugs, and we need to embed that in the strategies and solutions that are being put in.

Emma Hutchins: I would just add the example of Moving Social Work, which is a programme of training and education for the social work profession. It is co-produced with disabled people, people with health conditions, professionals and academics at Durham University; I would just like to flag that as example of where this is happening. Obviously, it is just one initiative, and it is not everywhere, but things like that are really promising for how they can offer people the personalised support they need through social work.

Gregory Stafford: Thank you. Having practical examples is very helpful to the Committee.

Q95 **Chair:** Martin, can I just pick up something you said? You mentioned that things that are not working might need to be decommissioned. Can you give us a few examples of what those things might be?

Professor Green: There are some things that are personal. For example, there is a tendency to prescribe constantly, and that needs to be looked at. People need to think about why they are prescribing a particular drug. There also need to be regular reviews, so there is that personal stuff.

Also, there are a lot of things going on in the system that do not put the person at the centre. For example, a lot of older people find they are never asked what would make a difference to them. The professionals say, "You need this," or, "You need that," because that is the orthodoxy in which we have developed our approach to health and social care. What we need to do is decommission some stuff that might be about our view of what people want and start asking them, "What makes the difference to you?"

For example, I reviewed some very high-level cases in Lambeth many years ago. People were getting loads of district nurse input, and they were getting lots of equipment, but they were not asked whether it was going to make a difference to them. I said to these people, "You have very expensive care packages. How is it working for you?" What was



really frightening was that lots of people said to me, "Nobody's asked us that before." One of them said, "I don't need all these people coming in and out of the house, but I do need to know that on a Thursday respite care is available for my husband for four hours, because that's when I want to go to see my sister, who's not very well. Her husband's just died, and we meet up regularly." She said that would make a big impact on her and on her sister, but also on her husband, because they were in the house together all the time and there was no escape for either of them.

She also said, "If you look at what's happening, people are coming in but they aren't actually doing what I need them to do; they're doing a series of tasks rather than thinking about what I want to achieve in my life. A lot of the tasks they're doing, I could actually do." She also made the point that things are so incredibly controlled. These people were coming in to do personal care, and they would not do anything else, even something minor. For instance, she had a problem with a screw on the ironing board and she asked if somebody could help with it; the immediate response was, "That isn't our job, we can't do that, we aren't insured for that." That came up a lot; the excuse that was always used was that they were not insured. So we have a system which is working for the system but not for the individual.

We have to start thinking differently about how we use our resources and asking people what makes a difference to them. Sometimes that means you can pull out some very expensive resources that are not delivering and put in some alternatives that might well deliver. For example, a lady I know had a stroke and then got very nervous about going out because she was frightened of falling. She went to a tai chi group, which not only gave her the confidence to understand how to balance, but also gave her a network of friends. Suddenly she had this network of friends she had met at the tai chi group. Nobody is commissioning that stuff, but they would commission someone to come in three times a day if she did have a fall.

Q96 Danny Beales: Emma, you talked very briefly earlier about Diagnosis Connect. What opportunities do you see for schemes like this to embed voluntary sector support and physical activity programmes into the management of care for people with long-term health conditions?

Emma Hutchins: I have talked about how Diagnosis Connect would connect around diagnosis but, in broader terms, there is an opportunity for the voluntary sector to be involved at a much earlier stage with health services and to be seen as an equal partner with the health system. The voluntary sector can bring expertise, insight, trust and relationships with communities; the voluntary sector can do things that other kinds of organisations cannot. It is an independent, agile and very innovative sector. So there is a huge role for the voluntary sector to play.

However, there are barriers preventing that: it is not viewed as an equal partner, or is viewed as only providing services at an individual level rather than being part of the systemic support available to people. There



are ways that these issues could be overcome, through building relationships and cultures of trust, and ensuring more transparent and consistent communication between the health system, Government and the voluntary sector. The civil society covenant set out some principles for how this might look, and we really welcome the intention, but we need to see an action plan implemented so that the role of the voluntary sector is maximised.

A really pressing opportunity is in the development of neighbourhood health. The voluntary sector could be playing a huge role there; many voluntary sector organisations—both large ones like ourselves but also thousands of small ones—are experts in their neighbourhoods and in the communities where they work. It would be a missed opportunity not to embed the voluntary sector from a very early stage in the design of neighbourhood health.

Q97 Danny Beales: Specifically regarding Diagnosis Connect, from what we have seen in the evidence, this is an app-based approach that will enable people to directly connect to broader voluntary sector services at the point of diagnosis, is that correct?

Emma Hutchins: Yes. We are still working up all the details, so we do not know exactly what it will look like, but the idea is that support will be available for people once they have been diagnosed with a condition. They will be directed to ways they can manage their condition and access a range of voluntary sector services in a much more automated fashion than relying on time-pressed health professionals or people who may not know what offer is out there. It seeks to systematise that process.

Q98 Danny Beales: Are there any thoughts about how this would relate to the NHS app that is under development and expansion? Is it going to be a completely parallel system?

Emma Hutchins: I am honestly not sure of the answer. It is something that is still to be developed, but we can follow up separately on that if my colleagues know more than me.

Q99 Danny Beales: I understand what you say about the need for social prescribing and the value of the voluntary sector, and that often those links are not being made at diagnosis; people are given pills but not Pilates. But do you think there is a risk that something like Diagnosis Connect or voluntary sector-led support is seen as secondary to the NHS, that these are not the same health and care packages but another form of support? Do you think there is an inherent undervaluing of this support in the way that these services are developed, provided and referred to rather than directly provided in the GP centre?

Emma Hutchins: Part of the challenge is that the voluntary sector is not seen as an equal partner, and it is not seen as having equal value. We need to shift that perception and show that, while the voluntary sector may not be offering the exact same thing as the health service, it is offering something more and something different, which speaks to



HOUSE OF COMMONS

people's lived experience of long-term conditions and may interplay with other aspects of their life. As you say, there is a real need for the Government and the health service to recognise the unique role of the voluntary sector, and to see it as an equal.

Q100 Danny Beales: What would need to happen to genuinely get that parity, that sense from the patient that they are being given something just as important as a prescription for drugs or just as valuable as the GP appointment that they often desperately want? How can Diagnosis Connect and the support that sector provides be seen as relevant and valuable to people?

Emma Hutchins: As I mentioned before, there are some practicalities around data sharing and data interoperability between the two systems; it needs to feel like a seamless experience for the patient. They need to feel like it is part of the wraparound support they are receiving, not that they have been sent out of health and into another sector. Funding arrangements and commissioning processes for the voluntary sector could work better and be more sustainable, and that would enable the voluntary sector to maximise its role. Speaking to some issues that Adam raised earlier around where these activities exist within the community, many rely on short-term funding and are project-based. Making sure that they are on a sustainable footing and that they can be reliably signposted by health professionals is a really big barrier to overcome.

As I said, that communication piece is important so that the voluntary sector knows where to go when it wants to contact the health system and is brought into these conversations proactively. There is more that can be done around communication and engagement to build the relationships, both at a local and a national level.

Q101 Danny Beales: We have heard a lot about short-term funding issues and poor access to data being key barriers to collaboration with the voluntary sector. Do you have any thoughts about how the data issue can be overcome at a local or national level? Do you think there needs to be full local integration with providers in accessing records?

Emma Hutchins: It is incredibly complex. There are even issues with charity email accounts. Some NHS emails have a padlock, and you are not allowed to open them and things like that. There are really practical day-to-day things that could be looked at, but they speak to much broader issues. If we are going to be looking at more digital solutions and more data sharing, we need to look in detail at what those barriers are, where the blocks are coming up and what they are preventing from happening so that we can remove those barriers. That needs concerted attention as part of the shift towards digital.

Q102 Danny Beales: Adam, do you have any thoughts on the barriers to the sector's participation in the provision and planning of services?

Adam Blaze: Yes, lots, but for the sake of this panel I will not go into them all. The perception challenge that you talked about is really



HOUSE OF COMMONS

important. There is a perception that things that are not medical or NHS driven, that might be in the voluntary sector or elsewhere, are not as important or not as good. We need to get over that challenge.

I also think we need a massive societal and political shift in the way we think about physical activity. I cannot work out if the fact that this panel is talking about physical activity in this context is the first small step or a massive leap forward, but we need to shift this.

We had it through covid, which is the only time I can remember when politicians stood up and said, "You have to go outside. It is really important that you are exercising and getting out, as there are benefits to this." For the first time we had that message, but it then dissipated. The importance of that argument was forgotten, and we need to shift that. We need to really think about where physical activity fits in our communities and what it can do for our society in bringing people together, helping us age better, helping us all feel like we belong through activity and sport, because we could do that quite quickly.

Q103 Danny Beales: Touching on leadership, direction and strategy moves me on to the role of national strategy setting. The Richmond Group has submitted evidence that makes clear recommendations about the role of Government, cross-departmental leadership and ministerial leadership. Do you have any thoughts about the balance between having a single national strategy for physical activity, or whether this should be something that is mainstreamed across DCMS, DHSC and DfT, or about the levers that are needed to bring change across Departments?

Emma Hutchins: If you look at the 10-year health plan with a physical activity lens, you will see that there is a long-term aim to get millions more people moving, and there are lots of commitments on physical activity such as the national campaign and better use of the app. But what is missing is a long-term plan to get millions more people moving without short-term interventions, and how we lead sustainable behaviour change by removing those systemic barriers.

It is great to see that there is a plan for a sport and physical activity strategy from DCMS, but we have been on this panel for nearly an hour and we have barely talked about the role of sport because there is just so much to talk about when it comes to physical activity. The sport and physical activity sector is part of the solution, and a strong sector is one of a range of ways to move but, as you say, it cuts across all Government Departments and policy areas. This is not just about people playing sport, although that is a big part of it; it is also about how people move when they are in care settings, how they travel, how they go to the shops, and how they support themselves to live well. For that, we need a strategy that focuses on movement more broadly and has a cross-Departmental remit to mainstream through what is already happening. As Adam says, there is so much already happening that is just not co-ordinated and not joined up.



Q104 Danny Beales: You have talked about a million more movements. Do you think the Government are right in their approach, or do you think they should focus on a very specific group of the population? Should they focus on a number of groups? Is there value in picking a small, discrete section of the population and really focusing Government attention on that, or in trying to do a more general, society-wide movement campaign and strategy?

Emma Hutchins: I would refer to the CMO's comments about how the biggest gains are to be made in targeting the least active who, in doing just a little more, will gain huge benefits. That is where a strategy could really focus its efforts: targeting those who are not currently engaging in sport and physical activity. They are not getting this form of support; they might not even think they can be active or that being active is for them. Putting the least active first would really transform how we think about movement and physical activity.

Prioritising people who already have long-term conditions will also intersect with a lot of other inequalities. People with long-term conditions are more likely to be from lower socioeconomic groups, minority ethnic backgrounds, and to be older, as we are talking about. Using that as a lens will really tap into the least active groups, and making that the focus of a strategy could be transformational.

Q105 Danny Beales: Do you have any thoughts about local system leadership? Obviously, national strategies can set a broad direction, but lots of things we have talked about are down to individual practice, individual perceptions in the health system and local system leadership—how they do or do not work with the voluntary sector, or how they do or do not prioritise this. How can we embed local leadership?

Emma Hutchins: I have focused on how the national can set a direction for the local. Local systems need that mandate to tackle physical inactivity and to provide this support. I know that Adam and Professor Green have more to add on place-based approaches and ICBs.

Professor Green: My view is that you have to make it part of something that you measure. You need to tell people that this is what they have to deliver as part of their success criteria. We need regulators as well. For example, within the care sector I want to see the CQC looking at this issue and using it as a definer between excellence and good. We need to see all the bits of the system coming together.

We also have to shift the dial a bit, to stop thinking about organisation and process and start thinking about people and outcomes. We have an amazing opportunity to really start shifting the dial with all that is going on with the 10-year plan and with the abolition of NHS England.

But my real concern is that these conversations about things like implementing the 10-year plan are all based on tweaking what we are doing at the moment. Let us be really radical about this. Let us define



what we want to achieve in terms of a vision. It is then much easier to say, "Your responsibility is such and such, and this is how we are going to encourage you to make sure you lead that agenda," whether to an individual care worker in their own practice, to the chair or chief executive of an ICB, or to a Minister or the Secretary of State for Health and Social Care. It is very complex and very fragmented, but we have to use this opportunity of change to set the dial differently.

Danny Beales: Adam, do you have anything to add?

Adam Blaze: Yes, just on where to focus. Clearly, I have a bias as my role is around supporting disabled people and those with long-term health conditions. We did some social value work with a Treasury-approved methodology, and it showed that if disabled people and those with long-term health conditions meet the CMO's guidelines, it is worth £6,200 per person per year. That is three to four times what it is for non-disabled people. Even if they are just doing light-intensity activity or are not hitting 150 minutes, there is still significant value of over £4,000 per person per year.

If you focus on those who need support the most, the return is bigger, financially and economically, but the benefits are better. If you make a service more accessible, it is accessible for everyone. If the customer service desk is more inclusive and accessible, that benefits not just the disabled person but everyone. There is definitely something around where you focus; if it is on the people who most need support, that will have benefits for everyone.

The place-based stuff is also important, which comes back to the theme of the session. We have solutions that can help deliver the national strategy, which we can show you through one of our programmes, Get Out Get Active. We can get more people active by delivering yoga in gurdwaras, which is a place where people feel comfortable and is part of their community.

There are many examples like that where local place-based interventions have worked and are delivering a return on investment. They should be part of the solution to delivering a national plan.

Chair: That brings us to the end of our first panel and leaves me to say a massive thank you to you all for your exemplary timing and very rich answers. We will now swap over to the second panel, but you are very welcome to stay.

Examination of witnesses

Witnesses: Professor Elizabeth Orton, Professor Dawn Skelton, Professor Chris Todd.

Q106 **Chair:** Hello, it is lovely to see all three of you. We really appreciate your being here with us today. We shall start the panel the same way we



HOUSE OF COMMONS

started the last one, so if you would not mind introducing yourselves and what your organisations do.

Professor Orton: Hello, I am a professor of public health at the University of Nottingham and a consultant in public health for Leicestershire County Council. I am here today as a representative of the University of Nottingham.

Professor Todd: Hello, I am professor of primary care and community health at the University of Manchester. I also lead the policy research unit and the applied research collaborations at the National Institute for Health and Care Research—NIHR. Like my colleagues I am speaking as a university professor rather than on behalf of NIHR. We are always told to say we are expressing our own views, not the views of the NIHR.

Chair: That is very clear, thank you very much.

Professor Skelton: I am a professor of ageing and health at Glasgow Caledonian University. I am also representing the falls and bone health section of the British Geriatrics Society and the national falls prevention co-ordination group. I also work with a not-for-profit training provider, so I wear a number of hats, but I am really here for Glasgow Caledonian University.

Chair: Thank you all very much. We are here to examine frailty, and I will start with Josh Fenton-Glynn.

Q107 **Josh Fenton-Glynn:** Professor Orton, on the frailty scale and identifying frailty, we have received evidence that the current tools and incentives are not good at picking up older people at risk of frailty or who have pre-frailty. Do you think we should be more focused on identifying these groups?

Professor Orton: We have tools that are very sensitive and specific for identifying people with frailty and at risk of falling, but they are not consistently available. Frailty scales are consistently available in primary care, but when we have done research on the implementation of that scale we find that GPs are often either very underconfident to classify frailty, as it takes an incredible amount of resource to bring people in and confirm that the digital classification of their frailty is accurate, and the resources then to do something about it are inconsistently available, so where you would refer or signpost people to for any kind of intervention is inconsistent. Also, eFalls is another tool that has been developed which is sensitive and specific, but it is not available across the country at the moment.

There are other ways of identifying people who are frail. As you have heard from the previous panel, there are lots of people who come into contact with older people or people with frailty and pre-frailty, such as the ambulance service, social care, public health practitioners and social prescribers, and they also need to have a place in identifying people who are most at risk of frailty.



HOUSE OF COMMONS

Q108 Josh Fenton-Glynn: Picking up on a couple of things you said there about the different services and conversations being available, the CQC does an annual State of Care report, which came out a couple of weeks ago. You can be forgiven for not having read that, but it specifically said that there is regional variation in outcomes around frailty. I wonder if we can better use assessment tools to try to identify pre-frailty in a more organised way?

Professor Orton: We are moving towards that with the neighbourhood health services and the emphasis on population health management.

Q109 Josh Fenton-Glynn: If I could just pause you there, you said that we are moving towards the neighbourhood health services. Is that our plan, or are we actually seeing results?

Professor Orton: It is just starting to be implemented, so some areas will have been using that approach for some time, where they have systems for stratifying their population to identify specific frailty groups: people with multiple long-term conditions. Those systems have been available for some time and some areas are using those already, but there will be more emphasis on that as a way of, if you like, case finding people.

Q110 Josh Fenton-Glynn: Apart from Leicester, can you point to an example of people who are using those well?

Professor Orton: It is Leicestershire.

Josh Fenton-Glynn: Sorry, yes.

Professor Orton: We are using that in Leicestershire, that is for sure. But also in Wigan, a pilot of the eFalls risk stratification is being done through primary care to identify people who would benefit from evidence-based strength and balance exercise programmes. Those people, many of whom will be frail or pre-frail, can then benefit from those programmes to try to slow the progression and hopefully reverse their frailty, so that is another example. We have been doing a lot of work around a whole-system approach to frailty and falls prevention across the country in Devon, too.

Q111 Josh Fenton-Glynn: That is really interesting, thank you. Moving on to Professor Todd, how well prepared are health professionals to have conversations with older people who identify as being frail or pre-frail to refer them to better support?

Professor Todd: It might be useful if we take turns answering these. Unlike the previous panel, we know one another quite well and have been working together on these issues over the years. Picking up on what Liz was saying, the work we have been doing in Wigan clearly shows that we can identify people, case find them, refer them on to suitable services and really think about how those strength and balance services can be implemented.



HOUSE OF COMMONS

Coming to your particular question on these issues, the tools that we have been using are not widely enough used overall. While eFalls and EFI—the frailty index—are being used to identify people with severe frailty, they are not being used to identify people who are at risk of developing frailty in the future. That is not in the GP contract.

- Q112 **Josh Fenton-Glynn:** I will pick up on that, because my follow-up question was on the GP contract. The Quality and Outcomes Framework currently rewards the identification of frailty, but it does not reward signing people up to the right interventions, which means that only 50% of patients are given a recorded intervention. I know there are time and resource constraints on primary care, but do we need to change the outcomes framework to make sure we are referring people properly?

Professor Todd: I would say yes, because we want to move more towards prevention rather than just picking up the pieces, as it were. If we want to prevent the development of frailty, there is an important point to be made here. There is a view that frailty is unidirectional: you become frail and you become frailer. The evidence on resistance training in particular—the sorts of things that we will be talking about—is quite clear. If we use resistance training at the right doses, we can prevent frailty from developing and actually reverse it. We can move it backwards from being severely frail to less frail, so if our view is that we should be preventing things, clearly the answer to your question is, yes, we should be doing more.

- Q113 **Josh Fenton-Glynn:** How do we best incentivise that in primary care?

Professor Todd: We would have to do more case finding. We could use electronic health records to identify people who are at future risk, and then we would have to have services that are able to deliver. This is going to be a full-system approach, as was said earlier, to deliver services that would be able to deliver resistance training exercise for older people, and actually starting younger. I do not think we should just be looking at older people, or people in their 60s like me. Chair, I think you mentioned your age earlier.

Chair: I am in my 40s, and I am happy to admit it. Yes, I am the target market. I said it earlier, it's okay.

Professor Todd: We should be looking at younger people as well, to ensure that they become more active. We want to make the point about the difference between activity and exercise, and I do not know whether Dawn wants to say something about that.

Professor Skelton: Just on your point about how we get something happening rather just finding them in any setting, we are currently doing an audit of the provision of exercise in physiotherapy, and they are not identifying people who are frail, and they are not offering. We have a big workforce issue in the first place. Essentially, frailty is characterised by slow gait, poor strength, poor balance and lack of reserves, so all we



need to do is look at any normative dataset—of which there are lots—to physical function at different age ranges, and these exist from 50-plus, and saying, “You are below where you should be for your age for this particular strength or balance test, let’s have a conversation about how you can improve that.” I do not think GPs have the time to do that, but with these new thoughts about neighbourhood work, they could have somebody in who knows how to have that conversation, signpost people in the right direction, support them and decide whether they need an evidence-based programme, because they need exercise as treatment rather than just prevention.

There is a workforce out there. It still needs skilling-up and we need more, but the problem is that if it’s everybody’s business, nobody is going to concentrate on it. You need specialists who will work in those different settings.

- Q114 **Josh Fenton-Glynn:** This is my last question, as I recognise time is short. I am also thinking about various mechanisms we could look at, and about the conversation between the GP and the trainee—or something similar—where they say, “Looking at this case where you have identified frailty, what do you recommend people do?” It is almost whether we need to hold people to account more at some point, maybe in the training conversation, by saying, “Well, why aren’t you referring people straight on?” and looking at that in terms that they reflect on it.

Professor Skelton: Early education is the important thing. I used to train medical students, and I believe they still get only a couple of hours on physical activity and health, or exercise treatment.

- Q115 **Josh Fenton-Glynn:** Within your whole five-year medical degree, you get maybe a couple of hours?

Professor Skelton: Absolutely. Then you come to physiotherapists. They are very much about sorting out joint issues, and they do not get anything about how to progress physical fitness. So in almost all the workforce, whether it be care staff or specialist rehab, we need earlier education on exercise treatment in terms of its progressive, structured nature that makes a difference to outcomes of frailty, sarcopenia and falls.

It needs to become as important as a drug prescription. We would not give half a dose of chemotherapy to somebody, but we will give half a dose of an evidence-based exercise programme. Physical activity—exercise—has fewer side effects and has much greater benefits than whatever it is you are working on, in terms of prevention of various other health conditions. It does not make sense that it does not have a much bigger priority in all that health care training.

Professor Todd: And ironically—

Chair: We are starting to stray into upcoming questions, so if I could just hold your enthusiasm before I pass to Dr Beccy Cooper.



HOUSE OF COMMONS

Q116 **Dr Cooper:** Very much continuing in that vein, I would like you to concentrate on the falls management exercise programme—FaME.

Professor Skelton: Live forever.

Dr Cooper: Yes, nobody wants to live forever. Dawn, I wonder if you could outline for the Committee the current criteria for accessing this programme.

Professor Skelton: It is a postcode lottery. In some areas you have to have had a fall in the last six months, and in other areas you just have to be concerned and avoiding activity—in some areas you have to have both. In some areas you have to be signposted through a physiotherapy department, which might have a nine-month waiting list before you can even start, and in other places it is self-referral. Unfortunately, it is not equitable at the moment.

Q117 **Dr Cooper:** That does not sound great. Are you telling us that it is not standardised across the country?

Professor Skelton: Yes.

Q118 **Dr Cooper:** That sounds like it should be standardised. Moving on from that, do you have a sense of what the coverage is across the country? You said it is a postcode lottery. What is the percentage of coverage? Is coverage better in the south or the north? Liz, you are nodding your head.

Professor Orton: Yes, because we have just done a survey of all local authorities and ICBs—health boards—across the UK. We specifically asked about the commissioning of FaME, and we only see that commissioning in 5% of ICBs.

Q119 **Dr Cooper:** Just 5%?

Professor Orton: Yes, and 15% of local authorities. That is not to say they are not providing something, but we specifically asked about FaME because that is the programme that has the best evidence on preventing falls.

Q120 **Dr Cooper:** I wonder if I could just pick up on the commissioning issue, because obviously you have mentioned integrated care boards, which are our health commissioning, and local authorities, which are our public health commissioning. Bearing in mind we are moving to strategic commissioning for ICBs, but public health—to the best of our knowledge—is essentially remaining in local authorities, do you have a sense of where it should be commissioned from?

Professor Orton: Yes, you need to look at the spectrum of physical activity through to exercise as treatment, from primary prevention right the way through to treatment. The local authority public health teams have a responsibility for commissioning physical activity programmes that are primary prevention, from the campaigns to move everybody a little bit to that left shift, a bit more active, and the inactive to being active.



HOUSE OF COMMONS

That is really important. There has not been good enough messaging around the strength and balance component of the Chief Medical Officer's guidelines. We tend to focus solely on the 150 minutes in our messaging, but strength and balance are so important, and it is part of the guidelines.

Q121 **Dr Cooper:** Just to be clear, what I am hearing from you is that the commissioning of FaME should rest with public health bodies in local authorities?

Professor Orton: No. As people shift into being at risk of falling, because they have had a fall or because they have a fear of falling, we start to shift into exercise as treatment. It is prescribed and progressive, and it is tailored to the individual.

Q122 **Dr Cooper:** My apologies for my misunderstanding, but is FaME not a falls prevention programme?

Professor Orton: It absolutely is.

Q123 **Dr Cooper:** Going back to what Dawn said in terms of who is able to access it, it may well be that some people are accessing it who have not yet had a fall, so it is pre-frailty, potentially?

Professor Orton: It is people who are at risk of falling, so you are starting to get into secondary prevention.

Q124 **Dr Cooper:** So it is not primary prevention but secondary prevention?

Professor Orton: It can be used in that way, but primarily it is when resources are constrained. I would be putting it in secondary prevention, which is not uncommon in health improvement where you have a spectrum.

Dr Cooper: I absolutely appreciate that, but just for the benefit of the Committee, if we make recommendations.

Professor Orton: Absolutely. The ICB is where we start to see treatment services: physical exercise as treatment. In public health we have exercise for frailty prevention.

Q125 **Dr Cooper:** I absolutely hear you: the falls management exercise programme—

Professor Skelton: Has evidence for both.

Dr Cooper: Excellent, so it is indeterminate where it falls. That is what I am trying to get to.

Professor Orton: That is part of the problem, because of the complexity of the system and the current lack of clear commissioning guidelines about where it sits.

Q126 **Dr Cooper:** That is clear in its lack of clarity. Thank you.



Moving on to some specifics around the FaME programme, you were talking earlier about the people who are delivering falls prevention and their training not necessarily being holistic, if you like. I understand that the FaME programme should at least be delivered by postural stability instructors. Is there a specific training programme for postural stability instructors?

Professor Skelton: There is, and it is not a half-day online course; it is face-to-face, practical training. They get assessed on their practical delivery, their behaviour change discussions, their exercise science knowledge, their progression and their understanding of long-term conditions.

Going back to where that fits in the continuum, we have physiotherapists and clinical exercise physiologists, and they generally do out-patient hospital treatment. Then you have your exercise referral instructors, personal physical trainers, dance instructors and so on. There is a massive gap between people leaving there and going there. There used to be a framework called level 4 specialist exercise instructors—your cardiac, pulmonary and cancer rehab and postural stability instructors. They were essentially set at undergraduate-level training with practical assessments. Things have changed a bit now we have a new governing body of the exercise world, and we just need to make sure we support that group. They do all that training, and it is hard to pass—and not everybody does. It is really important that we get it right for these people who need a timely, effective programme.

The issue is that they are nearly all on zero hours contracts, and of course during covid we lost loads of them because there was no job security and so on. They are not offered any support in terms of CPD. Later Life Training offers CPD, and because it is a not-for-profit company, a lot of it is really cheap. We are not professionalising or treating them with the same respect that we treat physios and clinical exercise physiologists, yet it is a professional workforce.

Q127 **Dr Cooper:** This is really interesting. Very quickly, what are their backgrounds, generally?

Professor Skelton: Exercise instructors.

Q128 **Dr Cooper:** They start as exercise instructors?

Professor Skelton: They start as personal trainers and then do exercise referral, so they have a knowledge of the lower-risk health conditions and how to manage them. But PSIs—postural stability instructors—bring in that real behaviour change per dose, because some of them come once a week to an evidence-based programme, and there will be an effect. But if they do two hours a week, the dose is right and it is progressive, so they have to do home exercise in between. That is really important when you have someone who is frailer, because they will compensate. They will go, “Oh, I went to a class this week. I am too tired to do anything tomorrow.” So the physical literacy, the education, is really important for behaviour



change and problem solving. The training has to be in that. It is not the case that anybody can do that. A volunteer or care worker can do just half an hour of online training, which does not give them enough skills, and they are not assessed in those skills. This is why it is important for that work.

Q129 Dr Cooper: That is really clear, thanks so much. Just one final question from me on the cost of the programme and the return on investment. I presume that evaluations have been done. Has a cost-benefit analysis been done, and what is the ROI?

Professor Orton: Public Health England and the falls and fragility fracture audit programme set the original social return on investment at £2.28 per individual for every £1 spent. We have recently updated those costs, because obviously that was done a number of years ago and costs have increased and changed. I am looking at Dawn, because I forget the precise figure.

Professor Skelton: £2.43.

Professor Orton: There you go. Yes, we have updated that. It is not yet published, but we are just about to submit it for publication.

Professor Skelton: That is just looking at falls as an outcome. Gateshead Older People's Assembly did its own cost analysis looking at health and social care provision and a variety of other things, and its figures were £50.89 per £1 invested.

Q130 Dr Cooper: So just to be clear, would your recommendation as a panel be that falls management exercise programmes should be commissioned consistently across the country as a secondary prevention programme, potentially with some primary prevention as well?

Professor Skelton: That and Otago, because there are two programmes in the UK that have an evidence base. Otago is for the frailer, and it really works more for those who are over 80, but those two programmes have really been shown to be effective.

I just wanted to say one thing. There has been a massive number of studies on exercise to prevent falls: nearly 200 randomised controlled trials. Half of them have not reduced falls. They have been designed by people who think they know what they are doing. They improve strength and balance risk factors for falls, but they do not reduce falls. We can fiddle around the edges all we like and think we are doing a good programme, but we do not know. However, we know that FaME and Otago work both in randomised controlled trials and real-life studies, so we should not fiddle with something that might look more interesting and a bit more fun. We have no time with these people. Of frequent fallers—those who fall more than three times within a year—20% will be dead, in a care home or in hospital. We do not have time to muck around the edges; we have to offer an effective and timely treatment.



Professor Todd: Dawn is completely right, and to go one stage further, it has to be effective and people have to follow the actual protocols of what you should be doing. You should not be reducing it because, “Oh, Mrs Smith will struggle with that.” Actually, being progressive and making sure that you put some effort in is exactly the issue here. We really have to make sure that it is delivered by properly trained personnel.

Q131 **Chair:** In the same way you would not fiddle with a dose of medicine, would you?

Professor Todd: You would not. Exactly so.

Q132 **Joe Robertson:** I would like to explore a large group of people who are particularly at risk of frailty, or indeed are frail, and that is those living with dementia. Could we start by having a reflection on the importance of physical activity in reducing the risk of dementia, and once somebody has dementia, the role of physical activity in slowing progression or improving wellbeing?

Professor Todd: The issue here, of course, is that there is a strong relationship between frailty and dementia, but it is bidirectional. Your risk of frailty is increased by having dementia, but likewise having dementia and cognitive problems is actually one of the defining characteristics within frailty, and one of the things that increases your frailty score. It is actually equivalent to having polypharmacy—taking four or more medicines—so how you actually estimate whether somebody is frail in those scores is really important.

The important issue here is that frailty can be changed; we can move it back. If we want to prevent the development of dementia, maybe we should really be aiming to reduce frailty, and one of the things that we have shown reduces frailty is exercise and activity. So the logic is simply that we will actually reduce dementia in the longer term if we get people more active now. It is one of the nine lifestyle components identified by the Lancet commission on dementia as being an important area for us to focus on.

Interestingly, however, we have just done a review of the literature, and the problem is that there isn’t massive evidence in the long-term studies where people have started doing exercise at an early stage and have been followed through in randomised trials. But if we look at the observational evidence, people who are more active at an earlier age are less likely to develop frailty and less likely to develop dementia, so it is observational rather than really good experimental studies.

Having said that, NICE work has recently been done looking at overviews of the literature, with thousands of people taking part in these studies, which suggest that you can reduce dementia and frailty through activity promotion.

Q133 **Joe Robertson:** As I understand it, we cannot reverse dementia, but we can perhaps slow the progression, as far as we know.



Professor Todd: We can, yes.

Q134 **Joe Robertson:** But what you are saying is that, because we can reverse frailty, we can reverse the poor outcomes of someone with dementia by reducing frailty.

Professor Todd: Yes, that is exactly right.

Joe Robertson: That is very interesting.

Professor Skelton: We know that if someone is frail, they do not go out. They are then socially isolated and do not get as much conversation, which can increase their risk of cognitive issues. Cognitive frailty is one of the reasons why people move into earlier dementia.

Your point is absolutely right: physical activity seems to be a good protective to push back the onset of dementia. We know that if you take people into vigorous exercise, it has a detrimental effect, and the control group does better than the group that does vigorous exercise. This is again why the workforce need to be—

Professor Todd: When they have dementia.

Professor Skelton: Yes, sorry, when they have moderate to severe dementia. That is why the workforce need to be skilled, or they are going to be offering the wrong interventions. That is the importance of the skilled workforce.

Professor Todd: The other interesting thing is that a lot of this evidence is around lower-intensity exercise or activities, and that lower-intensity exercise seems to have really quite positive effects. Whereas normally we would be saying that we want much higher-intensity exercise, this is one area where you are looking at lower and moderate levels of activity. We have clearly shown that you can improve general cognition with moderate exercise, you can improve executive function—decision-making skills and memory—and it can help with balance.

Professor Skelton: The balance work is what improves the executive function. That is the planning aspect, and that is one of the first things that goes with dementia. Falls prevention programmes are evidence-based. There is also evidence about improving executive function, so it is not just the aerobic side, we need that multicomponent fitness.

Professor Todd: Yes.

Q135 **Joe Robertson:** It is really helpful to get it on the record that while the progression of dementia as a disease ultimately heads only one way, at a lesser or greater pace, life and health outcomes can be improved through the right provision.

The CQC has found that some care homes are not good at providing person-centred activities, particularly in relation to physical activity. What are the challenges in supporting people living with dementia to be more



active, and not only in care homes?

Professor Skelton: Thirty years ago, I was not in academia; I was working and delivering exercise in care homes. One of the key things that I thought would change the world was training all care staff to do that. The turnover of staff is such that you train them, and six months later they have gone. We tried for three years to focus on giving them skills in chair-based and standing exercises, Otago and so on in Merton, Sutton and Wandsworth.

The issue we have is that it is generally not a well-skilled or well enough supported workforce, and they do not have the exercise science knowledge. They are worried, so they sit them down, but frailty, sarcopenia and falls exercise has to be in a standing position because it does not work if people are seated, although I understand that there are other good outcomes for doing seated work. In care, some people will have very low stamina for standing, so you might stand them for only five minutes, but that still works in reducing falls. If people are not confident and comfortable in working with someone who is frail, that is a scary thing.

We are expecting a relatively unskilled workforce, certainly in exercise science, to try to do something that may increase the risk of falls because they are increasing exposure to risk. This is again where we need external people to come in and support that workforce, rather than assuming that we can give them the opportunity and understanding in relatively short training programmes that are often online.

Q136 **Joe Robertson:** Just thinking of family carers as well, do you think there is perhaps a lack of understanding of just how important physical activity is, notwithstanding that dementias are diseases of the brain?

Professor Skelton: I am very broadly separating people with dementia into two groups, which I know is not really right, but if you have a conversation with carers, they will say that you get the walkers—the ones who do not sit down and who are constantly on the move—who do not fall. Then you have the ones who sit for prolonged periods, and it takes a lot to engage them into movement. So the carers can actually see that the people who are really active are not falling and are not frail; they are able to push frailty off a long way. It is an interesting thing about this perception of risk and, “Is someone going to get into trouble because someone’s fallen?” All the research on falls prevention in people with dementia indicates they should do it. It is not as effective the later they are into dementia, but it is still important.

Professor Todd: Previous members have talked about risk aversion. We have an issue here about risk aversion and making sure you do not do anything to put the person at risk. Actually, you are putting them at risk by not doing anything. For a lot of care staff, having the residents active is a low priority compared with the other priorities of everyday life in a care home.



Q137 **Joe Robertson:** My anecdotal experience, and why I assume it might be more widespread, is that family carers and those supporting people living with dementia immediately think that you have to keep the brain active, and think of ways to keep the brain active, which is obviously very important, but perhaps do not realise the importance of keeping the body active.

Professor Todd: That makes me think of some of the exergames that are around. These are electronic games that improve exercise but also affect cognitive function. They are games that use a mat and a screen where you get people to make decisions such as stepping forward and backward, and they have been demonstrated to increase physical activity and function, and improve balance, strength and cognition. Some of these exergames are beginning to be considered for use in care and residential homes. We have used them and demonstrated their effectiveness in sheltered housing, for example.

Professor Skelton: The carers of people with dementia also need to maintain their physical activity, and it would be so good if services allowed them to come together. But quite often they go, "Oh no, we have only got a certain number of places, but you have to go off and have a coffee." So they are not even learning from the education that the person they are caring for is getting, so we need to be more supportive of the carers of people with dementia.

Q138 **Paulette Hamilton:** Good morning. My question is on the activities themselves. The chief medical officer wrote a report in 2023 talking about an ageing society. What interests me is that he felt people needed to exercise for at least two days a week. Then I read that you, Professor Todd, had performed a systematic review on what was going on there. Believe it or not, my question is on other forms of strength exercise. The notes talk a lot about yoga and tai chi, which we used to do in parks in Birmingham but, as you know, as the funding went, everything went with it. Is there any evidence that other types of exercise are effective for preventing frailty?

Professor Todd: I am going to be really quick and say, yes, there are, but the absolute key here is resistance training, so actually putting in effort. That is what the FaME programme does: it makes people put in effort. There is evidence that tai chi works; less so for yoga and less so, funnily enough, for Pilates if you are talking about falls outcomes. I am a Pilates addict myself. I think it works, but the evidence is not so strong. My answer to your question is yes, but there has to be a resistance component.

Professor Skelton: First, the evidence for sarcopenia and frailty is at least six months of progressive multicomponent exercise where strength training is a key part. But it should have balance in there as well, because if you do not feel stable, you will not go for that walk or that general thing that will also build stamina. You will not be able to use the bench that someone has just put in because it is an ageing-friendly area. Again,



HOUSE OF COMMONS

we need to be able to identify people who are dropping below that to give them the prompt that it is important to go and do something that is going to help their strength and balance.

We have something called the functional fitness MOT. Like having an annual service for your car, the functional fitness MOT was conceived as an annual or biannual check-up of your physical function. Again, we would highlight people who were perhaps okay in stamina but not so good in balance; perhaps okay in flexibility but not so good in strength. And then you can have that conversation. Their preference might be walking. Walking does not improve strength and balance unless it is uphill with a backpack over routes and so on, but the point is that it is the most common thing that older people do. We need to have a conversation, and the person having that conversation needs to understand about activities. For example, cycling is really good for stamina but not very good for strength, unless you have a lot of hills. It is having those conversations to help people realise that a mixed bag would be good, not focusing on the one thing you prefer, but that anything you find a bit more difficult is something you should probably do. If you feel a bit wobbly, you should probably do that a bit more.

Q139 Paulette Hamilton: Over what period of time do you need to do that to actually start seeing the evidence? I am of an age where I should be doing all that you talk about, but I do not do it. I walk, so I am not building up my strength.

Professor Skelton: No. You can actually see an improvement in strength within six or eight weeks. However, it does not last that long because most of that is your brain getting better at using your muscles, and which muscle to use when. We know that you have to carry on for at least 12 weeks before you start seeing some muscle size changes, protein building up in the muscle so you are going to have a better effect.

We know that habit is important, as in the body wanting a habit for strength training. Ideally, you want it at least twice a week, and you want it for at least three months before you start getting the brain switch going, "I'm going to have to make this person stronger because they're really making me work hard on a regular basis." That is exercise physiology. If someone is already frail or sarcopenic, it is at least six months. Then all you are going to do is tip them a little above that disability threshold. They will then have a urinary tract infection or go into hospital and they will become dependent again. We need something that is actually longer for the frailer. They will have quick responses, but we need to get them way above that reserve otherwise they are going to be back in hospital at the slightest thing.

For prevention, I would say at least three months, preferably six. You need to know the muscle is working, so the muscle needs to feel tense, taut and a bit shaky. If you are not doing that, you are not having a strength training effect. We need to educate the public, like the public know about their five fruit and veg. They need to know what strength



should feel like and what balance work should feel like. We need a campaign.

Paulette Hamilton: On what they need to do.

Professor Todd: And how long it goes on. I often think of it as like a dog not being just for Christmas. Exercise is not just for Christmas; this is for life, so you have to carry on doing that exercise. But, actually, once you start it becomes a lot easier. It is often that first start, and then I was going to say you can become addicted to it, which is not a bad thing.

Q140 **Paulette Hamilton:** I would not go as far as that. I see some people around this table have got addicted to exercise. Fortunately, I am not one of them. I used to do parkrun every Saturday, I swear. I have the card; I have the evidence. But once I stopped, I did not miss it. I really did not, but I thoroughly enjoyed doing it at the time. I am not an addict. I do not have the bug.

Professor Todd: You enjoyed it. That is a really important word.

Paulette Hamilton: I did enjoy it.

Professor Skelton: It is really important that we do not just say, "You should do this." We should present things and provide exercise opportunities that people enjoy. If they enjoy them and have social interactions with other people, they will carry on doing it.

Professor Orton: That is what keeps people going to classes when they are frailer. They are meeting new people because they have probably been socially isolated for a couple of years while they were waiting for their knee replacement and it had not happened and so on. All of a sudden, they have a newish network of people; they have social opportunity at the end of the class. They will learn from each other and go, "Oh, goodness. She looks much frailer than me, yet she does that." You have some social comparison; you have buddies who you might go and do other things with. It is really important to think about that aspect.

Q141 **Paulette Hamilton:** I am going to stop you there because I will run out of time. I want to ask Professor Orton about certain groups. What are the opportunities for expanding access to exercise for older groups from both under-represented communities or marginalised groups? In somewhere like Birmingham, a super-diverse community, it is never as easy to get that social element going because of the language barriers and other reasons. How would you suggest we work towards that?

Professor Orton: We see this over and over again. In the data you see under-representation of people with disabilities, different minority ethnic communities, and by age and gender; we see these inequalities clearly. We have done some work to look at what the barriers are that people face. For example, we have done some work to understand the importance of strength training during menopause in south Asian women, and they tell us, "We want single-sex spaces; we want instructors who



are the same sex as us. We need to have the messaging around the importance of it to maintaining our wellbeing to be able to maintain our family roles.” That is what they tell us.

We have done three case studies on the falls management exercise programme: one where we have looked at programmes specifically for men, because typically you see fairly affluent women of white ethnicity in the falls management exercise programme. Areas that reach really well for men have tended to focus on the social side, have looked at the messaging around retaining your strength and independence, and it just feels like different messaging from other programmes in the advertising and so on.

If you put the FaME classes in an area of disadvantage, we have seen that people come from outside and go to those areas. Unless there is financial support in some way, such as free transport, or the classes are free or very low cost, those are the things that we know work. What we want to see is a clear national specification on the active ingredients that should not be messed with, that the fidelity needs to be there for any programme but that you can adapt and tailor it so that it meets the needs of particular groups.

Q142 Paulette Hamilton: How do those groups get linked in? If you were going to give any advice while you are talking to us now, who would you say are the key people in getting people into these groups?

Professor Orton: Again, it is about having a whole-system view on what is provided in a local area, having delivery partners who are really embedded in their community—whatever that community is, whether it be a faith community or a particular ethnic community—and providers who understand their communities. Then, using the whole-system capacity we have in social prescribing in the healthcare sector, it is about really signposting people to those services and building trust that the provision is going to be safe for them.

Q143 Paulette Hamilton: Finally, as somebody who is an expert in public health, how have the funding cuts in public health really caused problems in some areas? You struggle to get people in those areas because the funding is removed, so where you would once have worked with local churches, mosques, synagogues and what have you, where you would do things in the park and in other places, you are not able to give the funding for that to be done. How has that affected what you are trying to do?

Professor Orton: Of course, we have a ringfenced budget for public health, but in real terms it has reduced over time. Around us, there are also cuts in social care. The health service is under real pressure now, and the community and voluntary sector have seen reductions in funding. All those other providers that are part of the system have been struggling too. We know that as soon as there are pressures on budgets, prevention



is the first thing that gets cut because the demand is not there right now—the demand is in 10 to 15 years' time.

Q144 Paulette Hamilton: What would be the one thing you would like to see so that does not happen?

Professor Orton: We need a protected budget for this. It needs to be clearly prioritised with parity of physical and pharmacological interventions.

Paulette Hamilton: Fantastic.

Q145 Danny Beales: Professor Skelton, the 10-year health plan recognises the role of technology, particularly wearables, in getting people active. To what extent do you think there is a role for wearables and digital technology with older people?

Professor Skelton: Older people are a very big group. You have people who are 65 who are fitter than someone who is 20, and then you have someone who is 95.

Q146 Danny Beales: Is there a role for digital technology for particular groups and not for others?

Professor Skelton: Yes. Once you get to the very frail and the ones with multiple comorbidities—their eyesight, the amount of oil in their fingers and so on—it means that a lot of those digital technologies are hard to use. For example, they cannot see the screens on their phones. Wearables like I wear are great at picking up steps; they are a great way of potentially getting people to move more and break up sedentary behaviour. But they do not pick up any reference to whether you have done strength and balance work, so they are not motivational in that way. There are apps that have some evidence base in improving strength and balance when used by older people. I am sure I will pass on to Chris on that in a second.

The issue at this point is that treatments should be timely if they are frail or a faller. Face-to-face has much better evidence for the social side as well, but the apps could support home exercise between doses. That is really important if somebody is digitally literate and you can bring them along with you. At the moment, there is no evidence that purely digital delivery is going to make a difference to frailty and so on. What we need is not just to give everybody an app. Singapore, for example, actually incentivises people by the number of steps on their Healthy 365 app. There is some feedback, some reductions on things and costs. Those are great in the prevention space. I worry that the move to digital is going to lose that really important face-to-face social gain, loneliness reduction and so on.

Q147 Danny Beales: A blended model is a better approach?

Professor Skelton: Yes, a blended model would make all the difference for an older person who is frailer.



Professor Todd: We did some work looking at apps during the pandemic because it was obvious we were not getting face-to-face opportunities. There were more than 7,500 apps purporting to offer strength or activity work for older people. When we actually drilled down through those apps, there were only 12 that really did that, of which only four had any evidence that they worked. From 7,500, we came down to four apps where there was any evidence that they were of any use to older people in preventing falls and making them more active. We called that Map the Apps, so it was quite nice and it got quite a lot of traction. Now, there is evidence that two of those apps really have evidence that they are effective in preventing falls: the Standing Tall app in America, and the Keep On Keep Up app, which was developed by colleagues in Manchester. I have to say there is no conflict of interest, but it is a local piece of work.

The other thing we have to think about with apps and digital is digital exclusion. As Dawn said, the problem is that older people may not be used to using apps, or may not be able to use them. We also see that older people who are poorer, come from deprived areas or are from ethnic minority groups have even more problems using these apps unless we develop them in ways that fit their cultural requirements. The other irony here is in the cities. I do not know if you have ever noticed how poor 4G or 5G is in some poorer areas. In order to cut costs, many older people will get rid of their landline, so we cannot put wi-fi into their homes and we are dependent on 5G, if we can use it. There are real issues here. It is a potential for the future, but we really must make sure that we join everything up.

Professor Skelton: If we are looking at treatment, it has to be progressive. A lot of those apps are either pointing in the direction of a video, which is the same exercise that you just keep watching and, again, you lose that progressiveness that is going to make a difference to physiology, which will therefore make a difference to your outcomes.

Q148 **Danny Beales:** Is there a case for investing more in designing specific digital interventions for older people? As the private market is gearing to a different consumer, do the NHS or the public sector have to invest in this?

Professor Todd: That is exactly how I would say it. If you look at all these apps, they are shiny and have bells and whistles, but they do not actually do anything. The KOKU app—Keep On Keep Up—has taken five years of development to get to the point where it does. It does not have lots of bells and whistles, but it does do what it purports to do.

Professor Skelton: It was co-designed with the population it is meant to work with.

Q149 **Danny Beales:** As you say, designing these wearables and technologies may not be as exciting, sexy or multifunctional, but they must be usable for people with limited mobility or dexterity or visual—



HOUSE OF COMMONS

Professor Todd: Dawn has used the word I want to just push home. Co-production, co-design. It is about doing a lot of work with older people on what they want so that we design a product or an app with them that actually works for those people. This app is now available in Urdu and Hindi.

Professor Skelton: I was also going to say it has been adapted for each of the cultural groups that want to work with it. They have removed certain things and added certain other things because that then makes it more acceptable.

Professor Todd: For example, an image of a fridge: in the Anglo-Saxon, white version, there is a bottle of beer and meat in there. For the version we have produced for people from Muslim backgrounds those items would of course be completely inappropriate, so those are not in there.

Q150 **Andrew George:** We do not have a lot of time, but I was just taken aback by concerns that there was such a postcode lottery with regard to the current commissioning of services if we are to move from sickness to prevention. In other words, exercise programmes being commissioned not to treat but to prevent. I noticed in the 10-year plan that, next year, there is an upcoming modern service framework. Professor Skelton, I just wonder whether you think the introduction of that will actually help co-ordination across the country with regard to the delivery of this preventive activity.

Professor Skelton: Yes, potentially, and active partnerships would have to be key within that. We should stop funding lots of pilot schemes and actually fund sustainable things. One of the important things here is that, from prevention to treatment, across that whole range you need a skilled workforce. You need to work with the voluntary sector because there is not the capacity within almost any system to deliver that. The voluntary sector needs to be supported to be skilled as well. There is the potential, but I worry that we are going to lose the message by it being all about primary prevention, which means we will lose the importance of structured exercise—that is what makes the difference to frailty, sarcopenia and falls. My concern is with watering down, and that the modern service framework might water it down by saying it is everybody's business, which means it is nobody's. There needs to be a real focus, not just at Government level but local government level. Do we have the right tools across that continuum, the right workforce with the right training and the right understanding?

Q151 **Andrew George:** It seems that there is a need for better integration between what the Government are trying to commission through the modern service framework and what already exists on the ground through running clubs, sports associations, gyms and so on. Professor Todd, just taking your point that people will often join a gym in January and then it all dissipates by Easter because of a lack of self-motivation, there is always a sock drawer to go and tidy rather than go out on your own. Whereas if you are in a club, you are more likely to turn up.



HOUSE OF COMMONS

Therefore, is it not right that the existing infrastructure of voluntary organisations needs to be encouraged to be part of the network of services available?

Professor Todd: I completely agree that we have to ensure that the voluntary sector, the NGOs and so on are involved. However, we have to grasp one or two nettles that are out there. Those nettles are, for example, the huge north/south divide, which we have demonstrated. Both levels of activity are lower in the north than in the south, and frailty, falls and so on are actually worse in the north than in the south. So, we have to grasp that, and the big driver is basically wealth and poverty. Those are the things that are clearly driving these differences.

Therefore, these become underserved groups, and they often include ethnic minority groups. We really need to think about how we target those groups if we really want to make a big impact in the future. You are worried about watering down overall; I am worried that if we spread it too thinly, we will not get a good enough effect, and we really need to look at the most deprived groups. The policy research unit has just done a review looking at how we can change and improve physical activity among marginalised and ethnic minority groups, and the messages that come from that are essentially that we need to think about cost.

One of the best programmes we have seen was when leisure services were made free. When those services were free, their usage in poorer areas in the north of England really shot up. When they became charged again, usage immediately went down. If we are trying to change things for deprived areas, we have to think about how we deliver those services there.

The other part is that we also looked at cycling schemes and running schemes. You mentioned running and walking, and we find that walking is attractive to older people from poorer, deprived backgrounds but cycling less so because you have to buy equipment, so that is a problem. If we get cycle schemes and walking schemes for overall physical activity, that would be a good thing. We need to focus and make sure that we have those higher-intensity programmes.

Q152 **Andrew George:** A lot of very good running clubs will have walk-around groups and so on, so they are not simply people who want to become Olympic athletes.

Professor Todd: We might not find them in your constituency in the same way, so we really have to think about how we focus on those.

Q153 **Andrew George:** Yes, how to target. There has to be a great deal more targeting of groups, individuals and ethnic groups, as well as communities.

Professor Todd: I agree.



HOUSE OF COMMONS

Professor Skelton: Just as a reminder, the number of people treated needed to prevent falls or frailty with an effective exercise programme is nine. You need only nine people in a programme to effectively change the trajectory. If you take a statin, 104 people are needed to prevent a future stroke, for example.

Professor Todd: One adverse outcome.

Professor Skelton: Yes.

Professor Todd: So the meaning of this number is how many people you have to treat to stop one adverse outcome.

Q154 **Chair:** That is very clear. I am going to make you all Prime Minister for 30 seconds, ideally less. You are allowed to give us only one thing that you would change, so be selective. I will start with Liz. What would you like to change?

Professor Orton: I would like to see a joined-up commissioning plan, a delivery plan that cuts across the different budgets from public health, social care, NHS and other partners so that we have one outcome that we are all—

Chair: One plan, one pot. Is that what I am hearing?

Professor Orton: Yes.

Professor Todd: I would like to see inequalities addressed. We really need to look at those inequalities across the country and focus on the areas of highest deprivation.

Chair: One plan, one pot, seen through the eyes of inequalities?

Professor Todd: Yes.

Professor Skelton: I would like to commission somebody who is really aimed at ageing well, because 25% of our population is in that group. I would like to bring back the NHS England ageing well budget, because that would have transformed the care of older people and physical activity.

Chair: So, one plan, one pot, called the Ageing Well budget, delivered through the eyes of inequality and managed by a commissioner. Have I got that right?

Professor Skelton: Yes.

Chair: Thank you very much.