House of Commons

Health and Social Care Committee

Healthy Ageing: physical activity in an ageing society

Eighth Report of Session 2024–26

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Health and Social Care Committee

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Summary

Shifting from illness to prevention is one of the government's three priorities for the NHS. This report addresses the essential role of physical activity in preventing illness among older people. We are living longer, yet too many people are spending those extra years in poor health, with low levels of physical activity being a major driver of ill health in later life. Increasing movement—especially among the least active—can prevent many of the leading causes of death, prevent the onset of frailty, dementia and disability and help narrow the unacceptable 20-year gap in healthy life expectancy between the most and least deprived areas of the country.

Despite the overwhelming evidence of the benefits of physical activity—often described as more effective than many drugs—it continues to be treated as an optional extra across the NHS and social care. If the government is serious about creating an NHS that is "fit for the future" and shifting from treatment to prevention, it cannot ignore one of the safest and most cost-effective interventions available. To achieve this, we are calling on the government to:

- Embed routine conversations about physical activity as a core part of clinical practice. Health professionals are a trusted source of advice, but too many people report never being encouraged to be active. Expanding access to best-practice models will support more health professionals to have the skills and confidence to promote physical activity.
- Commission evidence-based exercise programmes to reverse frailty, reduce falls and help prevent or delay dementia. While access remains inconsistent older people will not realise the benefits frailty reduction can provide in preventing and delaying dementia or supporting them to retain their independence.
- Make better use of leisure and physical activity infrastructure and workforce to deliver care closer to where older people live and support them to remain active. While there are local examples of this being done well, fragile funding arrangements and weak national direction prevent this from being utilised consistently.
- Recognise social prescribing as a core mechanism for increasing physical activity and expand support and resources so that it can act as a bridge between health services and community physical activity opportunities.

- Use its reform of the social care system to address the high levels of physical inactivity, including placing a greater emphasis on physical activity in the Care Quality Commission's assessment framework.

Supporting older people to age well is a societal challenge that health services will not solve alone. There is an urgent need for government to respond to an ageing population and for everyone to understand that remaining active in older age is beneficial and achievable. Too often later life is framed as an inevitable decline, reinforcing low expectations and inaction. By changing attitudes to ageing and promoting everyday movement and ways to improve strength and balance, we can prevent many age-related illnesses and support people to stay independent for longer. To respond to this challenge, we are calling on the government to:

- Launch a national movement campaign—focused on those approaching retirement and the least active—that starts a multi-generational conversation challenging negative assumptions about ageing.
- Embed active design principles into planning guidance to support the creation of healthy, active places that allow everyone to age well and remain active.
- Act across government to remove the policy, funding and accountability barriers that have led to inactivity being designed into daily life, particularly for older people. This includes local action to remedy poorly paved streets, unsafe crossings and a lack of toilets and seating, combined with national transport and planning decisions that make moving easier.

The consequences of inaction are predictable: rising rates of frailty and dementia, deepening inequalities and escalating demand on NHS and social care—with costs borne by individuals, their families and the wider economy. The case for action is equally clear: healthier ageing, stronger communities and a meaningful way to deliver on the government's prevention agenda and support its NHS reforms.

Introduction

> If physical activity were a drug, we would refer to it as a miracle cure, due to the great many illnesses it can prevent and help treat.[1]
>
> UK Chief Medical Officers

1. The UK's population is ageing. In 2022, there were around 12.7 million people aged 65 or over, approximately 19% of the population, which is expected to rise to 22.1 million people (27% of the population) by 2072.[2] While many more people are living longer, improvements in healthy life expectancy—the number of years we can expect to live in good health—have stalled. The average person is only expected to live in good health until the age of 61.[3] Older people are more likely to have multiple health conditions. In 2015, 54% of people aged over 65 had two or more health conditions, by 2035 this could rise to 68%.[4] Living with multiple conditions can lead to greater complexity in care needs, a higher risk of hospital admissions, longer hospital stays and lower quality of life.[5]

2. There is also significant health inequality linked to deprivation. In 2022–24, children born in Blackpool could expect to live 50.9 (male) and 51.8 (female) years respectively in good health, while children born in Richmond upon Thames could expect to live 69.3 and 70.3 years respectively in good health.[6] The government has committed in the *10 Year Health Plan for England* to "halve the gap in healthy life expectancy between the richest and poorest regions, while increasing [healthy life expectancy] for everyone."[7]

3. Physical inactivity is linked with many health conditions, including obesity and overweight, type 2 diabetes, and some types of cancer, and is a cause of early death.[8] Low levels of physical activity is the fourth leading risk

1 UK Chief Medical Officers, Physical Activity Guidelines, gov.uk, 7 September 2019
2 House of Commons Library, The UK's changing population, 16 July 2024
3 Office for National Statistics, Healthy life expectancy, UK: between 2011 to 2013 and 2022 to 2024, 19 February 2026. Life expectancy at birth is 60.7 years for males and 60.9 years.
4 Parliamentary Office of Science and Technology, Healthy ageing and care for older populations, 7 October 2024
5 Parliamentary Office of Science and Technology, Healthy ageing and care for older populations, 7 October 2024
6 Office for National Statistics, Healthy life expectancy, UK: between 2011 to 2013 and 2022 to 2024, 19 February 2026
7 Department of Health and Social Care, Fit for the future: 10 Year Health Plan for England, gov.uk, 30 July 2025
8 NHS England, Why we should sit less, accessed 24 March 2026

factor contributing to deaths and the burden of disease globally, ahead of obesity or overweight.[9] In the UK, physical inactivity is associated with one in six deaths and is estimated to cost £7.4 billion annually.[10]

4. There is extensive evidence of the benefits of physical activity in supporting healthy ageing. Physical activity is recommended in 98 National Institute for Health and Care Excellence (NICE)" clinical guidelines and quality standards[11] and has been described as being "as good as or better" than many drug treatments by Public Health England.[12] Being physically active reduces the risk of dementia, cardiovascular disease, stroke, type 2 diabetes, musculoskeletal conditions and some cancers, and has protective benefits for cognitive function and mental health.[13] Regular physical activity contributes to the key factors of healthy ageing: good physical and mental function, opportunities for social interaction, a sense of control over and responsibility for your own health and wellbeing and managing long-term conditions. Remaining active in older age also contributes to increased physical function, reduced impairment, independent living and improved quality of life.[14]

5. However, the benefits are not being realised, despite the Chief Medical Officer describing exercise and physical activity as being a "simple" action than can support healthy ageing.[15] Physical activity refers to all bodily movement, including during leisure activities, for transport or as part of someone's work or domestic activities, along with specific evidence-based exercises that can be used to prevent, treat or reverse many health conditions. The UK Chief Medical Officers' *Physical Activity Guidelines* recommend older people should aim to accumulate 150 minutes of moderate intensity aerobic activity a week and do activities aimed at improving or maintaining muscle strength, balance and flexibility at least twice a week.[16] However, in 2023–24, 44% of people aged 75 and over were physically inactive, doing less than 30 minutes of moderate physical activity per week.

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9 NHS England, Health Survey England Additional Analyses, Ethnicity and Health, 2011–2019, 20 June 2022

10 Office for Health Improvement and Disparities, Physical activity: applying All Our Health, gov.uk, 10 March 2022

11 NICE clinical guidelines and quality standards are evidence-based recommendations designed to improve the quality of health and social care. They support commissioners and professionals deliver care based on the best evidence, promote clinical and cost effectiveness and reduce unwarranted variation in treatment.

12 Public Health England, Health matters: physical activity - prevention and management of long-term conditions, gov.uk, 23 January 2020

13 Department of Health and Social Care (HAP0084) and Sport England (HAP0091)

14 UK Chief Medical Officers, Physical Activity Guidelines, gov.uk, 7 September 2019

15 [Professor Chris Whitty] Q14

16 UK Chief Medical Officers, Physical Activity Guidelines, gov.uk, 7 September 2019

Inactivity is also higher among people living in the most deprived areas of England, with 38.2% of people aged 75 and over living in the most deprived areas physically inactive, compared to 17.8% in the least deprived areas.[17]

6. The government's *10 Year Health Plan for England* sets out to build movement back into everyday life and get millions more people moving.[18] Our inquiry set out to understand what actions government should take to bridge the gap between low physical activity levels and realising the opportunities of its role in preventing illness by supporting healthy ageing.

17 Sport England, Active Lives Survey Adult Data (Ages 16+), accessed 16 March 2026

18 Department of Health and Social Care (HAP0084)

1 Embedding physical activity in the health and social care system

7. In this first chapter we explore how the health and social care system can make better use of physical activity to prevent and treat ill health and support people to age well. We discuss:

   a. embedding physical activity in the health service by making it a strategic priority for integrated care boards

   b. strengthening links with partners outside of the health system including the leisure, physical activity and voluntary, community and social enterprise sectors

   c. tackling sedentary behaviour in the social care sector through physical activity opportunities.

Making physical activity a strategic priority for integrated care boards

8. In March 2025, NHS England published *Harnessing the benefits of physical activity*. This sets out its ambition to embed physical activity into "every aspect of life-long healthcare," while also recognising that many people do not receive the support they need to stay active. NHS England argues that "unlocking the potential" of physical activity will require healthcare leaders to be "much more ambitious" in incorporating physical activity promotion into prevention and long-term condition management.[19]

9. Throughout our inquiry we heard that while the benefits of physical activity were well understood in the health care sector, it was not widely embedded into care pathways. Adam Blaze, Chief Executive of Activity Alliance, argued that this was because physical activity was still largely viewed as an optional extra, added after strategies had been designed, rather than treated as a core solution to improving health.[20]

19 NHS England, Harnessing the benefits of physical activity, 31 March 2025
20 Q94

10. We also heard that despite prevention being a key government priority, embedding physical activity and a more preventive approach into integrated care board (ICB) strategies was difficult in the current funding environment. While NHS England's *Model ICB Blueprint* referred to a more preventive approach, Norfolk and Waveney ICB argued that this was not reflected in how NHS budgets were spent, with the majority of current funding supporting frontline care.[21] Bethany Badrock, Ageing Well Programme Manager at Greater Manchester Combined Authority, commented that currently all funding was "pumped into crisis response" to respond to demand.[22] Ryan Hughes, Head of Programmes and Partnerships at Active Norfolk, told us there was financial pressure to show positive outcomes from physical activity interventions in timeframes too short to realistically show results, resulting in prevention services being seen to have failed and decommissioned.[23]

11. We heard that some ICBs had prioritised physical activity to support healthy ageing and embedded it into care pathways. Buckinghamshire, Oxfordshire and Berkshire West ICB explained that a whole-system approach, working with Oxfordshire County Council Public Health, city and district councils and Active Oxfordshire, had allowed them to develop a coordinated physical activity strategy that enabled collaborative commissioning.[24] Norfolk and Waveney ICB, Active Norfolk and Norfolk County Council Public Health told us that physical activity and prevention had become prominent in local strategies because the ICB, acting as a strategic commissioner, had the "contractual levers" to embed physical activity in care pathways.[25] However, Ryan Hughes expressed concern that the ability for physical activity to remain as a strategic priority was "fragile" because as ICBs "go through changes and cuts [prevention was] still one of the first things to go."[26]

12.

CONCLUSION

Physical activity remains insufficiently prioritised across health and care systems despite its clear contribution to preventing illness, improving population health and reducing inequalities. While some integrated care boards (ICBs) have embedded physical activity into strategies, this is not yet consistent or widespread, with physical activity too often being treated as an optional add-on, rather than a core, evidence-based intervention.

21 Norfolk and Waveney ICB, Active Norfolk, Norfolk County Council Public Health (HAP0050)

22 Q241

23 Q228

24 Buckinghamshire, Oxfordshire & West Berkshire (BOB) Integrated Care Board (ICB), Oxfordshire County Council Public Health, Active Oxfordshire (HAP0088)

25 Norfolk and Waveney ICB, Active Norfolk, Norfolk County Council Public Health (HAP0050)

26 Q209

13. **RECOMMENDATION**
The Department should require ICBs to embed physical activity as a core preventive intervention within population health strategies. ICBs should demonstrate how physical activity is being integrated into healthy ageing, long-term condition management and health inequalities frameworks, with clear accountability for delivery.

Equipping the workforce to have conversations about physical activity

14. NHS England acknowledges the central role health and care staff can play in promoting the benefits of physical activity, citing research that one in four people would be more active if advised by a health professional.[27] We heard older people would benefit from health and care professionals across the system routinely having conversations about physical activity.[28] The National Institute for Health and Care Excellence (NICE) told us that brief advice interventions in primary care settings were "highly cost-effective,"[29] and highlighted its guidance that encourages health professionals to discuss physical activity in their advice.[30] The existing *Making Every Contact Count* framework encourages health and care staff to use brief interventions during regular interactions with patients to discuss how they could make positive improvements to their health or wellbeing.[31] Where these conversations do take place there is evidence that they are effective, with 76% of older people who spoke to a health or care professional about physical activity subsequently taking action or considering doing more activity.[32]

15. However, we heard that these conversations did not always happen. The Richmond Group of Charities reported that while 68% of adults with a long-term condition had spoken to a health professional within a period of a month, only 33% of them had discussed physical activity.[33] Professor Chris Whitty, Chief Medical Officer for England, described the lack of routine conversations about physical activity as a "failing of us as a [medical] profession" and emphasised clinicians' "professional responsibility" to make a "very clear statement" about its benefits.[34] NHS England has said

27 NHS England, Harnessing the benefits of physical activity, accessed 11 February 2026
28 College of Paramedics (HAP0114), Academic Centre for Healthy Ageing, Queen Mary University, London (HAP0138) and Age UK (HAP0149)
29 NICE (National Institute for Health and Care Excellence) (HAP0008)
30 National Institute for Health and Care Excellence, Physical Activity: brief advice for adults in primary care, Public Health Guidance PH44, 29 May 2013
31 National Institute for Health and Care Excellence, Making Every Contact Count, accessed 15 February 2026
32 The Richmond Group of Charities (HAP0126)
33 The Richmond Group of Charities (HAP0126)
34 Q24

that nearly three quarters of GPs do not speak about physical activity with patients, suggesting some professionals often "prioritise medication" either "out of fear" exercise might exacerbate conditions or due to concerns about how the information might be received by patients. NHS England also highlighted factors such as lack of time, resources or contractual obligation to promote physical activity as challenges to having these conversations.[35] This was reflected in what older people taking part in our distributed dialogue told us.[36] While participants' trust in GPs was high, they felt that time pressure during appointments, variable knowledge and mixed messages resulted in inconsistent advice and could create fear about doing physical activity.[37]

16. 80% of GPs reported being unfamiliar with the UK Chief Medical Officers' *Physical Activity Guidelines*, and 55% had received no specific training on having conversations about physical activity.[38] The Richmond Group of Charities told us that mandatory training and competencies should be embedded in training programmes and continued professional development for health professionals.[39] We heard that best-practice frameworks such as *Moving Medicine*, *Moving Healthcare Professionals* and the *Physical Activity Clinical Champions* programme provided useful foundations for building knowledge and confidence among staff.[40] Sport England reported that more than 157,000 professionals had engaged with *Moving Healthcare Professionals* and more than 40,000 health professionals had been trained to include physical activity conversations in their practice with patients.[41] Witnesses also highlighted the potential of digital tools to support health care professionals in further embedding the promotion of physical activity to manage health conditions. Sir Muir Gray, Director of the Optimal Ageing Programme, told us about W:ISH, technology that is integrated into the NHS app and uses a patient's NHS data to provide personalised activity prescriptions, alongside and sometimes instead of drug prescriptions.[42] However, the Faculty of Sport and Exercise Medicine argued that despite

35 NHS England, Health and care professionals should feel empowered to promote physical activity to their patients, and this is how we can support them, accessed 25 February 2026

36 To incorporate lived-experience, we created discussion packs around key questions about physical activity, and asked stakeholder organisations to conduct "distributed dialogues" with older people on our behalf—the results were sent back to us, and a summary can be found in Annex One of this report.

37 See Appendix 1: Distributed dialogue

38 Public Health England, Health matters: physical activity - prevention and management of long-term conditions, gov.uk, 23 January 2020

39 The Richmond Group of Charities (HAP0126)

40 Active Partnerships National Organisation (HAP0025), NHS Greater Manchester, Greater Manchester Moving, Greater Manchester Combined Authority (HAP0043), Norfolk and Waveney ICB, Active Norfolk, Norfolk County Council Public Health (HAP0050) and NHS NEL (HAP0072)

41 Sport England, Moving Healthcare Professionals, accessed 25 February 2026

42 Q67 and The Optimal Ageing Programme at Oxford (HAP0007)

the existence of tested frameworks and models, there was still "no widely accepted model for physical activity implementation" across primary or secondary care.[43] In January 2026, NHS England launched a blog and podcast series to promote the incorporation of physical activity into clinical practice.[44]

17. **CONCLUSION**

Physical activity can be more effective than drugs in preventing, treating and managing many long-term conditions. Health and care professionals have an important role in encouraging and supporting people to include physical activity in the management of their health. Conversations about physical activity must become a core component of clinical practice to implement current National Institute for Health and Care Excellence (NICE) guidance on physical activity. We welcome the recognition from NHS England that health and care staff must be supported to gain the skills and confidence to discuss and prescribe physical activity. However, for this to happen health leaders must demonstrate that it is a priority and ensure all staff have access to training and examples of best practice. The NHS will need to go further than encouragement alone and begin rebalancing how it invests in prevention—recognising that evidence-based physical activity can be as effective as drug treatment for many conditions—and shifting resources and spend towards its routine promotion and prescription.

18. **RECOMMENDATION**

We recommend that the Department work with integrated care boards (ICBs) to develop a national roll-out of existing best-practice models to support clinicians to have conversations about physical activity with patients, particularly older patients. This should include a communication strategy to reach all health professionals, clear messaging about the benefit and priority assigned to these conversations and resources to support managers to promote it to their staff.

19. **RECOMMENDATION**

In addition, we recommend that ICBs explore methods for increasing investment in the prescription of physical activity as part of a broader shift towards prevention. This should be pursued alongside appropriate clinical treatments, ensuring patients benefit from the full range of evidence-based interventions available.

43 Faculty of Sport and Exercise Medicine (HAP0051)

44 NHS England, The four ways forward: embedding physical activity at the heart of community centred care and prevention, accessed 25 February 2026

Commissioning evidence-based exercise programmes to reverse frailty

20. Frailty is a term used by medical professionals to identify the group of mainly older people who have the highest risk of adverse outcomes including falls, increased hospital admissions and the need for long-term care.[45] However, while the prevalence of frailty increases with age, with just over 50% of people aged over 85 living with moderate and severe frailty,[46] we heard that frailty was not an inevitable consequence of ageing.[47] The British Geriatrics Society stated that while frailty was a long-term condition, the degree of frailty that a person had was not static and could be made better or worse.[48]

21. We heard there was a strong link between frailty and dementia. Professor Chris Todd, Deputy Director at the National Institute for Health and Care Research (NIHR) Policy Research Unit in Health Ageing, told us the risk of developing frailty was increased by having dementia and that dementia was one of the identifying characteristics of frailty.[49] A UK study in 2020 found that people with pre-frailty and frailty were at higher risk of developing dementia and concluded that early interventions for frailty could result in preventing and delaying the onset of dementia.[50]

22. Professor Todd told us that evidence-based exercise programmes, particularly resistance training, could both prevent frailty from developing and reverse it.[51] He also highlighted that exercise programmes to prevent frailty could decrease the risk factors linked to developing conditions associated with ageing, including dementia.[52] The Falls Management Exercise (FaME)[53] programme was highlighted throughout our inquiry as an effective, evidence-based intervention that improved the indicators of frailty—low body mass, mobility and strength—while also increasing physical activity levels and reducing the risk of falls, hospitalisation and

45 Department of Health and Social Care, Chief Medical Officer's Annual Report 2023: health in an ageing society, gov.uk, 10 November 2023
46 National Institute for Health and Care Research, Frailty: research shows how to improve care, 24 October 2024
47 Oxford Brookes University (HAP0013)
48 British Geriatrics Society, Fit for Frailty, 14 May 2018
49 Q132
50 Petermann-Rocha F, Lyall D, Gray S et al., Associations between physical frailty and dementia incidence: a prospective study from UK Biobank, The Lancet Healthy Longevity, Volume 1, Issue 2, November 2020
51 Q112
52 Q132
53 Health Innovation South West, Falls Management Exercise (FaME) Programme, accessed 11 March 2026

mortality.[54] Evaluation has found that for every £1 of health care money invested in FaME, £2.36 is saved, while every £1 of public health money invested in FaME provides a £50.59 social return.[55]

23. The National Institute for Health and Care Excellence already recommends progressive exercise programmes should be prescribed to prevent falls in people at risk, including those with frailty.[56] Similarly, the 2019 *NHS Long Term Plan* committed to supporting people to age well, including through falls prevention schemes using exercise classes and strength and balance training.[57] However we were told that while awareness of the need for early intervention had increased across the health system, and in some areas community-based strength and balance programmes were offered, approaches remained inconsistent and varied significantly, creating a "postcode lottery" in provision.[58] Elizabeth Orton, Professor of Public Health at University of Nottingham, told us that a recent survey found that only 5% of integrated care boards (ICBs) and 15% of local authorities had commissioned the FaME programme.[59] We heard that many commissioned exercise programmes relied on temporary local grants or pilot funding, causing difficulties recruiting and retaining the highly trained staff required to deliver them.[60] This limited continuity for participants and risked eroding public trust when programmes closed suddenly.[61]

24. We also learnt that when FaME and other evidence-based programmes are commissioned, they can lack the specificity, frequency or duration of exercise required to improve outcomes.[62] Dawn Skelton, Professor of Ageing at Glasgow Caledonian University, told us the duration of evidence-based programmes needed to be viewed as being as important as when prescribing a drug, arguing that clinicians would not "give half a dose of chemotherapy to somebody."[63] Bethany Badrock, Ageing Well Programme Manager at Greater Manchester Combined Authority, told us that in some

54 Faculty of Sport and Exercise Medicine (HAP0051), Parkinson's UK (HAP0055), Centre for Ageing Better (HAP0067), Healthy Ageing Research Group, University of Manchester (HAP0076) and Later Life Training (HAP0079)
55 Health Innovation South West, Falls Management Exercise (FaME) Programme, accessed 11 March 2026
56 NICE (National Institute for Health and Care Excellence) (HAP0008)
57 NHS England, The NHS Long Term Plan, National Archives, accessed 11 March 2026
58 London Sport (HAP0141) and [Professor Dawn Skelton] Q116
59 Q118
60 Faculty of Sport and Exercise Medicine (HAP0051) and Later Life Training (HAP0079)
61 NHS NEL (HAP0072)
62 Dr Christopher Hurst (Senior Research Associate at Newcastle University) et al. (HAP0059), Later Life Training (HAP0079) and University of Nottingham (HAP0151)
63 Q115

localities, falls prevention programmes were commissioned for a third of the intended programme length, yet commissioners still expected to see the same outcomes.[64]

25. The government has committed to creating a Modern Service Framework (MSF) for frailty and dementia. MSFs are intended to identify the best evidenced interventions in their areas, set standards on how those interventions are used and provide a clear strategy to support and oversee uptake.[65] On 5 March 2026, Secretary of State for Health and Social Care, the Rt Hon Wes Streeting MP, committed to publishing the full MSF for frailty and dementia by the end of 2026[66] in response to Baroness Casey's recommendations for immediate action on dementia in relation to adult social care.[67] We expressed our scepticism on whether MSFs will succeed in driving change where other plans that set out standards and expectations have failed in previous reports on community mental health services[68] and palliative care,[69] calling for MSFs to be accompanied by clear accountability mechanisms to hold ICBs accountable for delivering the framework.[70]

26. **CONCLUSION**

Frailty is not an inevitable or irreversible aspect of ageing, and early intervention offers significant opportunities to prevent or slow its progression. Exercise programmes can reverse frailty, reduce the risk of developing dementia and improve outcomes for people living with dementia. However, these benefits will only be realised at scale if underpinned by a coherent national strategy. These interventions must also be understood by commissioners, and prescribed and delivered by health professionals, in a comparable way to drug treatments.

64 Q255
65 Department of Health and Social Care, Fit for the future: 10 Year Health Plan for England, gov.uk, 30 July 2025
66 Department of Health and Social Care, Letter from the Secretary of State for Health and Social Care to Baroness Casey of Blackstock DBE CB, gov.uk, 5 March 2026
67 Independent Commission on Adult Social Care, Immediate action on safeguarding, dementia and motor neurone disease, 3 March 2026
68 Health and Social Care Committee, Seventh Report of Session 2024–26, Community Mental Health Services: Commentary on the Government Response to the Committee's Fourth Report of the Session 2024–26, HC 1769
69 Health and Social Care, Sixth Report of the Session 2024–26, Palliative Care, HC1763
70 Health and Social Care, Sixth Report of the Session 2024–26, Palliative Care, HC1763, para 18

27. **RECOMMENDATION**
We recommend that as part of the Modern Service Framework (MSF) for frailty and dementia, the government identifies and sets clear standards for delivering exercise programmes to prevent and reverse frailty. This should include a requirement for integrated care boards (ICBs) to commission evidence-based exercise programmes at the duration and intensity necessary to deliver outcomes. We also ask that the government sets out the accountability arrangements that will accompany the MSF for frailty and dementia in its response to this report. This should include how the government will ensure consistent uptake of evidence-based exercise programmes among ICBs to remove the current national variation in access.

Using data to target interventions and reduce health inequalities

28. As we set out in the introduction, health inequalities have a major impact on the number of years people can expect to live in good health. These inequalities also impact the likelihood of people engaging in physical activity. In the least deprived areas 69% of older people are active, meeting the Chief Medical Officers' recommended physical activity levels, compared with only 55% in the most deprived.[71] This inequality is even more pronounced for older people with long-term conditions. The Richmond Group of Charities told us that only 39% of adults aged 55 and over with a disability or long-term condition were active, compared to 66% of those aged 55 and over without.[72]

29. Professor Chris Whitty told us that given the "transformational" health benefits that small increases in physical activity could have among people who were inactive, focusing resources on a small number of highly deprived wards would generate quicker and more cost-effective improvements than spreading interventions thinly across all areas.[73] This was borne out by the evidence we received from community programmes that had taken targeted approaches. Age UK Norwich's *Health Coaching Programme* showed that "personalised, multi-dimensional interventions" delivered in high-deprivation areas could significantly reduce health inequalities, with participants living in more deprived areas showing equal or greater improvements than their peers from less deprived areas.[74]

71 Sport England, Active Lives Adult Survey 2023–24 Report, 25 April 2025
72 The Richmond Group of Charities (HAP0126)
73 Qq29–32
74 Age UK (HAP0149)

30. We repeatedly heard that better use of population health data was essential to ensuring interventions reach the areas of greatest need.[75] Witnesses told us effective population health strategies would require hyper-local insight and a "street-led" understanding of communities to determine what supported older people to age well.[76] Newcastle University and Rise North East[77] described how the *Every Movement Matters* programme used electronic patient record data to target older people with long-term conditions in deprived communities.[78] The programme delivers tailored, group-based physical activity programmes in locations near to general practices, combined with health and lifestyle coaching. Evaluation found 74% of participants increased their activity levels and 95% reported improved health.[79]

31. We were told that this kind of targeting could be difficult due to shortcomings in data collected. The Local Government Association (LGA) told us that councils currently found the sample sizes used by national surveys, such as the *Active Lives Survey,* too small to understand and identify activity levels against multiple demographics. The LGA argued that larger data sets specifically looking at physical activity would enable councils to better understand activity levels and allow benchmarking and identification of good practice.[80] London South Bank University researchers told us data collection on reach and outcomes should be nationally standardised to support consistent evaluation and improvement.[81]

32. NHS England's *Model ICB Blueprint* sets out how, as strategic commissioners, integrated care boards (ICBs) will be responsible for setting long-term population health strategies, allocating resources and evaluating impact.[82] In March 2026, NHS England published new guidance on how ICBs should move towards population health delivery models, as part of the government's effort to support ICBs to become strategic commissioners. The guidance states that such an approach will require new ways of using population insight and intelligence to identify population health need, set outcomes and inform commissioning decisions. It states that commissioners will need to use:

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75 Centre for Exercise Activity and Rehabilitation, Institute for Lifecourse Development, School of Human Sciences, University of Greenwich (HAP0018), West Wales Sports Partnership Ltd (HAP0039), NHS Greater Manchester, Greater Manchester Moving, Greater Manchester Combined Authority (HAP0043) and Age UK (HAP0149)

76 [Bethany Badrock and Ryan Hughes] Q209 and Q237

77 A charity working to reduce health inequalities through physical activity.

78 Newcastle University (Jennifer Liddle), RISE (Michael Ali) (HAP0049)

79 RISE, Prescribing Movement, accessed 23 February 2026

80 Local Government Association (HAP0087)

81 London South Bank University (HAP0058)

82 NHS England, Update on the draft Model ICB Blueprint and progress on the future NHS Operating Model, 28 May 2025

joined-up, person-level data and intelligence (including user feedback, partner insight, outcomes data, public health resource and insight) to develop a deep and dynamic understanding of their local population and their needs now and in the future, and the biological, psychological and social drivers of risk and demand, proactively identifying underserved communities and assessing quality, performance and productivity of all existing provision.[83]

33. **CONCLUSION**
Addressing inequalities in healthy life expectancy will require integrated care boards (ICBs) to take a targeted approach with specific interventions targeting communities where inactivity and poor health outcomes are most concentrated. Successful development of population health delivery methods, using hyper-local insight, will ensure maximum value for money is achieved by delivering the most effective interventions in the areas where the need and the benefits are greatest.

34. **RECOMMENDATION**
We welcome the publication of the model ICB blueprint and the intention that ICBs will move towards population health delivery models, which should support more targeted intervention to address health inequalities in ageing. In its response to this report, the government should set out how it will judge whether ICBs are successfully moving towards this approach. This should include how the government will ensure ICBs' monitoring and data collection are standardised to allow for meaningful evaluation and learning of interventions across ICBs.

Strengthening links with partners outside of the health system

35. The *10 Year Health Plan for England* sets out the government's vision for a new model of NHS care that prioritises prevention and delivers more care in people's communities through a neighbourhood health service.[84] The government argues that the neighbourhood health model is designed to tackle health inequalities, improve access, and deliver more local, personalised care—especially for people with complex, long-term conditions.[85] We were told that physical activity had the potential to be

83 NHS England, Fit for the future: towards population health delivery models, 17 March 2026
84 Department of Health and Social Care, Fit for the future: 10 Year Health Plan for England, gov.uk, 30 July 2025
85 Department of Health and Social Care, Government takes action to deliver neighbourhood health services, gov.uk, 9 July 2025

a "prevention engine"[86] with trusted community organisations bridging the gap between health services and communities to deliver relevant and accessible interventions.[87] In this section of the report, we explore how collaboration with partners outside of the health system can support and deliver physical activity-based interventions and activities for older people in their communities.

Building partnerships with the leisure and physical activity sector

36. Throughout our inquiry we heard about the potential that the leisure and physical activity sector had to support the NHS in delivering physical activity-based interventions and help achieve the government's ambition to "shift care into the community."[88] We were told that if offered a choice, 61% of people would prefer to receive treatment or support for a health condition in a gym, leisure centre or pool, compared with 39% preferring a hospital.[89] Where strong relationships existed at a local level between the NHS and the leisure and physical activity sector, there was a "wealth of evidence" that these partnerships could support the delivery of care in community settings rather than hospitals.[90]

37. The treatment of musculoskeletal (MSK) conditions utilising leisure infrastructure was highlighted as an example of successfully improving patient outcomes whilst reducing pressure on NHS services.[91] The UK Research and Innovation-funded *MSK Hubs* pilot tested relocating MSK rehabilitation to leisure centres. Independent evaluation showed 44% of participants reported an improvement in pain management and every £1 invested delivered £5.30 in social value, including healthcare savings.[92] Two thirds of cancer prehabilitation and rehabilitation programmes already take place in leisure facilities,[93] alongside mental health, pulmonary, and

86 [Graeme Sinnott] Q181
87 Active Partnerships National Organisation (HAP0025)
88 Department of Health and Social Care, Fit for the future: 10 Year Health Plan for England, gov.uk, 30 July 2025
89 UKactive (HAP0116)
90 [Huw Edwards] Q182
91 UKactive (HAP0116), North Yorkshire Council (HAP0117), Versus Arthritis (HAP0119) and GLL (HAP0148)
92 Arthritis Action, ESCAPE-pain, Good Boost and UKactive, Transforming gyms into community Musculoskeletal (MSK) Hubs, UKactive, 9 September 2024
93 UKactive (HAP0116)

cardiovascular programmes.[94] However, despite this strong evidence base, we were told access to health services in leisure facilities remained uneven and dependent on local relationships.[95]

38. The ability of the health service to continue and expand these types of programmes depends on the existence of suitable leisure and physical activity infrastructure and services. The Local Government Association (LGA) told us local councils were the "biggest public funder and provider of the community assets that support people to be active" but that spending on culture and leisure services had fallen by £2.3 billion since 2010–11.[96] Huw Edwards, CEO at UKactive, told us the government had inherited an "accelerated market failure" in swimming provision, with 500 swimming pools closing in the last 15 years, three quarters of them since 2020.[97] We also heard that much of the remaining estate was ageing, with 63% of main sports halls and 60% of swimming pools in public leisure centres beyond their expected lifespan or requiring refurbishment.[98] UKactive emphasised that without urgent investment, essential infrastructure that could deliver health care services in the community was at risk of closure.[99]

39. In June 2025, the government announced a £400 million investment in grassroots sport facilities as part of the spending review. The fund will be invested in new and upgraded grassroots sports facilities that "promote health, wellbeing and community cohesion."[100] Leaders from across local government and the fitness and leisure sector argued that the funding should be directed towards "the facilities that people rely on every day to stay active and healthy," such as leisure centres, swimming pools and gyms.[101] The government said that the Department for Culture, Media and Sport would work closely with sporting bodies and local leaders to "establish what each community needs."[102] However, GLL, a charitable leisure organisation providing gyms, pools and sports centres, cautioned that unless this funding was directed to community sport and leisure infrastructure, health services located in these facilities did "not have a future."[103]

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94 Yorkshire Cancer Research (HAP0041), NHS Greater Manchester, Greater Manchester Moving, Greater Manchester Combined Authority (HAP0043), Chartered Society of Physiotherapy (HAP0065) and GLL (HAP0148)
95 [Huw Edwards] Q182
96 Local Government Association (HAP0087)
97 Q169
98 GLL (HAP0148)
99 UKactive (HAP0116)
100 Department for Culture, Media and Sport, Game changer for the nation, gov.uk, 19 June 2025
101 UKactive, Ensure grassroots sport funding reaches community gyms and swimming pools, say sector leaders, 1 August 2025
102 Department for Culture, Media and Sport, Game changer for the nation, gov.uk, 19 June 2025
103 GLL (HAP0148)

40. We also heard about the potential of the physical activity workforce to support delivery of these programmes. Graeme Sinnott, Director of Place and Strategy at Activity Partnerships National Organisation, told us that the 400,000-strong physical activity workforce, rooted in local communities, was an asset "hidden in plain sight."[104] He argued that it could strengthen capacity across the system and shift care closer to home.[105] Other contributors told us that despite its size, skills and reach, the workforce was not routinely considered by integrated care boards (ICBs) or local authorities when commissioning preventive or rehabilitative services.[106] However, we heard that health professionals often lacked confidence in referring patients to physical activity providers because their qualifications were not widely understood or seen as consistent with medical training.[107]

41. Swim England and the Chartered Institute for the Management of Sport and Physical Activity (CIMSPA) have both developed accreditation schemes to strengthen professional standards and ensure quality and safety.[108] CIMPSA argued that formal recognition of the physical activity workforce would allow these professionals to be built into commissioning pathways and contribute to multidisciplinary teams, alongside social prescribing link workers and allied health professionals.[109]

42. **CONCLUSION**

Partnerships between health services and the physical activity sector can deliver effective programmes in local settings, support long-term condition management and improve older people's health and wellbeing. Expanding these approaches could also ease pressure on hospital-based services and support the government's ambition to shift care from hospitals into the community. A lack of national strategy and the deterioration of leisure facilities mean opportunities to embed physical activity in community-based care remain limited. We welcome the £400 million the government has announced to support grassroots sports facilities. The government must use this funding strategically to support the infrastructure that the NHS will rely on to deliver care—particularly physical activity-based interventions—in the community.

104 Q194
105 Qq194–195
106 NHS Greater Manchester, Greater Manchester Moving, Greater Manchester Combined Authority (HAP0043)
107 Faculty of Sport and Exercise Medicine (HAP0051) and CIMSPA - The Chartered Institute for the Management of Sport and Physical Activity (HAP0098)
108 Swim England (HAP0021) and CIMSPA - The Chartered Institute for the Management of Sport and Physical Activity (HAP0098)
109 CIMSPA - The Chartered Institute for the Management of Sport and Physical Activity (HAP0098)

43. **RECOMMENDATION**
The Department should develop a national framework to support integrated care boards and local authorities to commission and scale health interventions delivered in leisure and physical activity settings. This should include preventive, treatment and long-term condition management programmes to support healthy ageing. It should also set out how appropriately qualified physical activity professionals can be safely integrated into care pathways and promote understanding among health professionals of the role this workforce can play.

Recognising social prescribing as an essential pathway to physical activity

44. Social prescribing is a non-medical prescription that connects people to activities and groups in their community to meet the practical, social and emotional needs that affect their health and wellbeing.[110] There have been more than 5.6 million referrals by GPs to social prescribing services since 2019,[111] with a quarter of referrals made to physical activity services.[112] Older people are more likely to be referred, with the most common age group using social prescribing being people aged 60–69.[113] The National Academy for Social Prescribing (NASP) told us that social prescribing could lead to significantly reduced health service use and costs, through a reduced need for GP appointments, A&E attendance and hospital admissions. Its research found there was a 42% drop in GP attendance among patients referred to social prescribing, compared to a 5% drop in a control group.[114]

45. Social prescribing often begins with a referral from a GP, hospital, charity or other organisation to one of the around 3,400 social prescribing link workers currently working in primary care teams.[115] We heard that expanding training standards for link workers, which prioritise physical activity promotion, would help realise social prescribing's potential to support older people to be more active.[116] Cheshire and Merseyside ICB said that improving link workers understanding of the benefits of physical activity could support them in signposting individuals to evidence-based interventions.

110 NHS England, Social Prescribing, accessed 26 March 2026
111 National Academy for Social Prescribing (HAP0142)
112 National Academy for Social Prescribing, Social prescribing link worker survey 2025 - full report, April 2025
113 National Academy for Social Prescribing (HAP0142)
114 National Academy for Social Prescribing (HAP0142)
115 National Academy for Social Prescribing (HAP0142)
116 Active Partnerships National Organisation (HAP0025), Derbyshire County Council, Public Health (HAP0066) and Devon County Council, One Devon, Active Devon (HAP0144)

It suggested following the example of the approach to smoking cessation—which uses clear assessment tools, standardised training and an established referral pathway—to remove confusing information that led to inaction.[117]

46. NASP currently receives funding from the Department of Health and Social Care to provide support, education and resources to the NHS and link workers nationally.[118] However, Charlotte Osborn-Forde, CEO at NASP told us that there had been a "big shift" in the central support available to NASP since the five-year national roll-out of social prescribing ended in 2022. She told us that NHS England's national infrastructure to support social prescribing had been significantly reduced, with a team of 20 people working on a range of support, including data and education, having been disbanded that year. The large regional social prescribing team, with staff in each NHS region supporting GP practices and link workers, had also been broken up. This, Ms Osborn-Forde explained, had resulted in online training, with access to a website and videos, being the only training provision available to link workers.[119]

47. **CONCLUSION**

If the NHS is serious about prevention, it seems perverse to reduce support for social prescribing. The benefits of social prescribing will only be realised at scale if it is recognised by the Department as a core mechanism for increasing physical activity, particularly among older people and those with long-term conditions. To fulfil its potential, social prescribing must be prioritised within the health system and supported with the workforce development, infrastructure and national leadership necessary to prescribe physical activity routinely and confidently. Social prescribing link workers are a vital bridge between the health system and the community-based organisations that deliver physical activity opportunities to older people. By connecting people to local programmes that reflect their interests and circumstances, link workers can turn clinical advice to become more active into meaningful, sustained behaviour change.

48. **RECOMMENDATION**

The Department should assess whether the overall funding, infrastructure and training available to social prescribing are sufficient to reflect its growing role in promoting physical activity and reducing demand on health services and set out how it will ensure social prescribing is consistently embedded, prioritised and supported across the health system.

117 Cheshire and Merseyside ICB (HAP0077)
118 [Charlotte Osborn-Forde] Q189
119 Qq188–189

49. **RECOMMENDATION**
We were disappointed to hear of the reduced support that NHS England is providing for social prescribing. This is directly impacting on the quality of related training and development for link workers. As part of the ongoing merger between NHS England and the Department, we recommend that the Department review and strengthen the support it provides for social prescribing. This should include ensuring the National Academy for Social Prescribing has the resources it needs to continue promoting best practice, supporting workforce development and acting as a national centre of expertise.

Funding a sustainable voluntary, community and social enterprise sector

50. Evidence to our inquiry argued that the voluntary, community and social enterprise (VCSE) sector was a vital partner in delivering the aims of the neighbourhood health model and supporting people to age well in their communities. We repeatedly heard that community-based VCSE organisations engaged older people, particularly those most at risk of inactivity and poor health through targeted outreach—often before they presented to health services.[120] Gloucestershire County Council and NHS Gloucestershire Integrated Care Board (ICB) told us that the VCSE sector was "vital" in both reducing demand on health services and strengthening social prescribing opportunities by providing culturally relevant and early, community-based interventions that embedded prevention and physical activity into everyday life, especially for those facing inequalities or disengaged from traditional health services.[121]

51. Age UK told us that 90% of local Age UK organisations provided physical activity programmes, with many already collaborating with the NHS, local authorities and Active Partnerships[122]. However, it argued that these organisations needed "sustainable funding and resource certainty to grow and thrive."[123] Dr Lis Boulton, Health and Care Policy Manager at Age UK, told us funding for VCSE organisations was "disappearing at a rate of knots" while demand for services was increasing from an ageing population.[124] Gloucestershire County Council and NHS Gloucestershire ICB argued

120 For example: Salford CVS (HAP0035), Norfolk and Waveney ICB, Active Norfolk, Norfolk County Council Public Health (HAP0050), Buckinghamshire, Oxfordshire & West Berkshire (BOB) Integrated Care Board (ICB), Oxfordshire County Council Public Health, Active Oxfordshire (HAP0088)
121 Gloucestershire County Council, NHS Gloucestershire Integrated Care Board (HAP0108)
122 Active Partnerships are a nationwide network of movement, physical activity and sport organisations
123 Age UK (HAP0149)
124 Q54

that to enable meaningful collaboration, integrated care boards (ICBs) needed to invest in both programme delivery and core costs that sustained VCSE organisations and work in partnership to co-design strategies. It recommended ICBs use a VCSE partnership model to co-develop sustainable VCSE infrastructure and invest in VCSE capacity through grants and targeted commissioning.[125]

52. In November 2025, NHS England published a *Strategic commissioning framework* setting out how ICBs will fulfil their role as strategic commissioners. The framework states that strategic commissioning should facilitate ongoing collaboration across the health and care system, including with the VCSE sector. This will require ICBs to understand "current and future costs of commissioned services and [consider] different financial and risk share models" to incentivise partnership working, including with the VCSE sector. It adds that commissioners should recognise that VCSE organisations reliant on grants "may need longer-term investment and certainty to modernise."[126]

53. In response to our report *Community Mental Health Services*,[127] the government accepted our recommendation that ICBs should be supported to commission multi-year contracts with VCSE organisations. The government states that during 2026–27 ICBs will be supported through a strategic commissioning development programme which will provide practical support to ICBs to strengthen the skills, tools and approaches required for commissioning sustainable neighbourhood health services that reflect the value and potential of VCSE organisations.[128]

54. **CONCLUSION**

The voluntary, community and social enterprise (VCSE) sector plays a vital role in engaging older people—particularly those at greatest risk of inactivity and poor health. However, VCSE organisations lack sustainable funding to plan for the future and continue delivering the physical activity programmes that health services rely on to achieve their prevention objectives.

125 Gloucestershire County Council, NHS Gloucestershire Integrated Care Board (HAP0108)

126 NHS England, Strategic commissioning framework, 6 November 2025

127 Health and Social Care Committee, Fourth Report of the Session 2024–26, Community Mental Health Service, Recommendation 14

128 Department of Health and Social Care, Government response to the Health and Social Care Committee's Fourth Report of the Session 2024 to 2026: community mental health services, gov.uk, 11 March 2026, Recommendation 14

55. **RECOMMENDATION**
We welcome the intention in the strategic commissioning framework for integrated care boards (ICB) to treat VCSE organisations as partners in the development and delivery of a neighbourhood health service. In its response to this report, we ask that the government provide more details on what support from the strategic commissioning development programme will look like in practice. This should include details of any training or guidance that will be offered to ICBs.

Making better use of physical activity in social care

56. Sedentary behaviour is a growing concern within social care.[129] Older people, whether in care homes or their own homes, who do not get enough opportunity to move around have an increased risk of reduced bone mass and muscle strength. This is known as "deconditioning" and can lead to reduced mobility, increasing dependence and the need for residential care.[130] Care England has argued that older people in care settings face significant barriers to staying active, including reduced mobility, fear of injury and low confidence.[131] It told us sedentary behaviour, even over short periods, could quickly lead to a decline in health, independence and quality of life.[132]

57. The Care Quality Commission (CQC) told us structured physical activity opportunities in social care environments resulted in positive health outcomes. It highlighted the care provider Belong Chester, which has an on-site exercise and rehabilitation department providing personalised exercise programmes. The programmes were found to improve mobility, mood and engagement with others.[133] Care England called for evidence-based exercise programmes to become a core part of social care delivery and for the government to create national standards for delivery with CQC inspection alignment.[134]

58. CQC assessment frameworks currently assess how social care providers support people to "manage their health and wellbeing" and support them to "live healthier lives," reducing their future needs for care and support.[135]

129 Care England, From inactivity to independence: a fitness approach for older people in adult social care, September 2025
130 British Geriatrics Society, Sit up, get dressed, keep moving, 29 July 2020
131 Care England, From inactivity to independence: a fitness approach for older people in adult social care, September 2025
132 Care England (HAP0037)
133 Care Quality Commission (HAP0047)
134 Care England (HAP0037)
135 Care Quality Commission (HAP0047)

People receiving social care should be able to get information and advice about staying well, have co-ordinated care and receive care that supports them to live well, including through opportunities for physical activity.[136]

59. The UK Chief Medical Officers' *Physical Activity Guidelines* state "older adults should break up prolonged periods of being sedentary with light activity when physically possible, or at least with standing, as this has distinct health benefits."[137] When we explored the reasons why more physical activity is not delivered in social care settings, Professor Martin Green OBE, Chief Executive at Care England, told us that the risks of sedentary behaviour and associated deconditioning were "not well understood" by health and care services.[138] Dawn Skelton, Professor of Ageing and Health at Glasgow Caledonian University, told us that a lack of training, skills and support had resulted in a social care workforce that lacked confidence in supporting older people to remain physically active.[139] We heard that older people were often not encouraged or supported to be active because of concerns that physical activity could cause harm, and these concerns could outweigh the harms of being sedentary.[140] Professor Green suggested there was an "expectation" that older people, particularly those receiving social care, could not be active[141] and that this resulted in health and care professionals carrying out care assessments that focused on what people could not do.[142]

60. Care England argues that social care staff must be trained to gain the confidence and skills to support movement and understand its value in the care environment.[143] Professor Green told us that training and development in social care lacked a systematic approach and the large training budget available to the NHS.[144] Care England called for the government to "fund and mandate basic physical activity and movement training as part of the Care Certificate and continued professional development pathway for care workers." It proposes that £96 million of NHS savings could be realised from an estimated £6.4 million investment to train 2% of the social care workforce.[145]

136 Care Quality Commission, Assessment framework, accessed 26 March 2026
137 UK Chief Medical Officers, Physical Activity Guidelines, gov.uk, 7 September 2019
138 Q89
139 Q135
140 [Professor Martin Green] Q72 and [Professor Chris Todd] Q136
141 Q72
142 Q84 and Q89
143 Care England, From inactivity to independence: a fitness approach for older people in adult social care, September 2025
144 Q92
145 Care England, From inactivity to independence: a fitness approach for older people in adult social care, September 2025

61. In our report *Adult Social Care Reform: the cost of inaction*, we argued that social care must be seen as an enabler, not only in supporting people to live independent lives, but also of healthcare reform.[146] Professor Green told us health and social care services currently had a "crisis approach" and only recognised and responded to sedentary behaviour and deconditioning once it had caused health issues. He called for all parts of the system, including local authorities, care providers and the NHS, to come together to develop a preventive approach to social care and recommended that services proactively identify older people receiving social care who were at risk and provide targeted interventions to prevent or reverse deconditioning.[147] He argued that the Independent Commission on Adult Social Care[148] provided an opportunity to "create a new vision" for how health and care systems could work together to enable people to live well.[149]

62. **CONCLUSION**

Physical activity must be recognised as an essential part of adult social care delivery—not an optional additional leisure activity. Equal weight must be given to the risks of inactivity as to the benefits of staying active so that older people receiving social care, whether at home or in a care setting, can remain healthy and confident. A preventive, strengths-based model of care can help older people maintain the abilities that underpin their health, wellbeing and independence. This will require a change in how the social care sector thinks about risk to support older people to remain active. Social care staff equipped with the right skills, and an approach that focuses on what people receiving care can and want to do, will be essential.

63. **RECOMMENDATION**

We recommend that Baroness Casey, as part of the Independent Commission on Adult Social Care, prioritise opportunities for physical activity to support a new, prevention-focused vision for the system. This should identify how government can support the social care sector to embed physical activity into the delivery of adult social care. It should include how local authorities, the NHS and social care providers can work together to identify older people at risk of sedentary behaviour and offer early, tailored interventions.

146 Health and Social Care Committee, Second Report of Session 2024–25, Adult Social Care Reform: the cost of inaction, HC 368

147 Qq89–90

148 Department of Health and Social Care, Independent commission into adult social care: terms of reference, gov.uk, July 2025

149 Q93

64. **RECOMMENDATION**
We also recommend that the Department work with social care providers to develop a national training programme for social care workers to improve their confidence and skills in supporting older people to be active, including understanding deconditioning and how to prevent it. This should include supporting the workforce to take a strengths-based approach to physical activity, with care assessments focusing on what older people can do.

65. **RECOMMENDATION**
The Department should work with the Care Quality Commission (CQC) to set national standards for the delivery of physical activity in social care settings, with physical activity being provided in line with the Chief Medical Officers' guidance. We also recommend that the CQC places a greater emphasis on physical activity in its assessment framework and inspections of social care provision.

2 Embedding physical activity in society

66. In the previous chapter we considered how the health and social care sector could better use physical activity to deliver health and social care in a way that supports healthy ageing. While the health and social care system can integrate physical activity into how it delivers care, creating a society that enables everyone—especially older people—to stay active depends on action across multiple parts of government, including planning, housing and transport. In this chapter we discuss the broader actions needed to address physical inactivity, particularly in later life, and build healthier and more active communities.

Challenging current attitudes to ageing

67. When we discussed with witnesses why older people tend not to engage in physical activity, ageism was frequently identified as a key barrier. Dr Martina Zimmerman, leading the Science of Ageing and Culture of Youth research programme at King's College London, argued that there was a "deeply rooted cultural pessimism" about ageing in the UK, that aligned ageing with decline and loss, and which could lead to structural, interpersonal and self-directed ageism.[150] Self-directed ageism could make older people less likely to engage in preventive health behaviours.[151] The Centre for Ageing Better's *State of Ageing 2025* report found that people stopped themselves taking part in activities after turning 50 because they thought it might not be appropriate for their age, including 31% avoiding or limiting physical activity.[152] This was reflected in what we heard from older people taking part in our distributed dialogue. Participants said that stereotypes from friends, family, society and internalised ageism created barriers to increasing physical activity: "if we are told we can't, then we won't."[153]

150 Dr Martina Zimmermann (Reader in Health Humanities and Health Sciences at King's College London); Ms Tianne Haggar (Research Associate at King's College London) (HAP0024) and The Open University (HAP0070)

151 [Dr Carole Easton] Q41, Dr Martina Zimmermann (Reader in Health Humanities and Health Sciences at King's College London); Ms Tianne Haggar (Research Associate at King's College London) (HAP0024) and The Open University (HAP0070)

152 Centre for Ageing Better, State of Ageing Report 2025, accessed 10 March 2026

153 See Appendix 1: Distributed dialogue

68. Sir Muir Gray told us that to counter negative attitudes towards ageing, older age should be viewed as a time of "renaissance," including educating people as they age on how to remain healthy.[154] Dr Zimmerman said that changing people's behaviour and knowledge about health throughout their life would both improve health outcomes in older age and increase a person's willingness to engage from a younger age. She argued that public perceptions needed to shift to accept ageing as a life-long process, by encouraging people to consider the positive opportunities of ageing and the continued benefits of physical activity.[155]

Targeting people entering older age

69. Professor Chris Whitty told us entering older age with high levels of physical activity improved the likelihood of reaching the end of life with minimal impact or poor health.[156] Age UK research found that 74% of adults aged 50–65 worried about staying healthy and 65% worried about losing their independence as they age. Despite these concerns, 47% said they felt they did not do enough or any physical activity. The research also found a lack of awareness, with 54% substantially underestimating the recommended weekly guidelines for physical activity. Age UK suggested this could lead to missed opportunities for preventive health benefits of physical activity, such as reducing the risk of chronic diseases and improving mobility.[157] The Chief Medical Officer's annual report recommended specifically targeting people approaching older age, suggesting interventions were often only targeted at younger adults, "forgetting that a small increase in activity by an older citizen may be substantially more beneficial to improve health."[158]

70. Evidence to our inquiry recommended interventions to promote physical activity focus on key milestone in a person's life and transition points as they enter older age—including retirement, bereavement, becoming a grandparent or receiving a new health diagnosis—when new routines or identities can offer an opportunity to reflect on health and change behaviour.[159] We heard that planning for retirement could be a key moment to promote the benefits of physical activity to support healthy ageing.[160]

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154 Q39

155 Dr Martina Zimmermann (Reader in Health Humanities and Health Sciences at King's College London); Ms Tianne Haggar (Research Associate at King's College London) (HAP0024)

156 Q10

157 Age UK, New research shows that 10 million mid-lifers worry about staying healthy as they age, 28 April 2025

158 Department of Health and Social Care, Chief Medical Officer's Annual Report 2023: health in an ageing society, gov.uk, 10 November 2023

159 Sport England (HAP0091) and Dr Rachael Frost (Senior Lecturer in Health and Social Care at Liverpool John Moores University) (HAP0028)

160 Gosport Older Persons Forum (HAP0011) and Sport England (HAP0091)

The Centre for Ageing Better found that while many people planned to stay active or increase their activity levels during retirement, few considered how they would achieve this. It noted there were few services or resources specifically aimed at supporting physical activity among people approaching older age, while a focus solely on children or older people risked missing a key opportunity for intervention.[161] We heard that retirement could act as a "teachable moment for becoming more active"[162] and that there was potential for public health campaigns to target this age group.[163] Witnesses told us there are opportunities to build in advice and promotion of physical activity as part of pension and retirement planning from trusted sources including workplaces, pension advisors and the Department for Work and Pensions.[164] Age UK launched its *Act Now, Age Better* campaign in April 2025, which called on people aged over 50 to "start preparing for their health in later life as they would prepare financially with a pension."[165] Age UK told us that public health messaging, such as its campaign, could help shift ageist narratives by encouraging older people to see physical activity as achievable and beneficial.[166]

Public health messaging

71. Professor Whitty told us that local and national government should make it clear how important physical activity was and the different types of activity people needed to do, suggesting that the cost was "minimal" compared to the gains.[167] We were told consistent messaging was needed to promote physical activity's vital role in healthy ageing, yet the Chartered Association of Sport and Exercise Sciences argued that less emphasis was placed on campaigns to improve rates of activity than those relating to smoking, diet and alcohol.[168]

72. We also heard that current public health messaging encouraged older people to be more active "quite poorly."[169] The main shortcomings identified through our inquiry were:

161 Centre for Ageing Better, Keep on moving: understanding physical inactivity among 50–70 year olds, September 2021
162 The Chartered Association of Sport and Exercise Sciences (CASES) (HAP0015)
163 South Northants Volunteer Bureau (HAP0019)
164 Sport England (HAP0091) and [Sir Muir Gray] Q39 and Q62
165 Age UK, New research shows that 10 million mid-lifers worry about staying healthy as they age, 28 April 2025
166 Age UK (HAP0149)
167 Q23
168 The Chartered Association of Sport and Exercise Sciences (CASES) (HAP0015)
169 Q11

a. **Type of activity.** As we age, we begin to lose muscle, bone strength and balance, the most common and addressable risk factors for falls. As we discussed earlier, these risks are best addressed by activities that focus on strength and balance. However, contributors noted that current physical activity messaging aimed at older people focused on "light or gentle" aerobic activity. Dr Ashley Gluchowski, University Fellow in Public Health at the University of Salford, argued that such activity would not increase uptake of strength and balance activities and that future messaging campaigns needed to align with current muscle strengthening guidelines.[170]

b. **Framing discussions on physical activity.** Research has found that there is confusion around what constitutes exercise, with a perception that exercise must involve participating in team sports or using gym facilities.[171] Dr Lis Boulton, Health and Care Policy Manager at Age UK, told us that the language of exercise and physical activity would not speak to older people who did not see themselves as "sporty" or capable of exercise.[172] Dr Carole Easton, CEO at the Centre for Ageing Better, told us that older people should be encouraged to "move, not to exercise."[173] Similarly, Buckinghamshire, Oxfordshire and West Berkshire Integrated Care Board argued that it was important to reframe what it meant to be physically active to include activities such as gardening, housework, walking and chair-based exercises.[174] Professor Whitty told us that current messaging resulted in people believing they have to do large amounts of structured exercise.[175] Researchers from the Department of Health at the University of Bath, said that home-based "exercise snacking" for just 10-minutes a day could improve physical function and help older people form lasting exercise habits.[176]

73. The Department of Health and Social Care told us that it was establishing a "national movement campaign" with Sir Brendan Foster, President of the Great North Run Company, to promote movement and walking and also highlighted its work with influencers including Angela Ripon and

170 Dr Ashley Gluchowski (Clinical Exercise Physiologist and University Fellow at University of Salford) (HAP0034) and Dr Rachael Frost (Senior Lecturer in Health and Social Care at Liverpool John Moores University) (HAP0028)
171 Academic Centre for Healthy Ageing, Queen Mary University, London (HAP0138)
172 Q39
173 Q41
174 Buckinghamshire, Oxfordshire & West Berkshire (BOB) Integrated Care Board (ICB), Oxfordshire County Council Public Health, Active Oxfordshire (HAP0088)
175 Q11
176 Dr Max Western (Senior Lecturer in Behavioural Science at University of Bath); Dr Oly Perkin (Lecturer in Health and Exercise Science at University of Bath); Prof Fiona Gillison (Professor in Health Psychology at University of Bath) (HAP0064)

Joe Wicks.[177] However, the King's Fund has argued that these types of initiatives risk only attracting people who are already physically active, missing people who are least active and unlikely to respond to initiatives aimed at the general population.[178] Evidence to our inquiry emphasised the opportunities for a national campaign that normalised movement in later life, dispelled myths about older age and featured "real people doing real exercise in real homes, not unrelatable celebrity workouts."[179] The Richmond Group of Charities and Sport England's *We Are Undefeatable* campaign was highlighted as successfully using relatable role models to inspire people with long-term conditions to become more active.[180] Evaluation of the campaign found that among people aged over 55 with long-term conditions, 61% related to the people in the adverts and 68% said the campaign made it easier to be active.[181]

74. **CONCLUSION**
The government must start a national conversation about ageing which talks about getting older in a more positive way, challenges assumptions about unavoidable and irreversible decline and motivates people to remain active.

75. **RECOMMENDATION**
We recommend that the Department's "national movement campaign" include targeted messaging aimed at the least active and people approaching older age. These messages should demonstrate how movement can be incorporated into daily habits, use relatable role models and focus on examples of movement that will increase strength and balance.

Building an active environment

76. The condition of the built environment and the way communities and public spaces are designed were also frequently raised as barriers to older people being more active.[182] A lack of seating and shelter that could be used

177 Department of Health and Social Care (HAP0084)
178 The King's Fund, Can we really be 'fit for the future' without physical activity, 13 January 2026
179 Move it or Lose it (HAP0052) and The Open University (HAP0070), UKactive (HAP0116), National Falls Prevention Coordination Group, British Geriatric Society Falls and Bone Health Special Interest Group (HAP0136) and Age UK (HAP0149)
180 For example: Get Berkshire Active (HAP0062), Local Government Association (HAP0087), Buckinghamshire, Oxfordshire & West Berkshire (BOB) Integrated Care Board (ICB), Oxfordshire County Council Public Health, Active Oxfordshire (HAP0088), Brighton & Hove City Council (HAP0124)
181 The Richmond Group of Charities (HAP0126)
182 Centre for Ageing Better (HAP0067) and [Professor Chris Whitty] Q10

while outside, insufficient and unsuitable toilets, poorly maintained and lit pavements, which made older people feel unsafe or at risk of falling, and a lack of access to green spaces were all raised as factors which made it difficult or unsafe for older people to be active in day-to-day life.[183] Professor Chris Whitty told us government needed to accept that a lot of the infrastructure that acted as a barrier belonged to the state and that removing those barriers was central to improving poor health in older people.[184] This was echoed by the Local Government Association, who argued that supporting people to be physically active was not just a health issue, but a societal one. Silos between sectors needed to be broken down to build environments that encouraged and enabled active lives.[185]

77. Versus Arthritis argued that physical activity had been "designed out" of housing, neighbourhood and business districts.[186] Similarly, Sport England told us there was a risk inactivity would be "built into" local places if national policy and local planning did not prioritise active design and healthy placemaking principles.[187] Working in collaboration with Active Travel England and the Office for Health Improvement and Disparities, Sport England created 10 active design principles to support planners.[188] Versus Arthritis told us that the government should embed increasing opportunities for physical activity into the new *National Planning Policy Framework*.[189]

78. The government is currently consulting on its proposed approach to revising the *National Planning Policy Framework*[190] and the accompanying *Design and Placemaking Planning Practice Guidance*.[191] The draft guidance argues that as streets and roads make up three quarters of all public space, how they are designed will make a significant impact on people's lives. The guidance suggests these should be designed to be accessible to all and consider the needs of older people.[192]

183 Sport England (HAP0091)
184 Q23
185 Local Government Association (HAP0087)
186 Versus Arthritis (HAP0119)
187 Sport England (HAP0091)
188 Sport England, Active Design, accessed 9 March 2026
189 Versus Arthritis (HAP0119)
190 Ministry of Housing, Communities and Local Government, National Planning Policy Framework: proposed reforms and other changes to the planning system, gov.uk, December 2025
191 Ministry of Housing, Communities and Local Government, Design and Placemaking Planning Practical Guidance, gov.uk, January 2026
192 Ministry of Housing, Communities and Local Government, Draft for consultation: Design and Placemaking Planning Practice Guidance, gov.uk, January 2026

79. **CONCLUSION**
Poorly designed built environments prevent older people from being able to leave their homes and actively participate in their communities. By embedding principles that promote physical activity into planning guidance, the government can ensure the creation of healthy places that support people to age well.

80. **RECOMMENDATION**
Designing a built environment that promotes physical activity for everyone, including older people, must become a core requirement when designing public spaces. We recommend that the revised National Planning Policy Framework and the Design and Placemaking Planning Practice Guidance embed Sport England's active design principles.

Making physical activity a cross-government priority

81. Throughout our inquiry we heard that the creation of a society that supports physical activity and healthy ageing would require leadership from the top of government to set out that prevention and physical activity are a national priority.[193] Huw Edwards, CEO at UKactive, told us that despite there being enough evidence about the role of physical activity in healthy ageing "to fill Westminster Hall" there remained a lack of seriousness about the issue at the top of government.[194] Professor Chris Whitty told us that the lack of focus on physical activity was about prioritisation, not difficulty.[195] He explained that people failed to realise the importance of physical activity and the significant preventive role it could have in reducing demand on services:

> A lot of people would much rather talk about the latest drug you use in stage 3 cancer, forgetting the fact that if you put in a park bench five years ago, the cancer might not have happened in the first place.[196]

82. In opposition, the Labour Party argued that avoiding the ageing population "totally overwhelming the health and care system" would require building an NHS "fit for the future" and a focus on prevention across government delivered through "secure jobs, fair pay, adequate housing, safe streets, clean air, accessible transport, the time and affordable facilities to exercise, nutritious food, and a fair society." It stated that this could not be achieved

193 British Gymnastics Foundation (HAP0147) and West Wales Sports Partnership Ltd (HAP0039)
194 Q164
195 Q20
196 Q25

by the Department of Health and Social Care alone but would require "cross-Whitehall joined-up government." This would be achieved by creating a "mission delivery board" in central government to ensure that health was considered in policies by embedding long-term planning and bringing together all the Departments with an influence over the social determinants of health.[197]

83. In September 2025, the King's Fund and the Health Foundation argued that this rhetoric had not been matched by reality, stating that the government's *10 Year Health Plan for England* was a "plan for the NHS, not for our health."[198] They raised concerns that the commitment to a mission-driven government was at risk and highlighted that the Cabinet Office mission delivery unit, established to deliver the missions,[199] had just been disbanded.[200] This unit has since been reformed into a delivery unit led from Downing Street.[201]

84. We received evidence arguing that the government needed to create a method to deliver the health mission that removed existing departmental policy and funding silos.[202] We heard that this would require designing a mechanism that incentivised joint planning and spending to address the misalignment of incentives between spending in one department resulting in Department of Health and Social Care savings.[203] During our predecessor Committee's inquiry on *Prevention in health and social care: healthy places*, Professor Whitty explained that the costs and benefits of many aspects of delivering interventions to increase physical activity were not evenly split among Departments. He said:

> The problem for many of these issues is that the bad side of things going badly for public health ends up in Health, but the cost of solving it is in a different Department; let's say Transport. The cost of putting in cycle lanes and doing all those things is in Transport, both the political cost and the financial cost.[204]

197 Labour Party, Build and NHS Fit For The Future, May 2023
198 The King's Fund and Health Foundation, A prevention revolution - or another missed opportunity?, The King's Fund, 5 September 2025
199 Cabinet Office, Head of Mission Delivery Unit Appointed, gov.uk, 2 September 2024
200 The King's Fund and Health Foundation, A prevention revolution - or another missed opportunity?, The King's Fund, 5 September 2025
201 Prime Minister: Staff, UIN 71224, 2 October 2025
202 Central South Active Partnership (HAP0130), Sport England (HAP0091), Dr Fiona Duncan (Research Associate at Newcastle University); Professor Emily Oliver (Professor of Behavioural Sciences at Newcastle University); Dr Benjamin Rigby (Lecturer in Behavioural Sciences at Newcastle University); Dr Rachel Stocker (Lecturer in Exercise and Health Psychology at Newcastle University) (HAP0135) and The Richmond Group of Charities (HAP0126)
203 [Bethany Badrock] Q241 and Central South Active Partnership (HAP0130)
204 Health and Social Care Committee, First Report of Session 2023–24, Prevention in health and social care: healthy places, HC 484, para 58

85. Professor Whitty told this inquiry that while he was encouraged by the government's mission-based approach, he recognised it was hard to achieve in Whitehall.[205] He recommended changes to how Departments were funded, calling for the Treasury to create joint funding opportunities, in which Departments collectively bid for funding on a shared issue.[206] The *10 Year Health Plan for England* argues that the NHS will need to work in partnership with local authorities to deliver integrated, preventive care. It adds that areas where devolution and population health approaches are most advanced will be supported through exploring opportunities to pool budgets and reprofile public service spending towards prevention.[207] In response to our report *Community Mental Health Services*,[208] the government rejected our recommendation to expand the use of Section 75 of the NHS Act 2006[209] to enable more widespread pooling of budgets between NHS and local authorities.[210]

86. **CONCLUSION**

Physical activity remains insufficiently prioritised across government despite extensive evidence of its central role in prevention and healthy ageing. Tackling physical inactivity requires political leadership and cross-departmental collaboration—recognising that supporting people to age well will not be achieved by health alone. To make this a reality the government needs to create mechanisms that incentivise Departments and local government to jointly address traditionally siloed and fragmented efforts.

87. **RECOMMENDATION**

The government should restore the health mission and develop a cross-government 10-year plan to embed prevention and reduce inequalities in healthy life expectancy, that prioritises physical activity. This should include creating pooled budgets that require multi-department bids to access, supported by shared outcome and accountability measures to encourage joined up action to address public health challenges, such as addressing barriers to healthy aging.

205 Q26
206 Q34
207 Department of Health and Social Care, Fit for the future: 10 Year Health Plan for England, gov.uk, 30 July 2025
208 Health and Social Care Committee, Fourth Report of the Session 2024–26, Community Mental Health Service, Recommendation 13
209 For a discussion of how these arrangements work please see, Health and Social Care Committee, Fourth Report of the Session 2024–26, Community Mental Health Service, para 139 forward
210 Department of Health and Social Care, Community mental health services: government's response to the Health and Social Care Committee's report, 11 March 2026, CP 1525, Recommendation 13

Prevention and the public health grant

88. This is our first major report this parliament that has focused exclusively on prevention. The government is putting prevention at the heart of its plans for NHS reform, with the move from "sickness to prevention" being one of the three shifts it wants to bring about through its *10 Year Health Plan for England*. Public health teams provide vital preventive services that support healthy ageing and excellent value for money. Each additional year of good health achieved in the population by public health interventions costs £3,800, compared to £13,500 in NHS interventions associated with a year spent living in poor health.[211]

89. However, throughout this inquiry and other projects, including sessions on sexual health services in England,[212] we have heard that government ambition is not being reflected in the resources allocated. While Department of Health and Social Care spend on NHS England has increased in real terms over the past decade, there has been a 26% real-terms per person cut in the value of the public health grant between 2015–16 and 2025–26.[213] In February 2026, the government announced a three-year public health grant which allocates £13.4 billion of ring-fenced public health funding.[214] While this provides increased certainty for public health teams through a multi-year settlement beginning 2026–27,[215] and follows the grant increase of £224 million from 2025–26, the public health grant will remain below 2016–17 in real terms for the next three years.[216]

90. **RECOMMENDATION**

While we welcome the government's recent increase to the public health grant, we remain concerned that public health teams have been left with inadequate funds to carry out preventive interventions vital to healthy ageing. The shift to prevention will require a long-term, whole-system response. As part of this shift, the government must commit to shifting resources towards preventive interventions, including an immediate commitment to restoring the public health grant to 2016–17 levels in real terms. Such an investment is proven to save money, by preventing people developing ill health and reducing demand on health services.

211 The Health Foundation, Investing in the public health grant, 7 February 2025
212 Oral evidence taken on 22 October 2025, Q8 [Richard Angell]
213 The Health Foundation, Investing in the public health grant, 7 February 2025
214 Local Authority Public Health Grant Allocation, HCWS1316, 9 February 2026
215 Local Authority Public Health Grant Allocation, HCWS1316, 9 February 2026
216 The King's Fund, Measuring a moving target: the complex story of public health and prevention spending in local government, 10 Feb 2026

Annex 1: Distributed dialogue

91. To gather input from older people about their experiences of physical activity, we organised a distributed dialogue activity with stakeholder organisations. As part of this, we provided advice and advocacy organisations with discussion packs and they engaged directly with older people in focus groups and one-to-one conversations. Participants were asked for questions adapted from our call for evidence.

Supporting older people to stay healthy and active

- Participants said meeting the leader or peers before joining a physical activity opportunity helped people feel safe and included. Others flagged that staff leading physical activity should proactively ask about health conditions and accessibility needs—without creating administrative hurdles. One participant said they were asked about their health condition and "then prevented from accessing anything without a GPs letter."
- Participants said interests and capabilities changed with age and fluctuating conditions and suggested pay-as-you-go options would help those with variable symptoms avoid rigid memberships.
- Participants raised the relationship between mental and physical health. One participant said physical activity supported mood and resilience, they found enforced inactivity to be "horrendously difficult" mentally.
- Participants identified barriers including transport—particularly in rural areas—affordability and digital-only booking systems that constrained access and could lead some to give up trying to be more active. The absence of toilets and seating was identified as a significant barrier to older people being able to participate in physical activity.
- Participants suggested a lack of healthcare professionals who understood long-term conditions or could give practical advice was an additional barrier. One participant said, "my greatest wish would be that GPs would know a little more about my conditions and how to be active."
- Peer support was identified a significant enabler for taking part in physical activity. One participant said providing peer support "has kept me going and supports me to be as physically active as possible."

- Participants valued local, low-barrier options for physical activity such as gardening, when they were accessible and welcoming. Walking was identified as a popular activity but was often undermined by a lack of seating and access to toilets.

Stereotypes and assumptions about older people and physical activity

- Participants said there were negative assumptions about what older people were capable of doing or what activities were safe to participate in. Stereotypes from friends, family, society and internalised ageism were also identified as barriers to increasing physical activity levels, one participant said, "if we are told we can't, then we won't."

- Participants highlighted that older people could be "marginalised and pigeonholed" into certain activities such as chair-based exercise and that providers did not recognise people aged over 55 had different needs and abilities. One participant suggested terms such as "frailty" were overused and poorly understood.

Hearing older people's voices in service planning

- Participants identified co-production as important in designing physical activity opportunities that were useful and appropriate for older people. Participants said co-production was increasing, but could be inconsistent and not done meaningfully, with one participant describing it as a "tick box" exercise.

- Participants said they want ongoing involvement in how services were designed and delivered and not to be told "here is what we are providing" as decisions had already been made.

Health professionals promoting physical activity and supporting older people to be active

- Participants said time pressure during appointments, variable knowledge and mixed messages from health professionals meant advice was inconsistent and sometimes created fear about doing physical activity.

- Participants said advice was often clinical and "people are often told all the things they can't do" leaving people unsure about what they could do. Participants also raised a mistaken belief older people had to speak to a GP or get permission before doing physical activity.

- Participants agreed trust in GPs advice was high but flagged that many GPs lacked confidence or condition specific knowledge to advice on physical activity. Participants suggested clear, confident endorsements of safe, enjoyable activity would help more people to start and stay active.

Most suggested important action government could take to support older people to be more physically active

- Encouraging and enabling activity for people with health conditions, through clear public messaging that all "movement" counts, was identified as an important role for government. Participants suggested subsidised gym and activity memberships for older people and those with long-term conditions.
- Participants said expanding and standardising training for health and fitness professionals on physical activity and long-term conditions should be a priority. Participants suggested government should build and fund clinical pathways that led from clinical advice to community-based support to be more physically active.

Conclusions and recommendations

Embedding physical activity in the health and social care system

1. Physical activity remains insufficiently prioritised across health and care systems despite its clear contribution to preventing illness, improving population health and reducing inequalities. While some integrated care boards (ICBs) have embedded physical activity into strategies, this is not yet consistent or widespread, with physical activity too often being treated as an optional add-on, rather than a core, evidence-based intervention. (Conclusion, Paragraph 12)

2. The Department should require ICBs to embed physical activity as a core preventive intervention within population health strategies. ICBs should demonstrate how physical activity is being integrated into healthy ageing, long-term condition management and health inequalities frameworks, with clear accountability for delivery. (Recommendation, Paragraph 13)

3. Physical activity can be more effective than drugs in preventing, treating and managing many long-term conditions. Health and care professionals have an important role in encouraging and supporting people to include physical activity in the management of their health. Conversations about physical activity must become a core component of clinical practice to implement current National Institute for Health and Care Excellence (NICE) guidance on physical activity. We welcome the recognition from NHS England that health and care staff must be supported to gain the skills and confidence to discuss and prescribe physical activity. However, for this to happen health leaders must demonstrate that it is a priority and ensure all staff have access to training and examples of best practice. The NHS will need to go further than encouragement alone and begin rebalancing how it invests in prevention—recognising that evidence-based physical activity can be as effective as drug treatment for many conditions—and shifting resources and spend towards its routine promotion and prescription. (Conclusion, Paragraph 17)

4. We recommend that the Department work with integrated care boards (ICBs) to develop a national roll-out of existing best-practice models to support clinicians to have conversations about physical activity with patients, particularly older patients. This should include a communication strategy to reach all health professionals, clear messaging about the benefit and priority assigned to these conversations and resources to support managers to promote it to their staff. (Recommendation, Paragraph 18)

5. In addition, we recommend that ICBs explore methods for increasing investment in the prescription of physical activity as part of a broader shift towards prevention. This should be pursued alongside appropriate clinical treatments, ensuring patients benefit from the full range of evidence-based interventions available. (Recommendation, Paragraph 19)

6. Frailty is not an inevitable or irreversible aspect of ageing, and early intervention offers significant opportunities to prevent or slow its progression. Exercise programmes can reverse frailty, reduce the risk of developing dementia and improve outcomes for people living with dementia. However, these benefits will only be realised at scale if underpinned by a coherent national strategy. These interventions must also be understood by commissioners, and prescribed and delivered by health professionals, in a comparable way to drug treatments. (Conclusion, Paragraph 26)

7. We recommend that as part of the Modern Service Framework (MSF) for frailty and dementia, the government identifies and sets clear standards for delivering exercise programmes to prevent and reverse frailty. This should include a requirement for integrated care boards (ICBs) to commission evidence-based exercise programmes at the duration and intensity necessary to deliver outcomes. We also ask that the government sets out the accountability arrangements that will accompany the MSF for frailty and dementia in its response to this report. This should include how the government will ensure consistent uptake of evidence-based exercise programmes among ICBs to remove the current national variation in access. (Recommendation, Paragraph 27)

8. Addressing inequalities in healthy life expectancy will require integrated care boards (ICBs) to take a targeted approach with specific interventions targeting communities where inactivity and poor health outcomes are most concentrated. Successful development of population health delivery methods, using hyper-local insight, will ensure maximum value for money is achieved by delivering the most effective interventions in the areas where the need and the benefits are greatest. (Conclusion, Paragraph 33)

9. We welcome the publication of the model ICB blueprint and the intention that ICBs will move towards population health delivery models, which should support more targeted intervention to address health inequalities in

ageing. In its response to this report, the government should set out how it will judge whether ICBs are successfully moving towards this approach. This should include how the government will ensure ICBs' monitoring and data collection are standardised to allow for meaningful evaluation and learning of interventions across ICBs. (Recommendation, Paragraph 34)

10. Partnerships between health services and the physical activity sector can deliver effective programmes in local settings, support long-term condition management and improve older people's health and wellbeing. Expanding these approaches could also ease pressure on hospital-based services and support the government's ambition to shift care from hospitals into the community. A lack of national strategy and the deterioration of leisure facilities mean opportunities to embed physical activity in community-based care remain limited. We welcome the £400 million the government has announced to support grassroots sports facilities. The government must use this funding strategically to support the infrastructure that the NHS will rely on to deliver care—particularly physical activity-based interventions—in the community. (Conclusion, Paragraph 42)

11. The Department should develop a national framework to support integrated care boards and local authorities to commission and scale health interventions delivered in leisure and physical activity settings. This should include preventive, treatment and long-term condition management programmes to support healthy ageing. It should also set out how appropriately qualified physical activity professionals can be safely integrated into care pathways and promote understanding among health professionals of the role this workforce can play. (Recommendation, Paragraph 43)

12. If the NHS is serious about prevention, it seems perverse to reduce support for social prescribing. The benefits of social prescribing will only be realised at scale if it is recognised by the Department as a core mechanism for increasing physical activity, particularly among older people and those with long-term conditions. To fulfil its potential, social prescribing must be prioritised within the health system and supported with the workforce development, infrastructure and national leadership necessary to prescribe physical activity routinely and confidently. Social prescribing link workers are a vital bridge between the health system and the community-based organisations that deliver physical activity opportunities to older people. By connecting people to local programmes that reflect their interests and circumstances, link workers can turn clinical advice to become more active into meaningful, sustained behaviour change. (Conclusion, Paragraph 47)

13. The Department should assess whether the overall funding, infrastructure and training available to social prescribing are sufficient to reflect its growing role in promoting physical activity and reducing demand

on health services and set out how it will ensure social prescribing is consistently embedded, prioritised and supported across the health system. (Recommendation, Paragraph 48)

14. We were disappointed to hear of the reduced support that NHS England is providing for social prescribing. This is directly impacting on the quality of related training and development for link workers. As part of the ongoing merger between NHS England and the Department, we recommend that the Department review and strengthen the support it provides for social prescribing. This should include ensuring the National Academy for Social Prescribing has the resources it needs to continue promoting best practice, supporting workforce development and acting as a national centre of expertise. (Recommendation, Paragraph 49)

15. The voluntary, community and social enterprise (VCSE) sector plays a vital role in engaging older people—particularly those at greatest risk of inactivity and poor health. However, VCSE organisations lack sustainable funding to plan for the future and continue delivering the physical activity programmes that health services rely on to achieve their prevention objectives. (Conclusion, Paragraph 54)

16. We welcome the intention in the strategic commissioning framework for integrated care boards (ICB) to treat VCSE organisations as partners in the development and delivery of a neighbourhood health service. In its response to this report, we ask that the government provide more details on what support from the strategic commissioning development programme will look like in practice. This should include details of any training or guidance that will be offered to ICBs. (Recommendation, Paragraph 55)

17. Physical activity must be recognised as an essential part of adult social care delivery—not an optional additional leisure activity. Equal weight must be given to the risks of inactivity as to the benefits of staying active so that older people receiving social care, whether at home or in a care setting, can remain healthy and confident. A preventive, strengths-based model of care can help older people maintain the abilities that underpin their health, wellbeing and independence. This will require a change in how the social care sector thinks about risk to support older people to remain active. Social care staff equipped with the right skills, and an approach that focuses on what people receiving care can and want to do, will be essential. (Conclusion, Paragraph 62)

18. We recommend that Baroness Casey, as part of the Independent Commission on Adult Social Care, prioritise opportunities for physical activity to support a new, prevention-focused vision for the system. This should identify how government can support the social care sector to embed physical activity into the delivery of adult social care. It should

include how local authorities, the NHS and social care providers can work together to identify older people at risk of sedentary behaviour and offer early, tailored interventions. (Recommendation, Paragraph 63)

19. We also recommend that the Department work with social care providers to develop a national training programme for social care workers to improve their confidence and skills in supporting older people to be active, including understanding deconditioning and how to prevent it. This should include supporting the workforce to take a strengths-based approach to physical activity, with care assessments focusing on what older people can do. (Recommendation, Paragraph 64)

20. The Department should work with the Care Quality Commission (CQC) to set national standards for the delivery of physical activity in social care settings, with physical activity being provided in line with the Chief Medical Officers' guidance. We also recommend that the CQC places a greater emphasis on physical activity in its assessment framework and inspections of social care provision. (Recommendation, Paragraph 65)

Embedding physical activity in society

21. The government must start a national conversation about ageing which talks about getting older in a more positive way, challenges assumptions about unavoidable and irreversible decline and motivates people to remain active. (Conclusion, Paragraph 74)

22. We recommend that the Department's "national movement campaign" include targeted messaging aimed at the least active and people approaching older age. These messages should demonstrate how movement can be incorporated into daily habits, use relatable role models and focus on examples of movement that will increase strength and balance. (Recommendation, Paragraph 75)

23. Poorly designed built environments prevent older people from being able to leave their homes and actively participate in their communities. By embedding principles that promote physical activity into planning guidance, the government can ensure the creation of healthy places that support people to age well. (Conclusion, Paragraph 79)

24. Designing a built environment that promotes physical activity for everyone, including older people, must become a core requirement when designing public spaces. We recommend that the revised National Planning Policy Framework and the Design and Placemaking Planning Practice Guidance embed Sport England's active design principles. (Recommendation, Paragraph 80)

25. Physical activity remains insufficiently prioritised across government despite extensive evidence of its central role in prevention and healthy ageing. Tackling physical inactivity requires political leadership and cross-departmental collaboration—recognising that supporting people to age well will not be achieved by health alone. To make this a reality the government needs to create mechanisms that incentivise Departments and local government to jointly address traditionally siloed and fragmented efforts. (Conclusion, Paragraph 86)

26. The government should restore the health mission and develop a cross-government 10-year plan to embed prevention and reduce inequalities in healthy life expectancy, that prioritises physical activity. This should include creating pooled budgets that require multi-department bids to access, supported by shared outcome and accountability measures to encourage joined up action to address public health challenges, such as addressing barriers to healthy aging. (Recommendation, Paragraph 87)

27. While we welcome the government's recent increase to the public health grant, we remain concerned that public health teams have been left with inadequate funds to carry out preventive interventions vital to healthy ageing. The shift to prevention will require a long-term, whole-system response. As part of this shift, the government must commit to shifting resources towards preventive interventions, including an immediate commitment to restoring the public health grant to 2016–17 levels in real terms. Such an investment is proven to save money, by preventing people developing ill health and reducing demand on health services. (Recommendation, Paragraph 90)

Formal Minutes

Tuesday 28 April 2026

Members present:

Layla Moran, in the Chair

Danny Beales

Jen Craft

Ben Coleman

Dr Beccy Cooper

Josh Fenton-Glynn

Andrew George

Healthy Ageing: physical activity in an ageing society

Draft Report (*Healthy Ageing: physical activity in an ageing society*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraph 1 to 90 agreed to.

Annex and Summary agreed to.

Resolved, That the Report be the Eighth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

Adjournment

Adjourned till Tuesday 19 May at 1.15 pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Wednesday 29 October 2025

Professor Chris Whitty, Chief Medical Officer, Department of Health and Social Care (DHSC) Q1–38

Dr Lis Boulton, Health and Care Policy Manager, Age UK; **Sir Muir Gray**, Director of the Optimal Ageing Programme; **Dr Carole Easton**, Chief Executive, Centre for Ageing Better Q39–70

Wednesday 12 November 2025

Adam Blaze, Chief Executive, Activity Alliance; **Professor Martin Green OBE**, Chief Executive, Care England; **Emma Hutchins**, Physical Activity and Health Influencing Manager, Richmond Group of Charities Q71–105

Professor Elizabeth Orton, Professor of Public Health, The University of Nottingham; **Professor Dawn Skelton**, Professor of Ageing and Health, Glasgow Caledonian University; **Professor Chris Todd**, Deputy-Director, NIHR Policy Research Unit in Healthy Ageing Q106–154

Wednesday 10 December 2025

Jeanette Bain-Burnett, Executive Director for Policy and Integrity, Sport England; **Huw Edwards**, CEO, UKactive; **Charlotte Osborn-Forde**, CEO, National Academy for Social Prescribing; **Graeme Sinnott**, Director of Place and Strategy and Deputy CEO, Active Partnerships National Organisation Q155–205

Bethany Badrock, Ageing Well Programme Manager, GM Ageing Hub, Greater Manchester Combined Authority; **Siobhan Farmer**, Director of Public Health, Gloucestershire County Council; **Ryan Hughes**, Head of Programmes and Partnerships, Active Norfolk Q206–255

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

HAP numbers are generated by the evidence processing system and so may not be complete.

1	ARCO	HAP0033
2	Academic Centre for Healthy Ageing, Queen Mary University, London	HAP0138
3	Active Partnerships National Organisation	HAP0025
4	Activity Alliance	HAP0048
5	Advanced Wellbeing Research Centre	HAP0128
6	Age UK	HAP0149
7	Allen, Dr Fran, Senior Research Fellow and Physiotherapist at University of Nottingham	HAP0023
8	Alzheimer's Research UK	HAP0125
9	Amirpourabasi, Dr Arezoo (Research Fellow, Univeristy of Hertfordshire)	HAP0074
10	Association of Directors of Public Health	HAP0071
11	Astill, Professor Sarah (Professor of Motor Control, University of Leeds); Lucy Robertshaw (Director (Creative Health), Darts); Charlotte Armitage (Dance Development Core Artist, Darts); Jodie Bridger (Senior Partnerships Manager, Leisure Services, Get Doncaster Moving; City of Doncaster Council); Hannah Robertshaw (Creative Director, Yorkshire Dance); and Adie Nivison (Project Manager (Older Adults), Yorkshire Dance))	HAP0075
12	Austin, Dr Daphne	HAP0027
13	Badham, Dr Stephen (Associate Professor, Nottingham Trent University); Rich Pickford (Head of Nottingham Civic Exchange, Nottingham Trent University); Professor Babak Taheri (Professor, Texas A&M University); and Dr Daniele Magistro (Associate Professor, Nottingham Trent University)	HAP0006

14	Bolton, Mrs Sara (Chief Allied Health Professional (Physiotherapist), NHS England, Southeast region)	HAP0146
15	Brighton & Hove City Council	HAP0124
16	British Association for Nutrition and Lifestyle Medicine	HAP0014
17	British Association of Prosthetics and Orthotics	HAP0063
18	British Geriatrics Society	HAP0082
19	British Gymnastics Foundation	HAP0147
20	British Nordic Walking	HAP0061
21	British Society for Research on Ageing	HAP0038
22	Buckinghamshire, Oxfordshire & West Berkshire (BOB) Integrated Care Board (ICB); Oxfordshire County Council Public Health; and Active Oxfordshire	HAP0088
23	Burns Gym LTD	HAP0056
24	Callan, Professor Michael (Professor of Judo Education, University of Hertfordshire); Mr Jim Feenan (Vice-President, Judo Scotland); and Mr Richard Marsh (Director, 4-consulting – Policy & Management)	HAP0053
25	CIMSPA – The Chartered Institute for the Management of Sport and Physical Activity	HAP0098
26	CLOSER, the home of longitudinal research (UCL Social Research Institute)	HAP0110
27	Care England	HAP0037
28	Care Quality Commission	HAP0047
29	Carers UK	HAP0101
30	Central South Active Partnership	HAP0130
31	Centre for Ageing Better	HAP0067
32	Centre for Bone and Joint Health, Queen Mary University London	HAP0139
33	Centre for Exercise Activity and Rehabilitation, Institute for Lifecourse Development, School of Human Sciences, University of Greenwich	HAP0018
34	Chartered Society of Physiotherapy	HAP0065
35	Cheshire and Merseyside ICB	HAP0077
36	Chester Zoo	HAP0111
37	Clare, Professor Linda (Chief investigator of IDEAL, University of Exeter)	HAP0112

38	Clarke, Dr Nichola	HAP0094
39	Claxton, Dr Richard (Warders Medical Centre)	HAP0003
40	College of Paramedics	HAP0114
41	Collett, Dr Johnny (Oxford Brookes Universtity)	HAP0122
42	Dennison, Professor Elaine (Professor of Musculoskeletal Epidemiology and Honorary Consultant in Rheumatology (University of Southampton); and Dr Leo Westbury, (Lecturer, University of Southampton)	HAP0045
43	Department of Health and Social Care	HAP0084
44	Derbyshire County Council, Public Health	HAP0066
45	Devon County Council; One Devon; and Active Devon	HAP0144
46	Duncan, Dr Fiona (Research Associate, Newcastle University); Professor Emily Oliver (Professor of Behavioural Sciences, Newcastle University); Dr Benjamin Rigby (Lecturer in Behavioural Sciences, Newcastle University); and Dr Rachel Stocker (Lecturer in Exercise and Health Psychology, Newcastle University)	HAP0135
47	East Sussex County Council	HAP0118
48	English Football League (EFL) in the Community	HAP0093
49	Faculty of Sport and Exercise Medicine	HAP0051
50	Fawcus, Mrs Cris (Royal Devon University Health Care NHS Foundation Trust)	HAP0054
51	Frost, Dr Rachael (Liverpool John Moores University)	HAP0028
52	GLL (Greenwich Leisure Limited)	HAP0148
53	Get Berkshire Active	HAP0062
54	Ginman-Love, Mrs Helen (Health Consultant, Healthy Dialogues)	HAP0081
55	Gladwell, Professor Valerie (Professor in Health and Wellbeing, University of Suffolk); Dr Rob Southall-Edwards (Research Fellow, University of Suffolk); and Emily Oneill (Research Associate, University of Suffolk)	HAP0057
56	Gloucestershire County Council; and NHS Gloucestershire Integrated Care Board	HAP0108
57	Gluchowski, Dr Ashley (Clinical Exercise Physiologist and University Fellow, University of Salford)	HAP0034
58	Gogledd Cymru Actif North Wales	HAP0026
59	Gosport Older Persons Forum	HAP0011

60	Gray, Dr Laura Ann (University of Sheffield)	HAP0004
61	Greenhaff, Paul (MRC-Versus Arthritis Centre for Musculoskeletal Ageing Research (CMAR))	HAP0029
62	Hamer, Professor Mark (University College London)	HAP0012
63	Hampshire County Council	HAP0085
64	Health & Independent Living Support	HAP0099
65	Healthy Ageing Research Group, University of Manchester	HAP0076
66	Hertfordshire and West Essex ICB	HAP0121
67	Herts Sport & Physical Activity Partnership	HAP0016
68	Holland & Barrett	HAP0140
69	Horticultural Trades Association (HTA)	HAP0086
70	Howlett, Dr Neil (Reader in Behaviour Change and Public Health, University of Hertfordshire); Professor Katie Newby (Professor of Behaviour Change and Public Health, University of Hertfordshire); and Professor Angel Chater (Professor of Health Psychology and Behaviour Change, University of Bedfordshire)	HAP0044
71	Hurst, Dr Christopher (Senior Research Associate, Newcastle University); Professor Rachel Cooper (McArdle Chair in Ageing & Professor of Translational Epidemiology, Newcastle University); Dr Antoneta Granic (Principal Research Associate in Interdisciplinary Ageing Studies, Newcastle University); Professor Miles Witham (Professor of Trials for Older People, Newcastle University); and Professor Avan Sayer (William Leech Professor of Geriatric Medicine & Director, NIHR Newcastle Biomedical Research Centre, Newcastle University)	HAP0059
72	Innerva (Shapemaster Global Limited)	HAP0005
73	Inspiring Communities Together	HAP0042
74	Jackman, Dr Patricia (Associate Professor in Sport and Exercise Psychology, University of Lincoln); Professor Mo Ray (Professor of Health and Social Care, University of Lincoln); and Professor Yang Li (Professor of Geospatial Health Equity, University of Lincoln)	HAP0089
75	Jenkin, Dr Claire (University of Hertfordshire)	HAP0137

76	Jones, Dr Kerry (Senior Lecturer in End-of-Life Care, The Open University); Professor Martin Robb (Professor of Care Ethics and Culture, The Open University); and Dr Samantha Murphy (Senior Lecturer in Health and Social Care, The Open University)	HAP0009
77	Kingston University London	HAP0143
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80	Local Government Association	HAP0087
81	London South Bank University	HAP0058
82	London Sport	HAP0141
83	Lord, Professor Janet (University of Birmingham)	HAP0020
84	Maidment, Dr David (Loughborough University)	HAP0002
85	McLaughlin, Henry (West Sussex County Council)	HAP0095
86	Merton Council	HAP0107
87	Mind	HAP0097
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89	NHS Greater Manchester; Greater Manchester Moving; and Greater Manchester Combined Authority	HAP0043
90	NHS Horizons	HAP0092
91	NHS North East London	HAP0072
92	NICE (National Institute for Health and Care Excellence)	HAP0008
93	National Academy for Social Prescribing	HAP0142
94	National Activity Providers Association	HAP0152
95	National Centre for Creative Health	HAP0113
96	National Falls Prevention Coordination Group; and British Geriatric Society Falls and Bone Health Special Interest Group	HAP0136
97	Liddle, Dr Jennifer (Newcastle University)	HAP0049
98	Norfolk and Waveney ICB; Active Norfolk; and Norfolk County Council Public Health	HAP0050
99	North Northamptonshire Council	HAP0106
100	North Yorkshire Council	HAP0117
101	North Yorkshire Sport	HAP0131
102	Northern Health Science Alliance	HAP0109

103	Nuffield Council on Bioethics	HAP0120
104	Orton, Professor Elizabeth, Professor and Consultant in Public Health at University of Nottingham	HAP0151
105	Oxford Brookes University	HAP0013
106	Parkinson's UK	HAP0055
107	People's Health Trust	HAP0150
108	Public Health Leeds City Council	HAP0103
109	Reeves, Professor Neil (Lancaster University)	HAP0010
110	Rotherham Public Health (Rotherham Metropolitan Borough Council)	HAP0102
111	Royal College of Podiatry	HAP0104
112	Salford Community and Voluntary Services	HAP0035
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114	Social Care Institute for Excellence (SCIE)	HAP0022
115	Somani, Dr Yasina (University of Leeds)	HAP0073
116	South Hambleton and Ryedale PCN; and NHS Humber and North Yorkshire Integrated Care Board (ICB)	HAP0129
117	South Northants Volunteer Bureau	HAP0019
118	Sport England	HAP0091
119	Sport and Recreation Alliance	HAP0133
120	Stathi, Professor Afroditi (Professor of Physical Activity and Community Health, University of Birmingham); Professor Colin James Greaves (Professor of Psychology Applied to Health, University of Birmingham); Doctor Max Western (Associate Professor of Behavioural Science, University of Bath); and Professor Kenneth Fox (Emeritus Professor of Exercise and Health Sciences, University of Bristol)	HAP0083
121	Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)	HAP0068
122	Stocks, Dr Joanne	HAP0145
123	Swim England	HAP0021
124	Tew, Professor Garry (Professor of Clinical Exercise Science, York St John University); Ruth Kay (PhD Student and Advanced Clinical Specialist Occupational Therapist, York St John University); and Dr Sophie Carter (Senior Lecturer in Sport and Exercise Physiology, York St John University)	HAP0031

125	The Chartered Association of Sport and Exercise Sciences (CASES)	HAP0015
126	The Open University	HAP0070
127	The Optimal Ageing Programme at Oxford	HAP0007
128	The R&A	HAP0040
129	The Richmond Group of Charities	HAP0126
130	The Third Age Trust	HAP0134
131	The Welsh Institute of Physical Activity, Health and Sport	HAP0105
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134	University of East Anglia; University of East Anglia; and Norfolk and Norwich University Hospitals (part of the Norfolk and Waveney University Hospitals Group)	HAP0132
135	Valley Leisure Ltd	HAP0096
136	Versus Arthritis	HAP0119
137	Wakefield Council	HAP0080
138	West Wales Sports Partnership Ltd	HAP0039
139	Western, Dr Max (Senior Lecturer in Behavioural Science, University of Bath); Dr Oly Perkin (Lecturer in Health and Exercise Science, University of Bath); and Prof Fiona Gillison (Professor in Health Psychology, University of Bath)	HAP0064
140	Women in Sport	HAP0115
141	Worcestershire County Council	HAP0032
142	Yorkshire Cancer Research	HAP0041
143	Zimmermann, Dr Martina (Reader in Health Humanities and Health Sciences, King's College London); and Ms Tianne Haggar (Research Associate, King's College London)	HAP0024

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