



Science and Technology Select Committee

Uncorrected oral evidence: Ageing: Science, Technology and Healthy Living

Tuesday 28 January 2020

10.20 am

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Members present: Lord Patel (The Chair); Lord Borwick; Lord Browne of Ladyton; Baroness Hilton of Eggardon; Lord Hollick; Lord Kakkar; Lord Mair; Baroness Manningham-Buller; Baroness Penn; Baroness Rock; Baroness Sheehan; Baroness Walmsley; Lord Winston.

Evidence Session No. 9

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Questions 65 - 71

Witnesses

Elaine Rashbrook, Consultant Specialist, Life Course, Public Health England; Dr Alison Giles, Associate Director for Healthy Ageing, Centre for Ageing Better; Councillor Ian Hudspeth, Chair, Local Government Association's Community Wellbeing Board, and Leader of Oxfordshire County Council.

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Examination of witnesses

Elaine Rashbrook, Dr Alison Giles and Councillor Ian Hudspeth.

Q65 **The Chair:** Good morning, ladies and gentlemen. Thank you for coming to help us with our inquiry today. This session is being televised live by the parliamentary channel, and on the internet if people want to follow it there. That means that if you have a private conversation it will be picked up, so refrain from it.

The Chair: Starting with you, Councillor Hudspeth, could you say who you are and who you represent? If you want to make an opening comment, please feel free to do so. We need to get this on record.

Councillor Ian Hudspeth: Thank you. I am chairman of the Local Government Association's Community Wellbeing Board, which is looking at adult social care and public health across the country. I am also leader of Oxfordshire County Council, which means that I experience the day-to-day delivery of social care, the pressures that we have and working with everybody to try to ensure the best service possible for our residents. I welcome technology, and think there is a lot we can, and should, be doing with it, to make sure that it is better for the residents and for our service providers and that their time is spent more efficiently and effectively, rather than on things that could be done using technology.

Technology is moving at a rapid pace. As we all see, what is modern technology today is outdated tomorrow. We have to have a very open mind about where we are going. However, we must not forget that we are dealing with people. We have to make sure that we are providing a really personal service to the residents so that they do not feel as if they are just a component. It is about using technology to deliver the best service possible while still having a caring approach to residents.

Dr Alison Giles: Good morning. I am associate director for healthy ageing at the Centre for Ageing Better. We are a charitable foundation which identifies what works in policy and practice in order to create the environments for us all to age well. Our work spans factors across the four fields of health, employment, housing and community.

On health, we share the Government's target to give people an extra five years of healthy, independent life by 2035, while reducing the gap between the rich and the poorest. Our work focuses in particular on adults approaching later life—people aged between 50 and 70—and making sure that we give them all the opportunities to live a fulfilling later life.

Elaine Rashbrook: Good morning. I work at Public Health England. I am the specialist consultant for the life course and I lead Public Health England's healthy ageing programme. Public Health England exists to protect and improve the nation's health and to improve health inequalities. We are an executive agency of the Department of Health, but we are a distinct organisation with autonomy for operational matters.

Q66 The Chair: Thank you very much. The background to this inquiry is exactly as you said, Dr Giles. It is focused on keeping people healthier for longer. The Government's strategy is to extend this by at least five years by 2035. We want to investigate the Government's strategies for this, how they will monitor it, and what your role might be.

I know from the background papers that funding for public health was allocated to local government in 2013. The King's Fund has published an independent assessment of England's local government public health reforms. We would like to hear how that has contributed to local authorities developing any strategies for healthy ageing. The Health and Social Care Act 2012 gave local authorities responsibility for improving the health of the local population and put the onus on Public Health England and other bodies to contribute to their strategy.

I would like to hear from you, first, what you think healthy ageing is—and, in the context I have just given, what your role in it will be—and any other comments you might have. Who would like to start? Dr Giles, you look eager.

Dr Alison Giles: I must watch that. The Centre for Ageing Better takes, as Public Health England does, the WHO's framework for healthy ageing. We are interested in people's intrinsic physical and mental capacity and in their functional ability. Even where health may start to decline, we must ensure that the environment does not disable people.

In terms of the five extra years of healthy, independent life, we are interested in primary prevention—delaying the onset of health conditions for as long as possible. It is also about the early detection and timely treatment of conditions to stop them getting worse, and to enable people to manage conditions well and remain able.

We are also thinking about the environment and making sure that people have access to aids and adaptations and that workplaces are flexible and allow people to modify their working environment so that they can keep able, active and fulfilled for as long as possible.

The Chair: What role will Public Health England have in developing this strategy?

Elaine Rashbrook: Public Health England's role is quite wide ranging. As I mentioned, our role is to improve health, and I concur with what Dr Giles said about the evidence on preventing ill health, delaying the onset of ill health and, if someone is living with a long-term condition, modifying the environment so that people can do the things they want to do.

Public Health England's role is really about providing the data and the evidence, and supporting change, at local and national level, to make healthy ageing a reality for more people. I will give some examples.

An example of national strategy is the prevention Green Paper, which mentions the healthy ageing consensus which Public Health England has developed with the Centre for Ageing Better. This is about making

England the best place to age well in. It sets out five principles for action, including prevention and addressing any issues such as ageism that may exist. It has a lot of sign-up. More than 100 organisations have pledged to work with us and take action across the whole system, and to start to look at what can be done to promote healthy ageing. It is looking at prevention, work, where people live, where people spend their time, in order to make sure that the environments are supportive of healthy ageing.

There are other strategies that support healthy ageing and to which Public Health England contributes. The loneliness strategy, for example, is a cross-government initiative targeting people of all ages, including older people. We have worked with the committee to look at some of the outcome measures so that we can start to understand whether we are making headway on addressing loneliness, which can be a real issue when it comes to healthy ageing.

Lastly, we are very supportive of the ageing grand challenge and are working towards the five extra years and reducing health inequalities.

The Chair: Councillor Hudspeth, what is the local authority's role?

Councillor Ian Hudspeth: Again, I agree with what has been said, but local authorities have an intrinsic part to play in prevention right at the start, because of course we are talking about the early years and moving right through to make sure that people age well.

It starts with childhood obesity and making sure that we can tackle that through our various strategies across local government, but in particular it is about place shaping and managing and developing communities—we have a healthy garden town, for example. So rather than building communities that are simply boxes everywhere, how can we design better routes to encourage people to cycle and enable them to walk easily so that by the time they are thinking about retirement they are active?

That is one of the key things: making sure that people remain active for longer, because obviously it needs to continue. But it is also about making sure that they start off being more active. Leisure centres are facilities that really need to be used, so we need to encourage people to go to them, and local authorities provide those. It is even about simple things like libraries, where communities can come together and more services can be collocated.

The Chair: How would me going to a library help me to live a healthier life for longer?

Councillor Ian Hudspeth: First, this is not just a traditional library where you go in, you have to borrow a book and you sit quietly by yourself. There is a café there and other people, so you are interacting. This is about making sure that we take out that loneliness. Perhaps if that library is next to the leisure centre, that will encourage you to move from a library into a leisure centre facility rather than just be in a library.

This is about collocation and trying to encourage people, particularly the more difficult people, and finding out how we can approach them and understand their needs so that we can make sure that we are providing the best facilities for them.

Baroness Sheehan: Where has the impact of local authority cuts mainly fallen when it comes to the agenda that we are talking about today? We understand that, in real terms between 2010-11 and 2016-17, funding fell by 49%.

Councillor Ian Hudspeth: It has been very difficult. It has been a real challenge, but 80 of the 120 indicators are as good as or better than before public health was returned to local government. Despite the cuts, local government has been innovative in its approach to funding. It is not a question of pushing down on local government and saying, "This is what you all must do"; it is individual councils coming up with various schemes and then, through the Local Government Association, having peer reviews in which your peers look at you and see and understand what you are doing. They can be very critical, which is one issue. However, it means that there is learning across the sector and seeing what the best practice is across the country.

Baroness Sheehan: Sure. May I press you a little more? You said that the vast majority of indicators are okay, but where is the pressure falling?

Councillor Ian Hudspeth: The pressure is on the more preventive measures right at the start, which is where we should be encouraging more funding to go in. That is where it is not statutory and we have the flexibility to reduce funding now.

Baroness Sheehan: Could you give one or two examples?

Councillor Ian Hudspeth: Not off the top of my head at the moment, I am afraid.

The Chair: Perhaps you can think about it.

Councillor Ian Hudspeth: I will think about it, yes.

Q67 **Lord Kakkar:** I declare an interest as professor of surgery at UCL, chairman of UCLPartners and chairman of the King's Fund.

How clear are we about having objective data and knowledge that helps us to be certain about the effectiveness of various interventions that are applied for healthy ageing? Do we have clear datasets, and are we clear that the actions that we are promoting and pushing forward have the kind of impact that we desire, and that we can speak to those with an objective evidence base?

Elaine Rashbrook: Part of Public Health England's role is to provide data and evidence. I will give an example of healthy ageing. Last year, we produced a productive healthy ageing profile, which brings together a range of data sources from a number of areas and looks at some of the

major risk factors relating to physical activity, healthy eating, smoking and alcohol, as well as some of the broader issues that impact on health. This data is available at local, regional level, so that local authorities can understand how they are doing in relation to other bodies. It also measures trends over time so that we can see the general direction of progress.

In addition, we have a good understanding of the evidence on the big-four individual risk factors relating to alcohol, tobacco, physical activity and healthy eating. Individually we know quite a bit about what works and where the evidence is strong.

We know a little less about how some of those areas interact, and about the intersection between the risk factors I mentioned and the wider environment: how individuals interact with their environment and the impact of that on healthy ageing. Those are some of the areas that we need to look a bit more at.

Lord Kakkar: How do you propose to go about collecting those data and making sure that we have that type of analysis, which is clearly very important?

Elaine Rashbrook: There is ongoing work to develop the healthy ageing profile. We already have a lot of data, so it is not necessarily about collecting more or different data. Some of it is about joining up the data collected in primary care—GP practices—and linking it with what is collected in hospitals so that you can really understand somebody's pathway through the health system. Then you can understand what personal healthcare gains are to be made. It is about the better use of data, rather than more data.

Lord Kakkar: One can see the continuity of health data being very important. What about the capacity to link those data with broader environmental questions—the communities that people live in, and access to facilities in them? Who is responsible for linking all that up together and then asking: what is the impact on an individual's capacity to age in a healthy way as a continuum of life experience?

Elaine Rashbrook: There are probably a number of interested parties here. At Public Health England, we work closely with a number of academics who are also looking at data and evidence. They have a role in this as well as us and other public bodies.

Councillor Ian Hudspeth: The director of public health produces a report every year about the health of the area in question. The data is there; we have to make sure that we use it correctly and effectively. One problem is that data for a large area can sometimes mask the local inequalities and issues that need to be drilled down into to understand exactly what is happening at a more local level.

It is important that the data is gathered and used. In Oxfordshire, the figure for smoking is around 7%, which is getting towards the target of

5%—or the 0% that we all want to achieve. However, if you drill down into areas, it is more prevalent and up to 35%. So on the one hand the data can look encouraging, but on the other we need to understand what it means in local areas so we can drill down. The question then is how we engage with those people and tackle it. So far, the engagement has not been as successful as we would like. Do we go to community centres, where people are, so they can understand how we can help them stop smoking?

Lord Kakkar: Are you then able to track specific interventions with the desired outcome, based on the datasets you currently have?

Councillor Ian Hudspeth: If we go down to the super output areas, yes.

Lord Kakkar: Has that happened?

Councillor Ian Hudspeth: I hope it happens. I encourage councils to look at and use that data. Rather than simply reporting it every year and saying, "This is the answer", they should look it and, if it has gone down, ask why. As was said earlier, there is an awful lot of data around. It is not a question of the amount of data; we need to make sure that we work better across the system so that our data is completely integrated with health data and we can all understand it, rather than just produce it.

Lord Kakkar: Do you think that popular interventions—an interesting diet or a proposition about exercise—help or hinder the capacity for thoughtful public health communication and discourse about healthy ageing?

Councillor Ian Hudspeth: We need to try different approaches—interventions that encourage people rather than the absolute "You can't do this" approach. If tackling and engaging with the last few per cent is not successful at the moment, we need to find different ways. How do we encourage people to eat healthily and give them the ability to know what a good diet is, rather than just tell them?

Baroness Walmsley: I have a question for Elaine Rashbrook. I was interested in the 100 organisations that you have a relationship with. It sounds as if there are lots of people doing the right things. I am interested in your relationship with government. As you said, your main relationship is, of course, with the Department of Health. Given that health should be a cross-government issue, what is your relationship with other government departments, and how helpful—or unhelpful—do you find particular departments in helping you achieve your objectives? Do you have relationships with the devolved Administrations? Do they do things differently in different parts of the country?

The Chair: All very briefly.

Elaine Rashbrook: On the first part of your question, Public Health England works with a range of government departments. As I mentioned, our role is to provide evidence and advice to Ministers on a range of

issues affecting healthy ageing. My own involvement includes the loneliness strategy, working with the Department for Digital, Culture, Media and Sport. I work closely with the Department of Health on issues such as dementia and risk reduction. Many colleagues have different relationships across government, but I cannot speak for them. The very helpful five extra years of healthy life is something which a number of government organisations are working towards.

There are a number of areas where the devolved Administrations are doing similar things. We all have public health strategies and there are some similarities. For example, we all have a priority of helping people to change their behaviour and live healthier lives. We are all aligned on issues such as mental health and the importance of the early years. There some differences in how we are organised and structured and some of our priorities are slightly different.

The Chair: Which department is taking the lead for the government strategy to extend healthy ageing by five years?

Elaine Rashbrook: That is led jointly by the Department of Health and BEIS.

The Chair: What is Public Health England's role in it?

Elaine Rashbrook: Our role is very much to support healthy ageing in a number of areas, such as improving behaviours where there are risk factors.

The Chair: I was after what your role is in developing this strategy, which BEIS is leading on.

Elaine Rashbrook: Our role is to—

The Chair: Do you have a role?

Elaine Rashbrook: We supply the evidence and advice to government. That is our main role.

The Chair: What kind of evidence have you hitherto supplied to them?

Elaine Rashbrook: Evidence about what works for healthy ageing—the risk factors and the wider environmental issues, such as housing and work and health. We know that these external factors have a big impact on health.

Dr Alison Giles: The ageing society grand challenge has shone a spotlight on health ageing and the need to act to enable people to age well. From the perspective of the Centre for Ageing Better, we need a named Minister to champion ageing across government rather than have more strategies. The loneliness strategy has been very helpful, but we need a named Minister with responsibility for ageing and more cross-departmental action to mirror what happens locally with things such as

housing and health and employment and health and to drive it at a government level.

Lord Hollick: Is data available that shows the impact of urban pollution on ageing? If it is available, what action do local authorities take to try to address that problem?

Councillor Ian Hudspeth: I am not sure whether the actual data to show the correlation is directly available. However, there is data to show where pollution levels are high, and of course the environmental authorities have to have a strategy to reduce air pollution to the best of their ability. Of course, one of the biggest impacts on that is transport, cars in particular, which sometimes leads to a disconnect between two authorities—it might not be the same authority that has responsibility for air quality and transport strategy.

On your point about devolution, where you have devolved powers it is easier to have a holistic view of everything and to look at the combination, rather than just focus on, “We have an issue. How do we change it?” A lot of councils are looking at zero-emission and low-emission zones to try to reduce pollution levels, but as for the correlation between the actual outcome and air quality, as far as I am aware there has been no data.

Lord Hollick: Does Public Health England have any insights into this?

Elaine Rashbrook: I can comment more generally on the issue. We know that pollution has an impact on people’s health, particularly on respiratory conditions, asthma and chronic obstructive pulmonary disease, and we are developing a strategy on air quality: actually, it is one of the 10 priority areas for Public Health England’s upcoming strategy.

I used to work in local government, and there are local monitoring stations for pollution levels so that people can be alerted in advance if they have a pre-existing condition such as asthma. They can sign up for alerts to let them know when it is reasonable to go outside and when they should confine their activities.

Dr Alison Giles: If you look at it at the population level, there is a win-win in terms of thinking about how people age and what environmental conditions will support that. Enabling more walking and cycling and improving public transport will reduce car use, which is good for connections, good for physical activity, and good for air quality. Trying to think holistically about the conditions that people need in order to age well can sometimes be better and more effective than thinking about air quality in one box, transport in another and ageing in another.

Baroness Hilton of Eggardon: I was on a previous study of obesity and we were very frustrated by the Government’s reluctance to introduce regulations on such things as salt, sugar and so on. Would you welcome more central-government regulations and directions on pollution, for

instance? We have a shocking record on levels of air pollution in our cities.

Do you think that central government should be doing more in the way of introducing general regulations?

Dr Alison Giles: Yes. The biggest impact that we can have on public health is through central government regulations. We have seen that in such things as the smoking ban and taxes. The soft drinks tax levy has been effective. We know that voluntary and nudge schemes go so far, but they are really quite small scale and open to abuse so, yes, the Centre for Ageing Better would very much welcome other regulatory measures on alcohol, obesity and air quality.

The Chair: Lord Browne has a very short question.

Lord Browne of Ladyton: Yes, it is about the value of data. We have heard evidence that 9%, I think, of premature mortality is caused by lack of physical activity. That is a worldwide observation by one of our witnesses and I am sure it is statistically correct. Public Health England and Sport England publish an annual survey of adult activity—presumably, that is just one such survey.

What does that tell us? I know the headlines rather than the granularity, but what does it tell us about the trend? Does it tell us, and do you have data that shows, how this compares internationally with countries that we would consider reasonable models for us to learn from? What insight does it give us into whether older people are actually taking more exercise, because the big picture the latest of these surveys indicates is that there is more physical activity among adults, people over 16, than ever before?

Elaine Rashbrook: With reference to levels of physical activity, the data tells us that as people age, they tend to be less active. Quite a small percentage of older people are reaching what was the previous high-level objective of around 150 minutes of activity a week. Some of the guidance has now changed, so the premise now is that anything is better than nothing in terms of getting active, but we know that as people age, there is a natural tendency to do less. We have to think of ways to overcome that.

Some of the evidence suggests the importance, as has been mentioned here, of changing the environment so that activities such as walking and cycling are easier to do and so that local amenities are available for people to use. There is also the issue of how people manage if they have a long-term condition. We want all older people to be as active as they can, and Sport England has produced new guidance on a campaign to encourage people with long-term conditions to get more active. These are all really helpful nudges: the campaigns, combined with some of the legislation or regulations relating to the environments we live and work in and the behaviour-change initiatives that people can be encouraged to take up can work together to improve those activity levels.

I am sorry, I do not have data about the international position, but we can find out and let you know.

The Chair: Thank you. Please write to us.

Q68 **Baroness Manningham-Buller:** First, I declare an interest. I am the chair of the Wellcome Trust.

I shall pick up on Baroness Hilton's question, which was answered by Dr Giles. You said, Ms Rashbrook, that we know what works, and I think you implied, Councillor, that you knew the same in some of your work. The Committee would like to hear whether the Government have the balance right between so-called nudge, seeking behaviour change, and greater regulation, potentially making it easier for people who find it difficult to take public health advice and messaging to alter their lifestyle. I would be interested to know what you think about that, bearing in mind that one of the things we hope will come out of our report is some recommendations to the Government on what they might do differently.

We are already collecting some of those ideas. We had your suggestion of a Minister for Ageing. What works? What would you like to see being done differently in a way that might work better? What combination of nudge and regulation would you like to see, or is there anything else you would like to suggest?

Dr Alison Giles: If the Government are serious about tackling obesity, we know that alcohol consumption is highest among 55 to 64 year-olds, so if we are thinking about preparing people for later life we need to tackle obesity and alcohol consumption. I think the Government should use every tool at their disposal to do that, rather than rely on individuals being able to scrutinise every packet and count every calorie that passes their lips.

The Obesity Health Alliance has very helpfully set out a number of regulations that it would like to see the Government implement. For adults in particular, this would be such things as mandatory calorie labelling in the whole out-of-home sector, so that people have the information when they are buying food; updating the soft drinks industry levy to include sweetened milk drinks, lowering the threshold and raising the rate to incentivise further reformulation. There are a number of things in connection with obesity that we could definitely ask the Government to implement.

On alcohol, the minimum unit price in Scotland is showing promising results, and Wales would like to pass the same legislation. I think that England must follow suit. Those are some of the things for us. Obesity in particular has a knock-on effect on so many other conditions that impact on people's ability in later life.

Baroness Manningham-Buller: I would like to give the other members of the panel the opportunity to answer, but before I do can I clarify what you have said? You think regulation is likely to be more effective than other ways of seeking to persuade people to behave differently.

Dr Alison Giles: Yes, in terms of scale and impact, because these are population-level policies that apply to everybody. As Councillor Hudspeth said, there are certain entrenched groups that need extra support and we need to give people one-to-one services, but regulation is important for a population-wide intervention.

Baroness Manningham-Buller: Perhaps not now, but I would certainly be interested in what we have seen elsewhere in the world, where increased regulation has led to good results. Let us leave that for the time being.

Councillor Ian Hudspeth: The sugar levy might, perhaps, be reallocated. At the moment, it goes to individual schools and is very beneficial for them. However, if it was allocated to a wider area, that area would be able to target those funds to where the main issues are. That would have the same benefit and give better outcomes. There is nothing in the licensing regulations now that refers to health issues. Should that be given greater consideration if there is a problem with licensed premises? Should that area be looked at? Again, it is about devolving down the power for local decisions.

Lord Browne of Ladyton: Specifically, on the question about licensing, correct me if I am wrong, but I assume that you are talking about licensing to sell alcohol. From your own knowledge in the important positions that you hold, when was the last time a licensee in any area for which you have responsibility had his or her licence restricted for selling too much alcohol to any individual?

Councillor Ian Hudspeth: Is that something that should be considered?

Lord Browne of Ladyton: Personally, I think so. The licence regulations are very clear about this, but streets in some areas are full of young people late at night who are very drunk. They clearly got the alcohol from somewhere. Somebody served it to them, but I have never seen any licensee reported as having lost a licence for it.

Baroness Manningham-Buller: Could I get Public Health England to answer my question and say what works? Earlier in your evidence you said confidently that you know what works. Where do you stand on the question of greater regulation, behavioural science and the range of things that government could do? Are you as firm as Dr Giles, or not?

Elaine Rashbrook: Many of the issues relating to ageing are complex, so we need to look at a range of approaches. A combination of behavioural intervention, supported by regulation, can often be effective.

Baroness Manningham-Buller: Can you give us an example from your experience of where that has worked well? Forget smoking for a minute.

Elaine Rashbrook: Taking the example of alcohol, we know that there are higher levels of consumption between the ages of 55 and 64, as people age. Some of the restrictions that have been put on where and when alcohol is sold, and who can purchase it, is one example. We have

heard how pricing can work in the devolved nations. Some of these things are being looked at in England through the prevention Green Paper. There is also a life course approach to addressing alcohol that involves looking at issues of alcohol-dependent parents. A combination of healthy ageing information and advice on alcohol, supported by changes to regulation, can have an impact.

As was mentioned in the Chief Medical Officer's report, a combination of approaches, looking at the physical environments that people live in, the economic situation in which people find themselves, social, commercial and digital factors, all play a part in healthy ageing. Public Health England's position is that a combination of these things can give us the right environment for healthy ageing and support behaviour change.

Lord Borwick: Back to smoking, I am afraid. The evidence has been that the smoking ban has been one of the most effective public health policies. Was is the definition of "effective" in that sentence? We still see large amounts of tobacco smuggling, large numbers of children smoking, and large areas of supermarkets and duty-free shops allocated to selling cigarettes. Would not an "effective" policy be more effective? If we are talking about the number of people smoking—I think the councillor said 7% of the population—what would an effective policy look like in terms of number of people smoking in, say, 10 years' time?

Elaine Rashbrook: The ambition is that we move towards a zero position.

Lord Borwick: That is right.

Elaine Rashbrook: Smoking rates across the population have now declined to 15%, so in one way this has been a public health success story at population level because of that decline and fewer young people taking up smoking. That has been because of a combination of many of the things we have talked about: legislation, an adjustment of public attitudes to smoking over a long time, support from plain packaging, and restrictions in the visibility of products in supermarkets and other places. All these have worked together to bring smoking rates down.

Obviously, there is more to do, and we want to continue the good progress in the right direction. This is often held up as a public health success story, albeit that there are still people in the population smoking.

Dr Alison Giles: In terms of the prevalence rates, the smoking ban had the biggest impact on making the curve decline more steeply. However, we had a combination of initiatives and interventions leading up to that ban. It was important that the public were brought along with the change. These big population-level interventions have their place. What we have seen in areas such as Greater Manchester is the importance of local leadership: setting a target and saying, "We are going to really crack this". Then they put a lot of resource and effort into reaching those entrenched groups, which are the hardest to convert. It needs the population-level work, then a real ambition to do the final push in local

areas by working with the social housing sector and others and going to the places where they know these groups are.

- Q69 **Baroness Walmsley:** I have no interest to declare, apart from my age. What are the main barriers to public health messaging on healthy ageing being acted on at an individual, personal level? Are there particular challenges relating to behaviour change in older people? I am particularly interested in the issue of a one-size-fits-all approach. If some older people acted on the messages about healthy eating, they would fade away. The level of activity that we are all expected to do is simply not appropriate for some people because they physically cannot do it.

Linked to that is also the question of people's attitudes and expectations of old age. I imagine some people feel: "I am getting older, so I should have all these aches and pains and I should not be able to walk down to the shops" and so on. What are the barriers to communicating what people could expect of a healthy older life?

Elaine Rashbrook: I guess there are a number of barriers at an individual level. You mentioned people's expectations of ageing. Through our public health consensus statement we have identified ageism as an issue that can pervade all sorts of areas—for instance, the media, where older people are often presented in quite a negative way. This can have an impact on individuals' expectations as they age and what they think it is appropriate to do. Are you an active person? Are you someone who does not want to do that? There is that sort of issue.

Another issue is one which Councillor Hudspeth mentioned: where these inequalities are concentrated. Many people face considerable challenges in changing their lifestyle, and we have to find better ways to reach people. If you live with multiple risk factors and in challenging circumstances, it can be more difficult to change your behaviour and to receive public health messaging. We also know that about 40% of people in England find it quite difficult to understand simple messaging and language, so how we convey the information is really important.

Some of the public health campaigns have had success, such as the One You campaign, which is aimed at 40 to 60 year-olds and is about changing lifestyle. It was based very much on insights from older people about what works from their perspective. The flu campaign was another one that had prominent messaging, and it has led to people taking up the flu vaccine.

Councillor Ian Hudspeth: Key to this is ensuring that the individual has the ability to understand what is around in their society and does not wait until they get to retirement and old age and then suddenly think, "Crikey, I've got to be more active", because, as has been said, that is very difficult to do.

Over-50s walking football, for instance, has been a great revelation to people who, when they were younger, played football and then, when they got older, of course, could not be as good. Suddenly, walking football levels it down so that you can take part in something. When it

was first introduced—I cannot remember when exactly—there was a bit of mockery about it. Now there are lots of leagues in which people are competing.

This, again, is about people taking up activity at the pre-retirement stage, because, as has been said, even if we cannot manage the required number of minutes per week, at least doing something is better than doing nothing. How do we encourage people to take up that activity and then link it to better food choices and better alcohol intake, and understand these things? The real difficulty is how we identify those people and then get the message to them so that they understand what can be done to improve their lifestyle. Of course, there is a very difficult balance to be struck in talking to people, because actually are we judging people, and do people like to be judged?

Baroness Walmsley: Those are interesting answers. Thank you. They bring me back to the tone of messaging. Going back to the previous question, clearly we got a lot of public buy-in to the smoking ban because people understood how dangerous it is. Really, it was based on fear. However, Councillor Hudspeth talked about an activity that is based on fun. There is a balance between fear of what happens if you do not and the good things that can happen if you do. How do you see that balance between fear and fun in relation specifically to healthy ageing?

Dr Alison Giles: The Centre for Ageing Better's focus on the enabling environment includes thinking about all the things that will enable people to lead a fulfilling older life. It does not have to be about being in 100% good health, but about enabling people to do what they want to do. In that context, the messaging is about what you want to be able to do or continue to be able to do, and how we enable that to happen.

I take it back to the supportive environment in which people can do these things, make these choices, and not putting it all down to the individual. Particularly with healthy eating, for example, it is quite difficult to navigate the food environment if it is conspiring against you.

There are also transitions that are useful. Whether it is women having the menopause, or becoming a carer or facing retirement, there are times when the health service or employers might be able to intervene to have conversations at key moments when perhaps people are ready to take a message on board and consider what the future might hold.

Q70 **Lord Mair:** We have heard that it is never too early or too late to make lifestyle changes and improve health prospects in old age. But to what extent do the policies address the young as well as the more elderly? My question is really to Public Health England.

Elaine Rashbrook: Public Health England advocates the life course approach. This is all about getting things right from the start of life. We have identified the different life stages, from preconception and early years to working age, ageing, old age and end of life, and have identified the key transition points that have already been mentioned, such as a

child starting school, being ready to learn and having the appropriate speech and language skills, to get the good education that can then lead to employment and better financial security outcomes in later life.

We have done work on getting the life course approach promoted and have produced a publication giving guidance and all sorts of evidence that helps with this type of approach. The life course approach can set things up well from the start and provide opportunities for intervention, early detection, better control of health, empowerment of the individual, and building resilience early in life for a healthy older age.

Lord Mair: Is it in practice, though, quite difficult to motivate young people about something that will happen to them very much further in the future?

Elaine Rashbrook: It is about the messaging. I guess for children in school it is the role of the parents and the wider environment, for instance speaking and communicating with your children. For young people around early adolescence and in early adult life, there are some really good campaigns, information and schemes, particularly at a local level, that engage young people in many decisions about their health. It is about building the life skills, and enabling people to retain them and to build resilience as they go through adult life.

Councillor Ian Hudspeth: Picking up on Baroness Walmsley's point about fun, we should be making it fun, for children in particular, rather than about the fear factor, so that it is fun to cook and to understand what the vegetables do and how it happens, that it is fun to go out. It is so important for young children to start with the ability to have fun rather than fear.

Dr Alison Giles: There is a bit of a gap in policy on the age group 50 to 70, which the Centre for Ageing Better is interested in. Generally when we think about ageing well we are thinking of people who already have mild to moderate frailty—the images of older people—and trying to enable them to teeter along. We need to be thinking of people who are still in work but have probably become carers, who may have the onset of long-term conditions. What can we put in place for those people to keep them in work and fulfilled and engaged, rather than waiting until they get to that older older age and into real difficulty?

Baroness Penn: On that specific point, do you have evidence on what kind of intervention works for that cohort, to get those messages out or fill the public policy gap that you mentioned?

Dr Alison Giles: Yes. We can provide more detailed evidence. I cover healthy ageing, but we have looked at workplaces and what makes employers age-friendly, to keep people in that age group in work, and interventions to get older adults back in to work if they have dropped out of it. We have looked at making sure that new-build housing is appropriate and people can stay in it for a long time. We have also just started working on the types of interventions we need in communities to

support the transition in to older age. We can give you more detail on that.

The Chair: We would be grateful if you could send us that.

Q71 **Lord Winston:** I have listened with great interest to what you have been saying. We have concentrated on certain narrow areas, such as smoking, drinking, pollution and so on. I would like to broaden this, if I may. One of the key issues that we have heard a great deal about is economic and socioeconomic differences and the extent to which they contribute to these things. Do you feel these are properly addressed in public health approaches to healthy ageing?

Elaine Rashbrook: We know that there are large inequalities due to socioeconomic status. The gap between those in the bottom 10% and those in the top 10% is about 19 years of healthy life expectancy, so it is a huge gap that needs to be narrowed. We know from work done by the King's Fund that there is a geographical clustering of the risk factors that accumulate for people experiencing the worst health. As I mentioned earlier, we know quite a bit about individual risk factors; what we are not so well aware of at this stage is how those factors interact and where we should focus most effort. Which risk factor should we look at first? Can we look at them all together? Many of the support mechanisms for that will be at a local level; the councillor has spoken about some of the initiatives. I am not sure whether that answers your question.

Lord Winston: Not entirely. Coming back to Lord Kakkar's question, there is clearly something else going on. These risk factors are not the only main contributors to ageing. For example, we know very well that babies born with low birth weight are likely to have a shortened longevity. They are more likely to have diabetes, hypertension and coronary problems; they probably have osteoporosis. One of the questions in the literature is whether this is due to socioeconomic issues, or something else. Do you feel you are collecting the right data to answer those sorts of questions?

Councillor Ian Hudspeth: I think the data is being collected. The issue is what we do with it.

The Chair: Who is collecting this data?

Councillor Ian Hudspeth: All the organisations are collecting the data you mentioned.

Lord Winston: So you have a person's birth weight?

Councillor Ian Hudspeth: Yes, and then we look at it, because a key thing is to make sure that mothers are healthy pre-pregnancy. Factors such as good housing, employment and security all feed in to it. We have super output area wards where people have problems with poor-quality housing, poor-quality security—physical or of tenure—and the education outputs are not as great, which leads back in to it.

Lord Winston: Councillor Hudspeth, I am not sure that I am entirely impressed by that. We have known for at least 25 years, from the work of Lars Bygren in Sweden, that if children have a high-fat diet and are well fed at the age of nine, their paternal grandchildren are more likely to have a shortened longevity. There is something else going on—in this case, it is probably epigenetic. You talk about pre-pregnancy, even before conception, but let us just deal with pregnancy. There is a huge amount that we do not know about pregnancy. For example, even our records of pre-diabetes in pregnancy are not particularly good in this country. Would you like to comment on that?

I do not know whether my Lord Chairman would agree with that. He has huge expertise in this.

The Chair: The question that Lord Winston asked earlier is important from the point of view of Public Health England. What data are you collecting?

Elaine Rashbrook: A huge range of data is collected, across many different aspects of health. This is pulled together in a number of ways by Public Health England. Some of the data is supplied by the NHS, some by other bodies. The issues we have just heard about may be of particular interest to academics in that field. We can look at the evidence emerging from their work and potentially turn it into public health guidance and advice. What stage the science is at and how that needs to feed into public policy is a slightly different question.

Lord Winston: Forgive me, but I do not think that we can simply dismiss it as being of interest to academics. I mean no disrespect—what you are trying to do is very important and we all respect that. But it seems to me that there are a lot of puzzling counter-issues in the data that we have, which suggest that sometimes someone from a high economic group who has a background of being well may still have influences that change their longevity, with quite common diseases later in life. Therefore, how we collect the data is of tremendous importance. That is rather missing, given that we have known about, for example, the foetal origins of adult disease for a long time.

Elaine Rashbrook: Public Health England has a programme called “Predictive Prevention”, which is about bringing together the primary and secondary data sources to understand more about how individuals’ health can be improved. That is in development stage. I would need to take back some of the specific questions that you have raised and seek further advice from colleagues.

Lord Winston: To be fair, I have gone a bit off piste. I think that the Committee was hoping to hear about what sort of systems and services might be needed in the public sector to help with these issues. The data seem to me to be of such great interest that I have gone for that, perhaps rather unreasonably in your case.

Lord Kakkar: Will the new programme that you mentioned as being in

development collect not only health data but data from other sources that may be of relevance, such as the environment in which people live and the kinds of employment that they have? Or will it be restricted merely to health outcomes?

Elaine Rashbrook: It is looking at how individual outcomes for people can be improved throughout life. On the specifics of the data collected, this is not really my policy area. I would need to go back and check and let you know.

The Chair: Do you have a copy of that to send to us?

Elaine Rashbrook: Information about the project? Yes.

Lord Hollick: What benchmarks are being used to determine whether the Government's objective will be achieved? How would you rate the chances of success?

Elaine Rashbrook: A number of public health outcome measures are in the public domain and look at some of the risk factors that we have heard about. It is about seeing whether those are all going in the right direction. We know that they contribute towards those five extra years. There are also measures on housing and employment—types of housing, the number of older people in employment—and some of those wider environmental issues. A range of metrics is available and it is about identifying which are the most appropriate to measure progress.

Lord Hollick: What is your view about the achievability of the target?

Elaine Rashbrook: Are you referring to the five extra years?

Lord Hollick: Yes, and the other target on levelling up socioeconomic base differences.

Elaine Rashbrook: These are challenging areas for us, on which we still need to do more work. I think that we are moving in the right direction.

Lord Hollick: At the right speed?

Elaine Rashbrook: There is always more that can be done and it needs a concerted effort across local and national positions.

The Chair: Do you think that the targets will be achieved? Be honest.

Elaine Rashbrook: As I say, I think that we are moving in the right direction. We need to monitor progress over a number of years to make sure that we are going the right way in trying to get to those targets. It is hard to say exactly whether we will, but the ambition is there.

The Chair: That is the kind of answer we usually get from civil servants. Dr Giles, do you think it is achievable?

Dr Alison Giles: I think it is a long shot—it is shooting for the moon—but we might get somewhere towards it. It is very ambitious. Without concerted cross-government ownership, a Minister who drives this

forward and some of the population-level interventions that we have discussed, it is difficult to see how everything will be aligned at the right pace to achieve the target, but it is worth shooting for.

Lord Winston: Perhaps this is a reasonable question to ask you. Given the risk factors that are identified—smoking and alcohol, for example—how do your data benchmark against those of other countries, where alcohol and smoking are used? Do we have some outliers that do not show the same effect on longevity in different countries?

Dr Alison Giles: We would have to get back to you on that, if we may.

Lord Winston: It would be important to look at that.

The Chair: Please do. We have gone slightly over time. Thank you very much for coming today. I know that some of our questions tend to be challenging, but that is our job. We are trying to help you and the Government to achieve the target and to identify issues that work against achieving the target. Thank you.