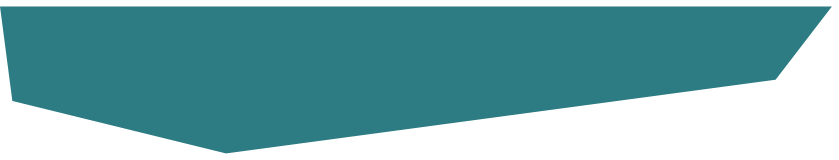
[](http://www.kpho.org.uk)

**Physical Activity in Adults and Older Adults**

**June 2025**



**|**

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# 1. Executive Summary

1 in 6 deaths in the UK is associated with physical inactivity at an estimated cost of £7.4 billion annually (including £0.9 billion to the NHS). The benefits of physical activity and exercise for health and wellbeing is well evidenced, strong and cannot be overstated. The Government is calling on health and care systems to make this a priority for older, and even frail adults, to maintain physical activity for as long as possible to delay the onset of disability, long-term health conditions and remain independent for longer.

Overall, Kent continues a positive trend for those aged 55+ meeting the recommended guidelines of at least 150 minutes of exercise weekly. In 2022-23, ages 75+ have seen a statistically significant increase of 1.6%, with 43% being active at recommended levels. However, there are clear variations in activity levels of some groups and places.

Just 15% of older adults are doing exercise at recommended levels to benefit muscle, strength and balance [MSB] which is key to delay the onset of disability, illness, reduce risk of falling, and prolong independence. Least likely to be doing MSB are women in Thanet, men in Gravesend, and women in urban areas. Districts with the lowest levels of activity are those in north Kent.

England data tells us that there are demographic differences with some groups tending to be less active than others. E.g. women, Asian and Black ethnicities, residents of lower socio-economic groups, heterosexual adults, older adults, and people living with disability or long-term conditions. People with Severe Mental Illness [SMI], have a life expectancy of 15-20 years shorter than the general population, with an estimated 2 in 3 premature deaths being from preventable physical illnesses.

There is an urgent necessity in Kent with a growing and increasingly ageing population, to view and prioritise physical activity as the fundamental cornerstone of good physical, mental and societal wellbeing, and as a major contributor to the effective and efficient use of the public purse.

A return on investment study for Kent in 2019, reported that the social and economic value of community sport and physical activity saw Canterbury district realising the largest return for physical and mental health outcomes, whilst Maidstone saw the largest return for mental wellbeing and social and community development.

There are many system-wide opportunities and actions which could be taken to address the hidden epidemic of physical inactivity in the population and realise the wider societal benefits, particularly those affecting older adults such as isolation. More needs to be done at scale to realise the potentially significant cost savings and health gains to be made by reaching out to those in our communities who will see the largest gains and making exercise options accessible and attractive for older adults. E.g. the reduction of emergency admissions, hospital in-stays, and service costs of enablement, rehabilitation, mental health services and social care.

The importance cannot be overstated of developing Intervention and Brief Advice for Physical Activity [IBA-PA] and comprehensively embedding this into health and care professional practice. This element should be accompanied by other measures to assure increasing activity in older adults is first and foremost seen as the principal prevention tactic for improved health outcomes. Other supportive measures should include amplified public and workforce health literacy, supportive policy, strategy, infrastructure, environments and investment.

Through education and enabling opportunities for adults particularly older adults aged 50+ to become more active, many health and wellbeing disadvantages and negative health and care system impacts, could be prevented and mitigated by implementing the recommendations in this report.

# 2. Recommendations

A total of 50 recommendations are contained in this report. It should be acknowledged that to varying degrees work not identified in this review may be underway or in development.

## 2.1 Strategies and Policies [6]

* Increasing physical activity for older adults, even frail older adults, should be of the highest priority for health and care systems and be incorporated into future strategy and policy developments as widely as possible. Whole system action at scale is required to address health inequalities in relation to older adults’ inactivity and resultant poor health outcomes.
* Strategies and interventions which increase both organisational and personal health literacy of the benefits of physical activity in older adults should be developed and implemented at scale. Existing ones should be amplified.
* Employers and workplaces should have a coordinated policy, practice and infrastructure to ensure that staff are less sedentary. Statutory organisations and large employers should be system leaders for this.
* ‘Prevention’ is a recognised gap in the Kent and Medway falls care pathway and should be addressed as related to the benefits of increasing activity in older adults.
* The ICB, Adult Social Care, and other relevant agencies should allocate sufficient time and resources to implement IBA-PA effectively in service commissioning.
* Workforce strategies need to plan to meet service demand in areas of projected higher levels of dependency of older adults across Kent. i.e. Maidstone, Canterbury and coastal areas of Dover, Thanet and Shepway.

## 2.2 Changes to Practice [16]

* Community asset building, micro-grant funding, voluntary, peer led activities, and health literacy are efficient and cost-effective ways to increase population physical activity and are recommended approaches to increase activity in older adults
* Recruitment of more volunteers to support community activity and sport is required from ethnic minorities and people with disability.
* More, if not all, GP practices should aim to achieve Active Practice Charter status.
* Behaviour change interventions targeted at hospitalised patients should be incorporated into care and discharge plans. Setting goals and giving performance feedback work best and should be widely introduced for older patients to prevent inpatient deconditioning of older adults.
* Where commissioned, befriending services should include motivational support to increase PA.
* Health and Adult Social Care assessments for adults aged 50 and older, should include physical activity Identification, Brief Advice [IBA] for Physical Activity [PA] and referral for activity. These should be universally introduced and amplified across all agencies including hospital in-patient and residential care settings.
* The assessment of physical activity as part of an annual comprehensive physical health assessment for people with severe mental illness as stressed in the NHS Core20Plus5 approach, should be implemented. I.e. use of Lester tool and IBA-PA
* A targeted approach is required to serve at-risk inactive groups and communities aged 50+. I.e. residents of areas with lower reported activity levels and people with long term conditions. Case finding tactics should be used.
* Commissioners should require providers of activities for ages 50+ to promote and maintain currency of related services on relevant social prescribing platforms and directories.
* It is recommended that further efforts be made to clarify and align service names and functions for the Kent Community Rehabilitation Team.
* It is recommended to encourage in-person shopping for older adults to incorporate physical activity into everyday life.
* Life changing events during the life course e.g. retirement, diagnosis of a health condition, bereavement, becoming a carer, should be routinely and systematically used as opportunities by professionals to advise on the benefits of physical activity to help manage these.
* Longer-term commissioning arrangements of community groups aimed at ages 50+ would be helpful for project sustainability.
* Older adults in care homes may lack adequate health and preventative care including physical activity which should be addressed. It is recommended that the number of care and nursing homes that have the provision or access to a physical activity coordinator be identified. Those homes without coordinators should be encouraged to arrange for these.
* Targeted support to promote physical activity (PA) programmes for care homes with higher fall rates and a greater number of council-funded residents is required.
* The introduction and promotion of suitable technologies to support physical activity in older adults within health, care, community settings and in peoples own homes, should be further explored and introduced as feasible.

## 2.3 Infrastructure [5]

* To encourage physical activity of older adults in communal spaces, investment in the environment, community infrastructure and safety should be made.
* The adoption of Age Friendly Communities across Kent would be an aid to assessing the degree to which environments in Kent support healthy ageing, physical activity and active travel for older adults, and is recommended.
* The funding, provision and promotion of social and green prescribing for ages 50+ is encouraged.
* The popularity, health and cost benefits of aqua activity over the life course and for those who cannot undertake other forms of activity, should be an area for further development and promotion.
* Minor home adaptations, digital solutions and personal aids, are effective interventions to support increased activity and reduce risk of injury and falls in older adults and should be widely encouraged.

## 2.4 Workforce Capacity and Education [2]

* Mandatory workforce education is recommended to inform and equip staff in health and social care services to offer effective Intervention and Brief Advice [IBA-PA]. for anchor institutions with large workforces, this will have the added benefit of increasing public health literacy.
* The KCC Delta workforce learning module should be reviewed to align with or be superseded by the NELH physical activity training modules for Health and Social Care staff. This would provide widely accessible, free, and consistent and content.

## 2.5 Public Information, Awareness and Health Literacy [8]

* Activity finding and resources for older adults aged 50+ should be made more prominent on the Active Kent and Medway website to ease identification and activity finding. i.e. like the tab for Children and Young People. This would help to emphasise the importance of physical activity in older adults.
* Any services promoted for increasing PA in older adults should display information on what types of exercises are particularly beneficial for ages 50+. i.e. muscle strength and balance.
* Participation in the [Snacktivity - University of Birmingham](https://www.birmingham.ac.uk/research/bctu/trials/primary-care/Snacktivity) research study should be widely promoted to workforces and older adults.
* [Adult learning courses in Kent | Community Learning and Skills](https://communitylearningandskills.co.uk/) should be used as a mechanism for improving health literacy amongst older adults. I.e. including the benefits of physical activity, preventative lifestyle risk factors and anticipatory health, wellbeing, financial and care planning would be helpful.
* Tactics promoting positive behaviour change must be accessible to target audiences. E.g. for those with disability, cognitive impairment, without digital technology, and be culturally and trauma informed. Messaging should include the use of digital, SMART apps and wearables to encourage activity.
* Enhance the Innovation and Business intelligence [KCC] support offer to reach industry and large employers with related health messaging as related to older adults within, and returning to the workforce.

## 2.6 Data [6]

* IBA-PA interventions for ages 50+ should be monitored, reviewed and reported within appropriate Governance arrangements and dashboards.
* Improve system-wide data collection, audit, contract monitoring, evaluation and research gaps related to physical activity of older adults.
* The identification, agreement and consistent use of a SNOMED data capture code[s] for physical activity ‘IBA-PA offered’ in healthcare records, is required for audit and simplification of the IBA process in health care settings.
* The development of a local solution for monitoring and reporting of workforce training completions for IBA-PA is recommended.
* The extent to which direct payments are used towards physical activity is unknown. If feasible, this would be helpful to know.
* All service directories on separate platforms should feature prominent links to each other or be incorporated or aligned with a single core service directory/platform e.g. Active Kent and Medway, District Council websites, the JOY social prescribing platform, and [KCC - Kent Community Asset Register](https://experience.arcgis.com/experience/3d5796d5f8e04a768934ef9d833d674a), [Get moving - Kent County Council](https://www.kent.gov.uk/social-care-and-health/health/one-you-kent/get-moving)

## 2.7 Research and Development [7]

* More information on the inability of older adults to participate in physical activity due to foot related issues and service access e.g., chiropody, podiatry and suitable footwear would be helpful.
* Factors contributing to or inhibiting the ability of older adults to maintain adequate nutritional status to support adequate muscle mass for strength.
* The likelihood and risks of poor outcomes in adulthood from having two or more adverse childhood experiences [ACE], as related to physical activity.
* The reasons why some areas without postural stability services would appear to have a lower incidence of falls, would be worthy of consideration.
* The application of Reminiscence Interactive Therapy Activities [RITA], to increase activity for people with Severe Mental Illness [SMI], and to mitigate the effects of deconditioning of hospitalised patients, would be of interest.
* Aquatic activities have enormous appeal and potential to support population health due to its accessibility and popularity across the life course especially for people who find land-based activity unacceptable. Opportunities in Kent to further develop these types of activity would be welcomed.

# 3. Introduction

1 in 6 deaths in the UK is associated with physical inactivity at an estimated cost of £7.4 billion annually (including £0.9 billion to the NHS).9 The Government is urging health and care systems to make physical activity in older adults a priority.

National and local organisations must act to encourage opportunities for people to be active, building this into our new and built environments, transport and strategies. Individuals and statutory care organisations need to understand their roles in reducing demand for health services and social care by being more active.

Investment in community sport and physical activity when measured against the costs of engagement and opportunity provision, is well evidenced and cost-effective. E.g. the return on investment [ROI] for every £1 spent, generated £3.91 for individuals and society [Sport England, 2024].

The United Nations Decade of Healthy Ageing (2021–2030), was aimed at sending a clear signal to governments and civil societies and the private sector, to “not only add years to life, but life to years”. ‘Central and local government (the State) have the principal responsibility for environmental factors which can delay or prevent the probability of early ageing (primary prevention).

Making it easy and attractive for people to exercise throughout their lives is one of the most effective ways of maintaining independence into older age.’ It is never too late to start being more active. Function improvement through activity may restore people’s abilities to levels they enjoyed 10 years earlier. The gap between the ‘best possible’ and ‘actual’ level of ability, can be reduced at any age, no matter how many long-term conditions the person may have.

Many people do not realise that activity has significant benefits for physical and mental health. Being physically active can help to prevent and manage over 20 chronic conditions and diseases, including some cancers, heart disease, type 2 diabetes, and depression.6 Regular physical activity contributes to the key determinants of health ageing such as having a sense of control and responsibility for our health, social connectiveness and our ability to cope with medical conditions.[[1]](#endnote-2)

Being independent for longer is the key motivator for individuals to increase activity levels. The benefits of physical activity and exercise for health and wellbeing is well evidenced, strong and cannot be overstated.

“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”.

UK Chief Medical Officers Report, 2019

## 3.1 Aims and Approach

The purpose of this report is to assess the impact of physical inactivity of older adults in Kent and review the barriers and opportunities available for them to be physically active. Many aspects of our lives, if not all, are affected by our physical health, and many societal circumstances have a direct or indirect impact upon on physical health and our ability to be physically active especially in older age. This report will attempt to identify these factors and those communities most vulnerable to the effects of physical inactivity. A reference group will be responsible for endorsing and implementation.

This report should be read in conjunction with Kent and Medway’s 2023-2027 strategy for sport and physical activity, the Public Health England [PHE] 2020-2025 strategy priorities, and the Health Equality Framework and Commissioning Guide – National Development Team for Inclusion [NDTi], and the keynote presentation by the Director of Public Health (DPH), in 2023. [Link](https://www.kpho.org.uk/joint-strategic-needs-assessment/health-intelligence/lifestyle/physical-activity#tab1)This report updates the last health needs assessment for adult physical activity (2017). [Link](https://www.kpho.org.uk/__data/assets/pdf_file/0008/72458/Adult-Physical-Activity-2017.pdf)

## 3.2 Scope

The identification of types and availability of beneficial physical activities, enablers and barriers for older adults to become more physically active in Kent.

Elements out of scope but worthy of consideration include:

* the role of structural and functional foot and ankle characteristics associated with falls and the ability and desirability of people to participate in physical activity due to foot related issues and service access e.g., chiropody, podiatry and suitable footwear.
* The ability of, and support for, older adults to maintain adequate nutritional status to support adequate muscle mass.

## 3.3 Definitions

* Sedentary behaviour is defined as time spent sitting or lying with low energy expenditure, while awake, in the context of occupational, educational, home and community settings and transportation.
* Physical activity guidelines: A set of evidence-based recommendations for how much and what kinds of physical activity we need to do to keep ourselves healthy.
* Physical activity: body movement that expends energy and raises the heart rate. At least moderate intensity activity, [vigorous counts as double], in bouts of 10 minutes or more than add up to one of the three levels of activity of active. Gardening is excluded. [Sports England].
  + Active - at least 150 minutes of activity per week [Sports England]
  + Fairly Active – an average of 30-149 minutes activity per week
  + Inactive – fewer than 30 minutes of activity per week
* Types of activity:
  + Everyday activity includes cycling, walking, heavy housework, active or manual work.
  + Active recreation includes dance, stretching, active play, recreational walking or cycling.
  + Sport includes aquatic activity, rowing, fitness training, climbing, parkour, tennis, organised sports.
* Wider determinants of health: the wider determinants of health are a diverse range of social, economic, and environmental factors which influence people’s mental and physical health. E.g., housing, transportation, employment.
* A fall is ‘an event which results in a person coming to rest inadvertently on the ground or floor or other lower level’ [WHO, 2018]. People aged over 60 are more likely to fall. Globally, falls are the second leading cause of unintentional injury, often leading to hospitalisation, disability and death.
* SNOMED CT is a structured clinical vocabulary for use in an electronic health record [clinical codes used by the NHS for patient records]. It is the most comprehensive and precise clinical health terminology product in the world.
* Identification and Brief Advice [IBA]. Used routinely by professionals to help people with alcohol misuse and tobacco dependence, this is a very brief intervention [30 seconds], to Ask, Advise and Act, to tackle risky lifestyle behaviours. Training is available to enable practitioners to be confident in doing these IBA’s.
* Health literacy means being able to access, understand, appraise, and use information and services in ways that promote and maintain good health and well-being, and is a determinant of health.
* Behavioural change. The theory of change widely used to bring about increased activity in older adults is called COM-B. The model proposes behaviour [B] change via Capability [C], Opportunity [O] and Motivation [M] to conduct the desired behaviour through these interdependent elements. The model identifies what needs to change for effective intervention, and by changing even one of these elements, it can lead to change. If any of these elements is missing, the change will not occur.

## 3.4 Method

An epidemiological and corporate approach was used to review the latest evidence, practice examples, lay and stakeholder views to:

* Describe and quantify the scale of health impacts and needs faced by older people related to physical activity (Epidemiology).
* Review community physical activity service offers and opportunities available for older adults against evidence-based/best practice standards, to assess met and unmet need, incorporating stakeholder and service provider views. (Corporate).

# 4. Epidemiology

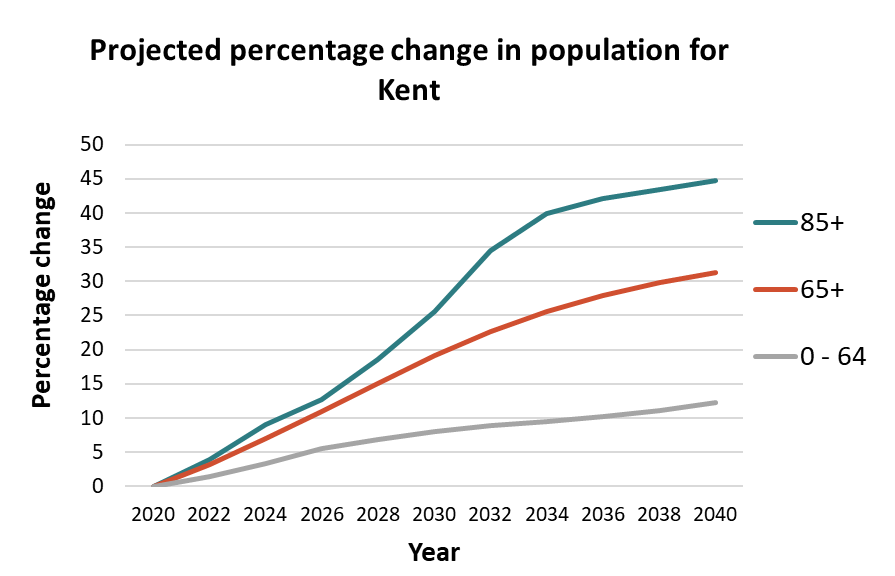
## 4.1 Kent’s Ageing Population

Like the England trend, Kent has an increasingly ageing population with the trend set to continue in coming years. If the trend continues, we will be 35% less active than we were in the 1960s. Some groups of people tend to be less active than others for a variety of reasons.

This means that the already considerable costs to provide health and care services will continue to increase if comprehensive and systematic action is not taken. The cycle of negative impacts of on individuals of being inactive is significant. It results in poorer health, which in time leads to loss of mobility, health, quality of life and loss of independence and the need for care.

* 1,593,200 people currently live in Kent. This is above both the average for the southeast [7.5%] and England [7.4%]. [[2]](#endnote-3)
* Kent has an ageing and a steadily increasing population growing by 9.4% between 2010-2020
* The number of people aged 65 and older is expected to rise by 44.9% between 2019-39. The proportion of people aged under 65, is forecast to increase by 12.2%. Table A

Figure 1: Kent population projections, 2020-2040.



Source: KCC Housing Led Forecasts, KPHO

In 2021, 40% [*n=* 633,943] of Kent’s population, were aged 50 or older. Districts with the highest numbers and proportions of people aged 50+ are shown below. Table A

Ages 50-64:

* Maidstone has the highest number
* Folkestone / Hythe has the highest proportion

Ages 65-74

* Canterbury has the highest number
* Folkestone / Hythe has the highest proportion

Ages 75-84

* Canterbury has the highest number
* Folkestone and Hythe have the highest proportion

Ages 85+

* Canterbury has the highest number
* Folkestone / Hythe and Sevenoaks both have the highest proportion

Table A: Kent district residents by age bands, single year, 2021.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Area/persons [2021] | Resident totals | Aged 50-64 |  | Aged 65-74 |  | Aged 75-84 |  | Aged 85 |  |
| Area | **Number** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** |
| Ashford | 132,752 | 26,694 | 20.1 | 13,892 | 10.5 | 8,909 | 6.7 | 3,199 | 24 |
| Canterbury | 157,431 | 29,222 | 18.6 | 17,916 | 11.4 | 11,639 | 7.4 | 4,699 | 3 |
| Dartford | 116,756 | 20,283 | 17.4 | 8,602 | 7.4 | 5,223 | 4.5 | 2,215 | 1.9 |
| Dover | 116,407 | 25,073 | 21.5 | 15,055 | 12.9 | 9,406 | 8.1 | 3,438 | 3 |
| Gravesham | 106,899 | 20,338 | 19 | 9,709 | 9 1 | 6,215 | 5.8 | 2,490 | 2.3 |
| Maidstone | 175,778 | 34,373 | 19.6 | 17,836 | 10.1 | 11,288 | 6.4 | 4,399 | 2.5 |
| Sevenoaks | 120,516 | 24,959 | 20.7 | 13,343 | 11.1 | 8,760 | 7.8 | 3,826 | 3.2 |
| Folkestone and Hythe | 109,754 | 23,940 | 21.8 | 14,691 | 13.4 | 9,263 | 8.4 | 3,473 | 3.2 |
| Swale | 151,678 | 30,235 | 19.9 | 15,976 | 10.5 | 9,675 | 6.4 | 3,261 | 2.1 |
| Thanet | 140,585 | 28,733 | 20.4 | 17,754 | 12.6 | 11,236 | 8 | 4,265 | 3 |
| Tonbridge and Malling | 132,196 | 26,938 | 20.4 | 13,173 | 10 | 8,772 | 6.6 | 3,360 | 2.5 |
| Tunbridge Wells | 115,311 | 23,825 | 20.7 | 11,330 | 9.8 | 7,646 | 6.6 | 3,396 | 2.9 |

Source: ONS, [Nomis on 26 October 2023], prepared by L. Smith

Of Health Care Partnerships [HCPs], east Kent has the most registered adults aged 50 and older, with Dartford, Gravesham and Swanley [DGS] HCP the fewest Table B.

Note: Figures are slightly different as not all Kent residents are registered with a GP [HCP], and these figures cover a different period [2023].

Table B: HCP GP registered populations aged 50+ years, 2023.

|  |  |  |  |
| --- | --- | --- | --- |
| HCP | Population | Aged 50+ | % |
| East Kent | 745,212 | 311,762 | 42 |
| West Kent | 528,328 | 208,922 | 39.5 |
| Medway and Swale | 449,542 | 161,309 | 36 |
| Dartford, Gravesham and Swanley | 289,956 | 100,533 | 35 |
| Total | **2,013,038** | **782,526** | **39** |

Source: registered PCIS GP practice populations [01/10/2023]

* Kent coastal fringe districts in east Kent are projected to have the highest dependency ratios for older residents aged 65 and older by 2018-2043especially Dover, Thanet and Shepway. With the potential for increased service demand, workforce strategies should take note. Table C

Table C: Projected dependency ratios of residents aged 65+, by district, 2018-2043

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| District / Year | 2030 | 2036 | 2037 | 2043 |
| Shepway | 27% |  |  | 33% |
| Thanet |  | 29% |  | 30% |
| Dover |  |  | 29% | 29% |

Source: KPHO

In many respects Kent is like other parts of England when it comes to levels of activity. The most recent data is encouraging with more people reporting being active especially older people. Kent is comparatively worse than elsewhere for cycling for travel / work:

* Canterbury, Dover, and Ashford on average the highest rates of Active Travel 2016-21. Dartford and Gravesham have the lowest rates. The rates observed in Kent are like those seen in its socio-economic neighbours.

The Active Lives Survey [2022-23], tell us that over the last seven years, men and women in England have shown increasing levels of activity. Lower activity levels recorded for the period 2019-21 coincide with coronavirus pandemic restrictions.

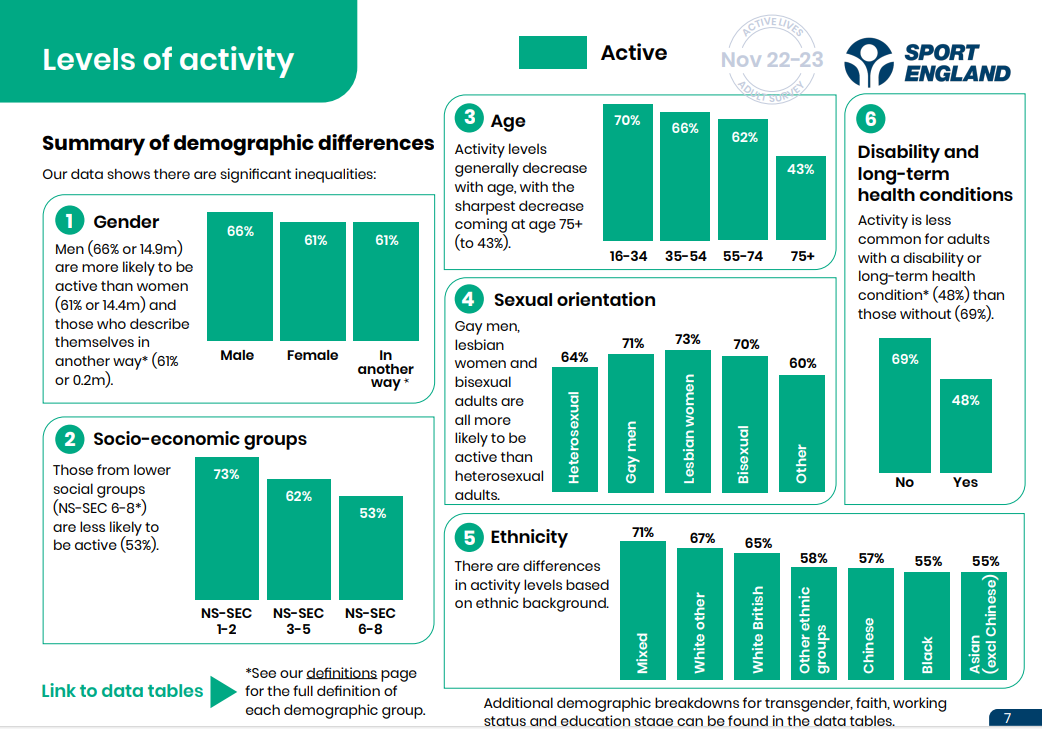
Compared to 2015-16, 2.0m adults are now more active, an increase of [+1.3%]. There has been no change in number who are ‘fairly’ inactive but there has been a decrease of 404,000 [-1.4%] for the ‘inactive’ group. [[3]](#endnote-4) There continues to be a significant upward trend of increasing activity in adults aged 55-74 and adults aged 75+.

The diverse range of social, economic and environmental factors which impact on people’s health, are most known as the wider or social determinants of health [WDH]. These determinants are recognised as interdependent success factors which need to be considered to effectively address health inequalities and improve health and wellbeing.

For many reasons, some individuals in our communities are noticeably less active than others as listed below. Fig.2

* Women
* Those from lower socioeconomic groups
* Age – the sharpest decline in activity is for those aged 75+
* Gay men, lesbian women and bisexual adults are all more likely to be active than heterosexual adults.
* Adults with a disability or long-term health condition (48%) than those without (69%)
* Differences between ethnicities: Asian [not Chinese], Black, Chinese and other groups, are less likely to be active than White, White/Other, White British adults.
* Men are more likely to report being active at the recommended level than women.

Figure 2: Summary of activity levels by demographic differences.



Source: Active lives national survey 2022-23, Sports England.

The pandemic has significantly reduced physical activity levels among older people. Many older individuals found it easier to stay active when physical activity was integrated into their daily routines, such as in-person shopping and socialising.[[4]](#endnote-5)

The increased reliance on online shopping and technology during the pandemic has disrupted these habits with many of them are yet to return to their pre pandemic routines. I.e. 40% of respondents aged over 50 years said they were carrying out more online activities like shopping than they did pre-pandemic.

* It is recommended to encourage in-person shopping to incorporate physical activity into everyday life.

## 4.2 Mental Health

The phrase severe mental illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired.

* Poor physical health is common amongst people with SMI.[[5]](#endnote-6)
* People with SMI face one of the greatest health inequality gaps in England, with a life expectancy 15-20 years shorter than that of the general population.[[6]](#endnote-7)
* It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented.[[7]](#endnote-8)
* Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes and hypertension.[[8]](#endnote-9)
* This is due to preventable physical illnesses many which may be prevented or mitigated by physical activity.[[9]](#endnote-10)
* The NHS Core20Plus5 approach to address this inequality stresses the importance of an assessment of physical activity as part of an annual comprehensive physical health assessment. It is recommended that this be implemented.[[10]](#endnote-11)
* Professionals are encouraged to use the updated framework of the [Lester Tool](https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/lester-tool-june-2023.pdf?sfvrsn=c08e2847_4) with patients which includes NICE guidance ‘don’t just screen, intervene’. [[11]](#endnote-12)
* For some, certain life events have been shown to be barriers to participate in physical activity. However, these occasions should be used by professionals as triggers for introducing IBA-PA. It is recommended that as with IBA for smoking and alcohol misuse, which is well established, IBA for increasing physical activity in adults especially older adults, be developed and introduced.
* Seven studies have shown the likelihood and risks of poor outcomes in adulthood from having 2+ ACE as related to physical activity. It remains unknown to what extent.[[12]](#endnote-13)

## 4.3 Workforce

With more older adults remaining in, and returning to employment within an increasingly ageing population, it is important that employers and businesses encourage and facilitate those using their premises to be less sedentary.

In 2023 the Government announced a consultation on new plans to boost health in the workplace:

* Employers are encouraged to take up Occupational Health offers to help employees access vital mental and physical health support at work.

Public Health Guidance for physical activity in the workplace [PH13], issued in 2008 is presently being updated with a focus on elements of sit-stand-desks [SMArT study / Stand More at Work]. This guidance encouraged the increase in the working population’s physical activity levels. [[13]](#endnote-14)

Efforts made in the workplace, alongside wider strategies to increase physical activity levels, could help to significantly improve population health and reduce absenteeism. E.g.

* 7.3m workdays in 2022 were lost due to musco-skeletal [MSK] which is pain affecting bones and muscles
* 41% of employees reported experiencing MSK pain
* 17% of employees reported this negatively impacted upon their work productivity.
* Actions to address these include physiotherapy, active breaks from desks and Display Screen Assessments [DSA].[[14]](#endnote-15)

The degree to which employers recognise, implement, and do not pay perfunctory regard to this responsibility, will have a direct impact on the future health status of the working population and demand for health and care services in Kent.

Large public sector organisations should set an example and standard for this. The importance and role of anchor institutions and large employers in Kent, to institute practices, policies and create an organisational culture that encourages and facilitates employees to reduce the amount of sedentary time spent, should not be underestimated.

98% of surveyed employees are motivated to make a positive change to improve their wellbeing. This provides an excellent opportunity for employers to positively enable physical activity and reduce sedentariness. Of the top ten areas employees wanted to focus on, increasing physical activity was in fifth place [26%]. [[15]](#endnote-16)

## 4.4 Primary Care Settings

In 2019, a collaboration between the Royal College of General Practitioners and Sports England saw the launch of the [Active Practice Charter](https://www.sportengland.org/news/rcgp-launch-active-practice-charter)  toolkit for GPs to encourage physical activity. Successful practices achieve recognition as an Active Practice through promotion of physical activity. For example, having less chairs in sitting areas, organising activity coaching and groups, and promotion of a variety of exercise links. To date, only six GP practices have signed up to this in Kent: Whitstable, Tenterden, Hamstreet, Headcorn, Charing, and Linton [Maidstone]. [map](https://www.google.com/maps/d/viewer?mid=18Vi9VpmvJfgiwijB07rtlTv0dNHMYO6C&ll=51.14939507643715%2C0.8590709842802458&z=9)

* It is recommended that more, if not all, GP practices achieve Active Practice Charter status.

In 2024, in other work with large employers, Active Kent have supported Bedfont Scientific and Greener NHS to discuss opportunities to support workplaces including activity challenges and workshops. In 2025, they will support Randox in delivery of health checks for KCC staff to discuss physical activity signposting opportunities and signposting via Everyday Active website and resources.

## 4.5 Hospital Settings

* Falls are the most frequently reported incident affecting hospital inpatients and deconditioning of elderly patients whilst in hospital is common.

In 2021, it was reported that 65% of older patients experience decline in function during hospitalisation. Many of these patients could prematurely end up in a care home because of ‘deconditioning’ and the loss of functional abilities in hospital.[[16]](#endnote-17)

A meta-analysis of 20 randomised controlled trials of behaviour change intervention in 2021 with 2,568 patients with an average age of 67 years, found that:

* targeted behaviour change interventions were associated with increases in physical activity in hospitalised patients.

There was moderate-certainty evidence that behaviour change interventions increased physical activity levels leading too small to moderate increases in physical activity in hospital.

* Setting goals and giving performance feedback were the tactics that worked best.[[17]](#endnote-18)
* Increasing physical activity should be incorporated into discharge care plans. I.e. Intervention and brief advice [IBA] for increasing physical activity, with signposting and referral to community-based activities.

## 4.6 Prevention in Primary Care Settings

Primary community prevention and education is a recognised gap in the current Kent falls care pathway. It is recommended that this be addressed with a stronger focus on Prevention. For example, as described in the current Prevention priorities for the Ageing Well of the Dartford, Gravesham and Swanley Health Care Partnership [HCP] who have set priorities for increasing physical activity in older adults aged 50+ by monitoring for improvement for:

* Increased numbers of adults 50+ being given IBA-PA in primary care and
* Identification and implementation of workforce training for IBA-PA

## 4.7 Care and Nursing Homes

Evidence suggests that people in care homes may lack adequate health and preventative care such as dentistry, vision, hearing, and health checks – including physical activity.

It is essential to highlight prevention by incorporating physical activity (PA) as a routine practice. Some care homes do have activity coordinators who provide various forms of PA. However, access to, and the quality of, these services vary significantly.

* It is recommended that the number of care and nursing homes that have the provision of, or access to, a physical activity coordinator be identified, and those without one be encouraged to provide this intervention.

A key recommendation from the WHELD programme, [Wellbeing and Health for people living with Dementia] and the MARQUE scheme, call for ‘training in person-centred care…along with antipsychotic [medication] review by GPs, social interaction and *exercise*’.

* The WHELD programme has proven effective and costs less to deliver than usual care.[[18]](#endnote-19)
* Targeted support to promote physical activity (PA) programmes for care homes with higher fall rates and a greater number of council-funded residents is required.

## 4.8 Socio-economic Impacts

## 4.8.1 Cost to Individuals

Kent is ranked 9th worse amongst English counties and authorities for the number of older people experiencing poverty and income deprivation, 11.6% [44,865] compared to England [14.2%] for the period 2021/22-2022/23. This poverty can inhibit older adults from accessing activities and services.

## 4.8.2 Cost to Healthcare

* The cost of hip fractures alone account for 1.8 million hospital bed days and £1.1 billion in hospital costs every year, excluding the high cost of social care.
* Falls in hospitals are the most reported patient safety incident with more than 240,000 reported in acute hospitals and mental health trusts in England and Wales.

## 4.8.3 Cost to Adult Social Care

In Kent, reasons for Adult Social Care [aged over 18], include sensory support, memory, cognition and *physical disability.*

* The gross current expenditure for 100,000 adults by care activity and type, in Kent for the period 2022-23 was mostly spent on provision of long-term care. [[19]](#endnote-20)
  + The unit cost of new clients aged 65+ whose primary support need was physical activity, was £801. This compares to £1,375 for those aged under 65.
  + 905 adults received directly supported care for physical support -specifically for access and mobility [75 per 100,000]
  + 3,080 adults accessed long term support [960 per 100,000].

## **Activity levels in Kent**

*Please note*

Data comparisons:

Data captured via the Health Survey for England [HSE] and includes housework, DIY, and gardening within estimates. Unlike the Office of Health Improvement and Disparities [OHID], who count gardening as an activity, the Active Lives Survey does not. Therefore, data between these two surveys are not comparable.

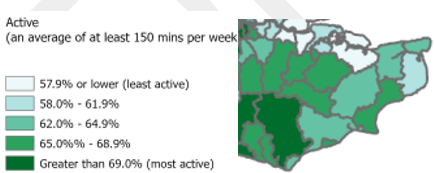
Differences in activity types:

It is important to remember that whilst being ‘active’ is desirable especially in older adults, attention is required to increase and maintain Muscle Strength and Balance [MSB] via specific types of exercise activity. A common term for this is ‘postural stability’. These types of activity inherently include elements of coordination and flexibility.

This is why both types of activity are specifically referred to in this report and commissioners and providers of postural stability services should ensure that evidenced based activities are performed for this purpose. I.e. not all activities will have the effect of improving and maintaining muscle strength and balance contributing towards Falls Risk Reduction [FRR].

Kent physical activity data for 2022-23 from Sports England shows us that there were clear variations in adult activity across Kent districts. Fig 3

Figure 3: Adult activity levels by Kent district [2022-23].



Source: Sport England, 2024

The Active Lives survey for 2021-22 tells us that:

* Overall, Kent continues a positive trend over time of increased activity
* is better compared to ‘like’ neighbours and England
* Residents in some areas e.g. coastal, are less active
* Between 2015-2023, the trend amongst Kent adults aged 55 and older who were active for 150+ minutes per week continued to increase.
* Ages 75+ have seen a statistically significant increase of 1.6% between 2022-23, with 43% active at the recommended levels per week. [[20]](#endnote-21)

In Kent, just 15% of older adults are doing muscle strength and balance improvement activities. Those least likely to be active and meet the twice weekly Muscle Strength Exercise [MSE] and Balance [B] guidelines are:

* Women in Thanet
* Adults pre and post 75 years
* Women are less likely to be active than men
* Women in urban areas less active than those in rural areas. For men, there is little difference between rural and urban settings.
* Men in Gravesham Table D

Table D: Kent Active Lives Survey Activity Trends, 2021-22.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Guidance / Characteristic | Age | Adults | Men | Women | Place / least likely | Place / most likely |
| Participation in activity |  | 27.5% | More likely | Less likely | Gravesham men [38%]  Thanet women [32%] |  |
| Meeting both guidelines for MSE-B |  | 15% | 17% | 14% | Urban [29%] | Rural [30%] |
| Meeting both guidelines for MSE- |  |  |  |  | Urban women [39.5] | Rural women [43%] |
| Meeting both guidelines for MSE- |  |  |  |  | Very little difference in men between rural and urban settings | Very little difference in men between rural and urban settings |
| IMD 1-3 residents / participating in twice weekly  MSE-B exercise | 55-74 [32%]  75+  [21%] |  |  |  |  |  |

Source: Active Lives Survey, 2021-22. Prepared by Linda Smith

## 4.9 Health Checks

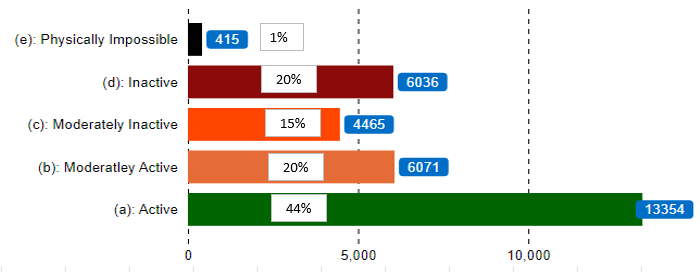
A health check is a general health assessment of an individual’s overall health which is offered to eligible adults between the ages of 40-74 years.[[21]](#endnote-22) Health checks are a preventative intervention based on evidence from a range of sources which aim to assess an individual’s risk of developing certain conditions. E.g., diabetes, heart, and kidney disease. As part of the assessment, individuals are asked about and provided information on exercise activity.

* In Kent, of adults aged 50+ who completed a health check during 2023-24, most report some level of activity, with 20% reported inactive. Fig 4

The criterion for what constitutes these levels is not described. No data is recorded with regards health check / physical activity data for people with disability or accommodation type e.g. residential care. Most people who are referred from a health check assessment to the *One You Kent* service or signposted to the website for lifestyle activities, decline.

* More women than men accepted an invite between April 2023-March 2024
* People living in the most deprived areas were least likely attend.
* most likely to attend are aged 40-49, then ages 50-59
* Ages 55+ then ages 75+ reporting the highest activity levels.[[22]](#endnote-23)

Figure 4: Physical activity levels, Health Check activity 2023-24.



Source: Health Check Dashboard, KCC. [Excluding Whitstable area].

Very few Roma individuals’ exercise. As found in local engagement with these communities across Kent, one stakeholder acknowledged this issue disproportionately affected women, which may be a result of cultural beliefs about physical appearance. [[23]](#endnote-24)

Although not reported, not taking part in formal exercise may also be a result of Roma women not having access to resources (e.g. independent transport or disposable income, which have been discussed as common issues). Mobility [transport] problems were reported by 25% of Gypsy, Romani people and Travellers compared with 15% seen in their counterparts. [[24]](#endnote-25)

## 4.10 Transport/Active Travel

There is strong evidence base for the benefits of active travel. [**Link**](#PEBR) Fewer households in Kent have household transport than the England average, 17.5% compared to 23.5%. [ONS Census, 2021]. Lack of transport potentially impacts negatively and disproportionately on older adults in several ways.

Economic impacts include lack of any or suitable public transport options may mean they have higher expenditure on private transport for basic daily activities such as health care appointments, food shopping, social and physical activity interactions.

* At 1.1%, Kent is joint worst in England for the proportion of adults cycling for travel at least three days per week [2019-20].

# 5. What Does The Evidence Say?

## 5.1 Benefits of Physical Activity

The benefit of regular physical activity provides an immediate and long-term range of physical, mental, and social benefits for individuals, communities, and society are displayed in Table E below. [[25]](#endnote-26)

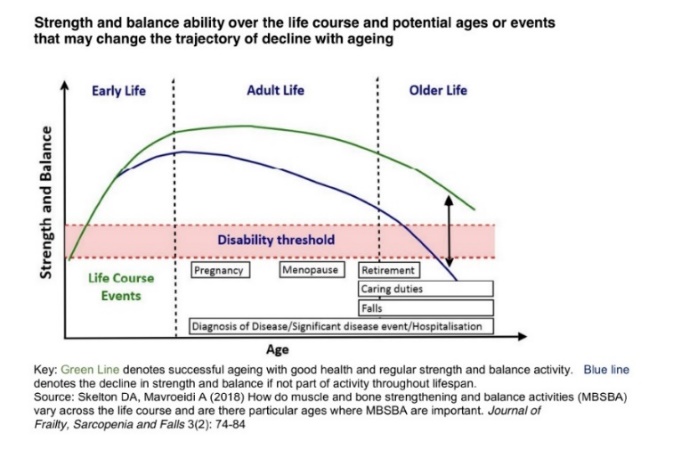
Table E: Benefits of regular physical activity.

|  |  |
| --- | --- |
| **Improves** | **Reduces / Prevents** |
| * Immediate improvement of sleep, reduced anxiety, blood pressure control * Helps to manage existing conditions * Aids good musculoskeletal health * Aids developing and maintaining physical and mental function * Aids maintaining independence * Supports social inclusion * Helps to maintain a healthy weight | * prevents some types of cancers * reduces the risk of many long-term conditions * reduction in cognitive decline, bone fractures, depression, heart disease, diabetes, bowel cancer * reduces inequalities for people with long-term conditions * reduces all-cause mortality [[26]](#endnote-27) |

* People who engage in lifelong activity benefiting strength and balance, remain independent for longer than those who did not.

This is evident in Figure 5, where the top green denotes ageing in good health and regular strength and balance activity [line is higher and longer], than the black line below showing the decline in strength and balance of those who did not do strength and balance activity regularly. It is striking the earlier decent into disability for this group.

Figure 5: Trajectory of strength and balance ability over the life course



‘It takes a child one year to acquire independent movement and ten years to acquire independent mobility. An old person can lose both in a day.’

[Professor Bernard Isaacs (1924–1995])

## 5.2 Return on Investment

The potential societal and economic benefits to individuals and the Kent integrated health and Adult Social Care system of increased population activity could be significant, particularly relating to the reduction of emergency admissions, hospital in-stays, enablement, rehabilitation, social care costs, and mental health services.

The costs of engagement and opportunity provision for physical activity, is well evidenced and cost-effective. E.g. the return on investment [ROI] for every £1 spent, generated £3.91 for individuals and society [Sport England, 2024].

In 2019, a comparison report of the social and economic value of community sport and physical activity for Kent was published. Canterbury district saw the largest return on investment for physical and mental health outcomes whilst Maidstone saw the largest return on investment for mental wellbeing and social and community development. Table F

Table F: Social and economic value of physical activity [2019], Kent compared to England

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Physical and mental health outcomes | Mental wellbeing | Social and community development | Totals |
| ENGLAND | £9,592,842,400 | £41,760,806,500 | £19,936,050,700 | £71,289,699,600 |
| Kent | **£275,363,700** | **£1,239,530,400** | **£593,910,600** | **£2,108,804,700** |
| Ashford | £20,456,900 | £100,164,600 | £48,624,700 | £169,246,200 |
| Canterbury | £31,627,000 | £134,926,700 | £64,026,800 | £230,580,500 |
| Dartford | £18,590,500 | £81,673,900 | £38,874,900 | £139,139,300 |
| Dover | £21,228,300 | £95,115,300 | £45,648,200 | £161,991,800 |
| Folkestone and Hythe | £20,762,900 | £102,998,400 | £49,596,400 | £173,357,700 |
| Gravesham | £16,207,500 | £75,847,600 | £36,579,300 | £128,634,400 |
| Maidstone | £30,227,500 | £136,608,900 | £65,075,700 | £231,912,100 |
| Sevenoaks | £22,403,400 | £98,736,800 | £47,285,000 | £168,425,200 |
| Swale | £23,589,400 | £97,838,800 | £46,559,300 | £167,987,500 |
| Thanet | £23,570,900 | £105,549,700 | £51,190,200 | £180,310,800 |
| Tonbridge and Malling | £23,899,600 | £114,930,600 | £55,373,400 | £194,203,600 |
| Tunbridge Wells | £22,799,800 | £95,139,000 | £45,076,600 | £163,015,400 |

Source: Sports England. Prepared by L. Smith

## 5.3 Key Documents and Guidance

There are several key global, national and local documents relating to the importance of physical activity. Key messages include:

* that activity at the recommended type and levels is best, but something is better than nothing.
* Muscle strength and balance is important to maintain as we age
* Even frail people can do some activity which will bring benefits

Prevention strategies should emphasize:

* Education
* Training
* Creating safer environments
* Prioritizing fall-related research
* Establishing effective policies to reduce risk” [WHO, 2024]
* Guidance from NICE exhorts us to ‘don’t just screen, intervene’, and ‘Ask, Act, Advise’ [IBA].
* The [Kent and Medway Integrated Care Strategy](https://www.kmhealthandcare.uk/application/files/8717/1267/5010/CS56370_Care_Strategy-final-accessible_v3.pdf) [2023], highlights the ambition and importance of increasing population physical activity. Through system wide action to address the wider determinants of health, along with behavioural change to help people adopt and maintain healthy lifestyles and reduce sedentariness.
* [Chief Medical Officer’s Annual Report 2023 – Health in an Ageing Society: Executive summary and recommendations](https://assets.publishing.service.gov.uk/media/667408ccf92bc4be25da7ec6/chief-medical-officers-annual-report-2023-executive-summary-web-accessible.pdf)
* [UK Chief Medical Officers' Physical Activity Guidelines](https://www.gov.wales/sites/default/files/publications/2022-03/uk-chief-medical-officers-physical-activity-guidelines.pdf) 2019 [Updated 2020].
* [Physical activity guidelines: UK Chief Medical Officers' report - GOV.UK](https://www.gov.uk/government/publications/physical-activity-guidelines-uk-chief-medical-officers-report) [2019; updated 2020]
* [NHS England » Green social prescribing](https://www.england.nhs.uk/personalisedcare/social-prescribing/green-social-prescribing/)
* A consensus on healthy ageing - GOV.UK (www.gov.uk)
* [Falls: applying All Our Health - GOV.UK](https://www.gov.uk/government/publications/falls-applying-all-our-health/falls-applying-all-our-health) [2022]
* Advancing our health: prevention in the 2020s – consultation document - GOV.UK ([www.gov.uk](http://www.gov.uk))
* [Physical activity for general health benefits in disabled adults: summary of a rapid evidence reviews for the UK CMO’s update of guidelines](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/748126/Physical_activity_for_general_health_benefits_in_disabled_adults.pdf) [2018]
* [Rights-of-Way-Improvement-Plan-2018-2028.pdf](https://www.kent.gov.uk/__data/assets/pdf_file/0005/90491/Rights-of-Way-Improvement-Plan-2018-2028.pdf) Kent County Council
* Clinical Guideline [CG161], falls in older people: assessing the risk and prevention [2013]
* Public Health Guidance for physical activity in the workplace [PH13]
* Public Health guidance: Physical Activity: brief advice for adults in primary care [PH44, 2013].
* [National Institute for Health and Care Excellence (NICE) guidelines](https://pathways.nice.org.uk/pathways/physical-activity#path=view%3A/pathways/physical-activity/encouraging-physical-activity-to-prevent-or-treat-specific-conditions.xml&content=view-index), and the promotion of physical activity helps to support their implementation.[[27]](#endnote-28)
* [Products - Physical activity | Topic | NICE](https://www.nice.org.uk/guidance/lifestyle-and-wellbeing/physical-activity/products?Status=Published)
* Physical activity and sedentary behaviour Guidelines for older adults [WHO, 2020].[[28]](#endnote-29)
* National Institute for Health and Care Excellence [NICE]: Falls assessment and prevention in older people and people over 50 and over at higher risk of a fall. *Publication pending March 2025*
* The Lester tool for people with mental health conditions: [ncap-lester-tool-intervention-framework.pdf](https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/eip-2024/ncap-lester-tool-intervention-framework.pdf?sfvrsn=21e45dbd_17) [Accessed 2025]
* The General Practice Physical Activity Questionnaire (GPPAQ) [Link](https://assets.publishing.service.gov.uk/media/5a7ac84ee5274a319e77ab03/GPPAQ_-_guidance.pdf#:~:text=The%20GPPAQ%20is%20a%20validated%20screening%20tool%20for,as%3A%20Active%2C%20Moderately%20Active%2C%20Moderately%20Inactive%2C%20and%20Inactive.) [Accessed 2025]
* Swim England [2017] [The Health and Wellbeing Benefits of Swimming report](https://www.swimming.org/swimengland/health-and-wellbeing-benefits-of-swimming/)
* [NHS Long Term Plan](https://www.longtermplan.nhs.uk/)
* [25 Year Environment Plan - GOV.UK](https://www.gov.uk/government/publications/25-year-environment-plan)
* [Social Prescribing Kent & Medway](https://socialprescribingkentandmedway.uk/)
* It is important to distinguish between types of physical activity that are particularly important for ageing well. I.e. muscle strength, balance and heart health (cardiovascular).

## 5.4 Recommended activities for strength, muscle and balance

Evidence-based strength and balance exercise programmes reduce falls rate and risk of falls, are cost-effective, increase confidence, and can increase habitual moderate physical activity towards meeting recommended physical activity guidelines.

A range of evidence based structured exercise programmes are available. The most widely accredited and commonly used are postural stability instruction via Falls Management Exercise [FaME] programme and the Otago Exercise Programme [OEP]. These services offer strength, balance, and exercise classes to be delivered in a variety of settings.

For those who are assessed at a low risk of experiencing a fall, these people are to be offered exercise and education. Some studies demonstrate quality of life positive impacts via video exercises, weekly phone calls, as do initial face-to-face professional assessments and exercise planning.

To increase reach and long-term engagement, these services can be delivered in homes, community settings and virtually. They can be group or home-based and can be embedded within everyday activities. Consider using telehealth and / or smart home systems as available, in combination with exercise programmes as part of a community-based falls prevention programme.

Key points of fidelity to both programmes are sufficient dose, [a minimum of 12-week course format], bespoke to individuals [10-12 participants], progressive and adaptive exercises, behavioural change support.

Different activities provide different health benefits. See more information in the appendix to see the range of activities and how well these benefit muscle function, balance, heart and bone health. [Appendix](#Appendix)

## 5.4 Approaches to Encourage Activity

Details of a rapid evidence review to support community engagement and improve health outcomes including physical activity is displayed in [App2](#App2)

Key findings include:

* The use of micro-grants for community groups to organise themselves is cost effective.
* Volunteering amongst older adults of all types, reduces mortality by up to one third.
* Peer led activities, health walks, multi-component interventions delivered via community hubs

During 2024-25, Active Kent and Medway [AKM] awarded 45 small grants to a range of projects and organisations. These included funding a local dance collective Moving Memory in Thanet to deliver three dance workshops to integrate older people into Thanet’s cultural programming and challenging people of all ages to change their perspective on ageing. This project addresses ageism which “leads to poorer health, social isolation, earlier deaths and costs economies billions” by showing the life enhancing, value of older adults’ lives, and their rich contribution to local communities. [[29]](#endnote-30)

## 5.5 Volunteering

A person can be considered as having volunteered if they have participated in a role to support sport or physical activity in the last 12 months. Sport England reported across four levels of volunteering within 12 months: one-off, a few times, least once a month through the year, at least once a week during the year.

* Between 2022-23, just over 21% [10m] adults volunteered to support sport and physical activity
* This was an increase of 2.3% [1.2m] on the previous year.
* Over the longer term, volunteering continues to decline, 1-2% dips post covid.
* There are 2.1m [5.8%] fewer volunteers with fewer adults are organising fundraising for sport compared to six years ago during 2016-17.
* The most common volunteering role with 8.9% [4.1m] is fundraising then providing transportation which has seen the second greatest reduction with 975,000 [2.4%] fewer adults volunteering.

Tables G and H below describe who is most likely to volunteer and the types of interventions and their effectiveness.

Table G: Volunteering to support activity, 2022-23

|  |  |
| --- | --- |
| **Likely to volunteer** | **Unlikely to volunteer** |
| * Men are most likely to volunteer [63%] * 10% of adults living in lower socio-economic groups were likely volunteer compared to 30% of the general population. * People between the ages of 45-54 are most likely to volunteer. * Bisexual adults are slightly overrepresented among regular volunteers. | * Volunteers from Black, white and other ethnic groups are underrepresented amongst regular volunteers. * People with disability and long-term health conditions account for 18% of regularly volunteers compared to 20% of the population. |

Table H: Intervention type and effectiveness of community engagement strategies

|  |  |
| --- | --- |
| **Intervention type** | **Effectiveness** |
| Volunteer led, group health walks | These improve participant health-related quality of life, cardiovascular fitness, mental well-being, improve social participation in older people and are low-cost to implement (SROI circa £9 return for every £1 invested). |
| Volunteering in the over 65s | Volunteering improves the physical and mental health of volunteers. The effect is best documented for a reduction in mortality. It supports functional capacity and may reduce depression. |
| Peer led community champions providing health and wellbeing support to local communities. | Improvements across many outcomes including improved self-reported health, increase in participation in physical activity, increased uptake of benefits and other resources and social connectedness. SROI £5-£12 per £1 invested. |
| Multi-component interventions delivered from community hubs | E.g. addressing physical activity and social isolation and targeted towards specific groups (e.g. diabetics, older people) improve health outcomes and decrease healthcare use. |
| Collaborative, from-the-ground-up participatory approaches to priority setting and service developments for specific communities | Outcomes include increased engagement with services, improvements to neighbourhoods, reduction in crime rates, improved health literacy and reduced use of healthcare services. |
| Improving social connectiveness 55+ years. LinkAge [Bristol] provides a range of services focused on befriending and encouraging physical activity. | Increased physical activity and social connectedness; daily physical activity increased from 27%-40%. Socially, increased from 14%-23%. SROI £1.20: £1.  Savings deemed to be considerable and underestimated. E.g. NHS savings from early intervention. Needs CVS input. |
| Creative Local Action Response and Engagement. Together we can make a difference: CLARE programme.  [I.e., offer micro-grants for groups to organise themselves - Age Friendly Communities framework, WHO] | A cost-effective model to reduces the need for/or delays the need for high intensity and costly health and social care services. 30 volunteers completed over 700 hours of volunteering over 12m.  Benefits for individuals and carers +++. Savings to ASC and NHS circa >£100k over 40 weeks via delayed residential care, supported discharge, befriending. |

Other evidenced based interventions include:

* Public realm infrastructure improvements are associated with increased mobility, physical activity, reduced body mass index [BMI], injury and other negative outcomes related to sedentary lifestyles.
* Lay interventions are better [more effective], than professional ones.
* Leisure [physical] activities benefit mental health, but social activities do not.
* Physical activities are more likely to increase social participation but not vice versa.
* Universal interventions have a higher effect size than targeted ones. These are most effective in adults. Employment, skills, and training interventions work best for behaviour change.
* There is strong evidence that minor home adaptations are an effective and cost-effective intervention to prevent falls and injuries.
* There is a strong evidence base for the benefits of active travel:
* Active travel infrastructure has good evidence base and realises physical and mental wellbeing benefits and economic benefits.
* Public transport has best evidence for associated health benefits.
* Prioritisation of road safety and active travel has a medium strength of supporting evidence for realised health benefits.
* Travel charges and discounts have proven health benefits with a variable evidence strength base.

## 5.6 Community Engagement Insights

During 2023-24, PH undertook community insight engagement relating to understanding activity preferences, barriers, and motivation for participation in activities and sustained associated behavioural change for increasing activity in older adults. E.g. criteria of activity attractiveness, types, acceptability, accessibility, location, and transport links. This information was used to propose service redesign proposals via public consultation in December 2024.

When considering the PH service offer to promote increased physical activity in older adults, identification of ‘best practice’ was triangulated between recommendations from stakeholder engagement, behavioural insights work to understand health needs and barriers to exercise encountered by older adults, and a rapid review of the topic knowledge base.

Confirming local engagement findings to date, research to understand physical inactivity among 50–70-year-olds by the Centre for Ageing Better [2021], revealed interesting behavioural insights to be considered when engaging with older adults to become more active. Table K, [[30]](#endnote-31)

It is noteworthy that whilst several factors are listed as ‘barriers’, it is plausible that these could be converted into opportunities i.e. advice and intervention triggers for professionals. E.g. to mitigate and manage the effects of life changing events, sometimes known as life ‘transition’ stages. These enabling factors should be read in conjunction with the rapid evidence review. Appendix 2.

Factors with enable activity include:

* A high level of knowledge of the benefits of physical activity within populations.
* The chief motivation to do so was to retain independence, and secondary was to prevent poor future health.
* The ability to participate in activity was related to being able to ‘fit it in’ with lifestyle / daily life.
* Offering relevant information and ensuring information is relayed in an appropriate format for the audience.
* Investing in workforce training to ensure there is understanding about cultural differences and experiences.
* Offering a joined-up approach / exploring / optimising partnership working
* Use established relationships and existing engagement routes
* GP referrals related to weight management. This emphasises the importance of professionals offering advice and referrals for modifiable risk factors e.g. physical activity, smoking etc.
* Life changing events / transition phases. Usually seen as blocks, these life transition stages could become ‘intervention triggers’ for increasing activity if recognised by professionals. I.e. coping / mitigating measures for people.
* Support from family and peers
* Building trust with the communities in a sustainable and proactive way.
* Negative role models –inspired them to be unlike these, mainly people they knew more so than a celebrity or public figure.
* Some were happy to access classes, mainly women. More men preferred to keep active or exercise alone
* Some people become more active in retirement i.e. more time to do so.
* Most people wanted to stay active and saw walking as the main way to do so.
* Service providers should also consider seasonal weather as a barrier especially for those seeking a low-cost activity e.g. walking.
* There are excellent opportunities for employers to positively enable increased activity within workforces. 98% of employees reported being motivated to make a positive change to improve their wellbeing.[[31]](#endnote-32)

Factors which stop people being more physically active include:

* Membership fees and cost
  + Need to be a member to use facilities
* Common life events
  + Diagnoses
  + Becoming a caregiver (life stage transition points)
* Physical activity and identity
  + Self-perception (e.g., feeling sporty, lazy, or inactive)
  + Feeling unsuitable due to age or fitness level
* Confidence
  + Leisure outlets not seen as welcoming for all ages or body types
  + Uncertainty about how to use equipment
  + Intimidation from environments where people “show off”
* Lack of family and peer support
  + Loneliness
* Prioritising physical activity
  + Lack of intrinsic motivation
  + Feelings of guilt, regret, or low self-worth
  + Self-labelling as lazy
* Lower socio-economic status / Time
  + Economic pressures to work multiple jobs
  + Limited time and money for physical activity
* Transport
  + Decline in sports volunteering due to transport issues
  + Dependence on public transport
  + 17.5% of Kent households have no car/van (vs. 23.5% in England)
* Lack of awareness
  + Not recognizing daily activities (e.g., housework, gardening) as valid physical activity
  + Belief that only organized activities count
* Environment
  + Lack of infrastructure (e.g., seating, toilets)
  + Weather conditions
* Mobility-related support
  + Mostly sought from GPs for weight loss
* Long-term condition management
  + Issues like stress incontinence
  + Poor accommodation for adjustment needs
  + Low access to postural stability services
* Lack of local, attractive, and suitable activities

## 5.7 Disability

Public Health England [PHE] commissioned an evidence review specifically focusing on the health benefits of physical activity for disabled adults. Evidence shows:

* a relationship between engaging in physical activity and positive health outcomes for disabled adults.[[32]](#endnote-33)
* Little evidence was found to show that physical activity is unsafe for disabled adults when it is performed at an appropriate level for their current level of activity and health conditions.
* Individuals with uncontrolled symptoms for cardiac, metabolic, renal and some musculoskeletal conditions should seek advice before greatly increasing physical activity.

## 5.8 Falls Prevention

* According to one research study reported in 2020, up to 75% of falls go unreported.
* It is estimated that around a third of all people aged 65+ fall each year, increasing to half of those age 80 and over,
* residents of deprived areas have a higher rate of falls. [[33]](#endnote-34)
* Worldwide, falls are responsible for over 38 million DALYs (disability-adjusted life years) lost each year
* Falls result in more years lived with disability than transport, injury, drowning, burns and poisoning combined. [[34]](#endnote-35)
* Falls can lead to serious injuries such as fractures, head traumas, and soft tissue damage, requiring extensive medical interventions and prolonged care recovery periods.
* Psychological impacts on the elderly from falls can lead to decreased confidence, fear of falling, and social isolation, which may further exacerbate their health conditions.
* Annually, fall hazards in the home are estimated to cost NHS England £435 million
* The UK total cost of fractures related to fragility, an estimated at £4.4 billion annually with hip fractures accounting for around £2 billion of this. This includes £1.1 billion for social care. [[35]](#endnote-36)

As we age, our ability to maintain a safe posture deteriorates. Structured exercise programmes and classes are aimed at people who are feeling vulnerable to falling, may be in a high-risk group or are experiencing mobility or balance issues. These interventions can be classed as Primary or Secondary interventions. [Link](#FallA)

* Remaining active in older age and postponing the onset of disease and disability as far as possible, is recommended in the Chief Medical Officer [CMO] 2023 annual report.

In 2022, a global initiative inclusive of the UK, saw the publication of a World Guideline for Falls Prevention and Management for Older Adults. Findings highlight the complexity and challenge of implementing a WSA with diverse stakeholders and partners.

Important enablers include leadership and planning, managing the discomfort and challenge of changing systems, and ongoing efforts to ensure effective collaboration to address inequalities in participation of physical activity via a WSA. It was acknowledged that important these recommendations would require flexible implementation strategies for local context. Table M

Interventions recommended within The World Falls Guideline includes:

* Multidomain interventions tailored to individual risk factors are effective.
* Opportunistic case finding is necessary to overcome underreporting and lack of presentation of falls.
* Recommendations may need local adaptation to suit specific circumstances.
* Engaging with individuals’ beliefs, attitudes, and priorities about falls management is essential.
* Activities that improve strength, balance, and flexibility for older adults are highly emphasized in the revised guidelines.
* Small increases in daily activity, including light intensity movement and reduced sedentary time, are beneficial—especially when building up to the recommended weekly amount of moderate to vigorous physical activity (MVPA).
* Activities with strength, balance, and flexibility elements can be integrated into MVPA sessions and do not need to be separate.
* Physical activity guidance applies to all adults, recognizing that frailty and physical impairment can occur at any age.

**Management of risk:**

Low risk:

Primary prevention [education on falls prevention and advice on physical activity]. Follow up 1 year. I.e. lower tier of PH Postural stability, education. Development of interventions to treat and prevent these modifiable risk factors may reduce risk of falls in older adults. [Inflexibility of big toes, and reduced calf muscle strength]. [[36]](#endnote-37)

Intermediate risk:

Secondary prevention to improve major risk factor [physio, bespoke gait and strength exercise, education. Follow up 1 year. [Falls service]. A falls study published in 2021, of community dwelling females aged 60-92 years [mean 70.5 +/-5.2], 74 participants [39.9%] of whom had fallen in the previous year, revealed several structural and functional foot and ankle characteristics were associated with falls.

## 5.9 System Opportunities to Encourage Activity

Desirable outcomes for services aimed at increasing strength, balance and physical activity in older adults would ideally:

* reduce the incidence of falls
* related hospital admissions
* delay the onset of disability and illness
* mitigate of the effects of existing medical conditions
* increased social connectivity

A study of ways to tackle population inactivity and inequalities to transform community provision for disabled and people with long term health conditions, identified the importance of working together with diverse system stakeholders and the distinct leadership approach that is required for the successful planning and implementation a Whole Systems Approach [WSA].[[37]](#endnote-38)

Findings highlight the complexity and challenge of implementing a WSA with diverse stakeholders and partners. Important enablers include:

* leadership and planning
* managing the discomfort and challenge of changing systems
* ongoing efforts to ensure effective collaboration to address inequalities in participation of physical activity via a WSA

This approach necessitates each organisation using the unique resources, influence and reach to raise awareness and conduct interventions to increase population physical activity into clinical and social care pathways, commissioned services, county sports partnerships, community and social enterprise partnerships, employers, local authorities, and public sector organisations.

It was highlighted during the Kent Whole Systems Obesity [WSO] engagement activity, that to enable people to enjoy nature, there was a need:

* promote confidence in those who have are / have been housebound and those with anxiety disorders
* It is recommended that where commissioned, befriending services include training and support to motivate individuals to increase their physical activity.

## 5.10 Data Collection

There is/are no universal or consistent local mechanism or priorities for identifying, data capture, monitoring or analysis of activity levels in the older population in Kent within health and care services. This means several services have no, missing or inadequate monitoring data collections.

* It is recommended that timely and relevant data collection within health and adult social care services should be developed.

Consistent clinical coding within health services should be identified and adopted for use, and ASC should likewise develop a data capture and reporting process. Workforce upskilling activities including learning plans, should be monitored, and evaluated and include exploring the service user journey along with key performance indicators.

The analysis and presentation would be ideally available on dashboards for review to inform service effectiveness, and the broader knowledge base, for research and evaluation. The recent development **a** dashboard **for the Kent and Medway Ageing Well Board** to monitor **useful** indicators **including physical activity of older adults,** is most useful.

A summary of opportunities for a whole system approach to increasing physical activity in older adults is shown below.

## System Opportunities for Increasing Physical Activity Interventions

## Settings

* GPs, hospital in/outpatient departments
* Adult Social Care services
* Mental health settings and services
* Community health services
* Pharmacy
* Optician
* Dentists
* Care/nursing home settings
* Other as appropriate

## Suggested actions

* Embed Intervention and Brief Advice (IBA) for physical activity (PA)
* Workforce training and develop local data capture systems
* Making Every Contact Count (MECC)
* Health promotion (e.g., videos in waiting rooms, social media, intranet messaging, campaigns)
* Active exercises for MSB even for frail adults
* Other modifiable lifestyle factors (e.g., smoking, alcohol, nutrition)
* New patient assessments
* Routine review
* Opportunistically
* Signposting aligned to local activity directory and systems (e.g., JOY system, One You, Active Kent and Medway, social/green prescribing)
* Care pathway design
* Other (e.g., Front Door/other)
* Regular audit (e.g., annual/bi-annual/quarterly via performance monitoring dashboards/other)
* Case finding
* Governance (e.g., GP practice, HCP/PCN, KM Ageing Well Board, other commissioners)
* Mandated promotion of activity services onto service directory (e.g., district pages of Active Kent, JOY)
* Service design
* Integration and collaboration with partners
* Performance monitoring (key performance indicators [KPIs])
* Research evaluation
* Strategy, developments, policy, investment

## Health Literacy, Communication, and Health Promotion

* Include and prioritise physical activity in populations, especially older adults
* Encourage use of communal spaces, public transport, accessible/walkable toilets, seating, and adequate lighting
* Com-b model of behavioural change
* Adverse Childhood Experience (ACE) trauma-informed care
* Investment and infrastructure for physical activity across the life course
* Comprehensive and integrated communication strategy
* Make mandatory to include this consideration in new strategy/policy/service development
* Workforce education and training
* Equip staff and providers to have conversations and advise
* E-learning for health modules for physical activity
* Local resources (e.g., Active Kent)
* Health and care workforces, partners, public
* Mandatory workforce training
* Link to communication strategy
* Monitor compliance (data from OHID or develop local systems)

# 6. Available Activities and Services

## 6.1 Active Kent

[Active Kent & Medway](https://activekent.org/)  Active Partnership supported by Sport England, works via the flagship campaign [Are you ready to start moving more in your everyday life? - Everyday Active Kent](https://www.everydayactivekent.org.uk/). The campaign was launched in 2020 to support practitioners to have effective conversations with the leisure sector industry, health and care providers and the public to increase physical activity. Via the <https://activekent.org/>website a range of resources and services can be found.

* It is recommended that resources for older adults aged 50+ be made more prominent on the website to ease identification and information finding, like the tab for Children and Young People. This would also emphasise the importance of physical activity in older adults.
* It is recommended that that the importance of physical activity in older adults has a stronger emphasis in any future Kent and Medway activity strategies.

Available resources and services include:

* A [Partner Hub - Everyday Active Kent](https://www.everydayactivekent.org.uk/partner-resource-hub/) is to assist practitioners to have effective conversations with people about activity leading to meaningful behavioural change for improved health and wellbeing.
* [Everyday Active Workshop - ActiveKent](https://activekent.org/health-wellbeing/everyday-active/everyday-active-workshop/) to upskill workforce and volunteers through improving knowledge and understanding of the benefits of physical activity and to feel confident about having conversations with others to help get more people, more active.
* Working with culturally diverse communities, lower socio-economic groups, and those with long term health conditions and disabilities, including strength and balance type activities e.g. paracise and exercise classes for seniors. [[38]](#endnote-39)
* Working with other facilitators across Kent for increasing exercise uptake include care coordinators, social prescribers, and a range of Community, Voluntary [CVS] organisations
* Everyday Active Champions support with creating and adding content about free or low cost inclusive physical activities opportunities to the [local community webpages](https://www.everydayactivekent.org.uk/communities/) on the [Everyday Active website](https://www.everydayactivekent.org.uk/). I.e. there are 499 published articles on the website with the most popular pages being the Home page, All Activities page, Couch to Walking 5k page and Communities page.
* Information is available via the Everyday Active website, social media channels (Facebook, Instagram, LinkedIn) and a Progressive Web Enabled App (PWA).
* Active Ageing and the [Live Longer Better](https://www.everydayactivekent.org.uk/live-longer-better/) network membership

Active Kent & Medway are working with Sport England on a place-based approach to tackling inactivity. Initial work will include asset mapping and community consultation and in addition, enable test and learning of projects in Gravesham – Northfleet North / West court, Thanet district.

## 6.2 Leisure Providers

In 2024, more than 178 organisations were found to be providing approximately 260 physical activities outlets for older adults across Kent. These included 93 district leisure centre operators, and over 260 discreet exercise offers and activities as shown below in Table O. These service offers are dynamic being commissioned by a variety of organisations e.g. district and borough councils, KCC, Health Care Partnerships and funding sources. As such, this listing is not exhaustive.

Table I: Activities for ages 50+, by Kent provider organisations [2024]

|  |  |
| --- | --- |
| Provider | Count |
| Kent | 178 |
| East Kent | 33\* |
| North Kent | 30 |
| West Kent | 25 |
| National / online | 9 |
| **Total** | **260** |

Source: prepared by Linda Smith, KCC.

Swimming is something almost anyone can participate in. A report by Swim England [2017], found it is one of the few activities that are more popular with women than men, and it is uncommon for aquatic-based activity to be recommended by Health professionals who tend to signpost people to land based activities. Promotion of the Medic-to-pool pathway can help with this.[[39]](#endnote-40)

People of all ages can benefit, especially those with injury, impairment, long term health conditions and those who struggle to exercise on land. Aquatic activity has a positive impact on a wide range of conditions, physically and mentally and it aids development of aerobic, strength and balance.

Other findings included a 28% lower risk of premature death, with a 41% reduced risk of death from heart disease and stroke*.* Evidence is building that swimming is a cost-effective activity with will save the nhs and social care money.Aquatic activities have enormous potential to support population health due to its accessibility and popularity across the life course. Ibid

[Community hubs](https://www.folkestone-hythe.gov.uk/community/hubs#:~:text=The%20%EE%80%80Community%20Hubs%EE%80%81%20were%20set%20up%20in%20March) to support residents with a wide range of services and support. The hubs also provide a space for those aged 50+ to get advice and engage in activities including exercise.

[Adult learning courses in Kent | Community Learning and Skills](https://communitylearningandskills.co.uk/) offer a variety of in-person and online offers across the county including classes for increasing physical activity.

## 6.3 Falls Services

The Kent and Medway Integrated Care Board [ICB] commission the Kent Falls Service.[[40]](#endnote-41) This is most often for 12 weeks duration but may be extended up to 24 weeks. This service is primarily delivered to people who are more dependent upon care and health services, who have had a fall and / or a degree of frailty, or who are at high risk of having a fall. Falls education both pre and post a fall, is available across Kent and can be described as happening within ‘Tiers’ Table P

Table J: Falls education available in Kent pre and post fall injury

|  |  |  |  |
| --- | --- | --- | --- |
| **Risk level** | **Tier** | **Referral mode** | **Service** |
| Low | 0-1 | Self-referral or professional referral | Falls prevention Service/postural stability services |
| Medium | 2 | Multi-factorial risk assessment [NICE] guidelines; known to services; discharge from 12-week falls service | Community support services |
| High | 3 | Professional referral | specialist falls assessment services for complex cases |

## 6.3 Frailty Team

People who have fallen or are at a higher risk of falling, can self-refer or be referred by another including health and care professionals into the Frailty service. This service sits within a wider Kent and Medway ICS falls prevention and frailty care pathway. This service is categorised as a ‘Secondary’ care intervention for people after a fall, and those of medium/high risk of falling such as people with frailty.

The purpose of the team is:

* to support people to remain at home or get home form hospital as soon as possible.
* provide assessment and medical management for patients who are acutely unwell, within their own home or care homes.
* referrals are from health professionals only
* the service operates as a virtual ward. Virtual wards support patients, who would otherwise be in hospital, to get the acute care, remote monitoring and treatment they need in their own home, including care homes.

## 6.4 Kent Postural Stability Services

Until recently, Public Health [KCC] commissioned two different organisations to provide postural stability courses up to 36 weeks. Confusingly, these services are commonly known interchangeably as the [Falls Prevention Service](https://www.kentcht.nhs.uk/service/falls-prevention-service/) and Postural Stability Services.

* Provided by the NHS Kent Community Hospitals Foundation Trust [KCHFT] in east Kent
* Provided by Involve in west Kent

Postural stability service provision is not a statutory requirement for local council authorities to provide. It is funded in Kent in the recognition of the whole system benefits of doing so. I.e. it improves health outcomes and is cost effective.

PH undertook a service review in acknowledgement that service improvements may be made to realise a more equitable, efficient and effective method of providing strength, balance, exercise, education and activity options to older adults. The result of a public consultation on the subsequent proposals for a service redesign of the postural stability services is due in 2025.

A comparative review of Kent and other local authorities’ postural stability services was undertaken in 2023.

* Findings would appear to support the importance the wider determinants of health and other modifiable factors play in falls prevention and risk reduction.

This is because some areas with the same or fewer recorded falls, do not have a commissioned postural stability service. The extent to which this may be true is outside the scope of this assessment, but which would be worthy of consideration and research.

A search of all County Council, Unitary, Metropolitan and London Borough Local Authority websites in 2023 was made to identify what types of falls prevention other areas were offering exercise programmes and education to adults aged 65+.

* Only two councils provided both an exercise class offer alongside an NHS falls service: Kent and North Yorkshire County Council.

## 6.5 Environment and Social Prescribing

Investment in the environment, infrastructure and community safety concerns is required to encourage use of communal spaces, high streets, public transport to make these accessible and walkable, with features like toilets, seating, and adequate lighting so that people can participate in exercise and contribute to their communities as they grow older.

There is a strong and growing evidence that nature based social including ‘green’ prescribing plays and important role in improving mental and physical health and reducing loneliness.

* It is recommended that provision and promotion of social and green prescribing continues.

A Government 2-year plan launched in 2021 to support the [NHS Long Term Plan](https://www.longtermplan.nhs.uk/) and help deliver the [Government’s 25 year environment plan](https://www.gov.uk/government/publications/25-year-environment-plan). It aimed to support more people, from all backgrounds, to engage with and spend time in green and blue spaces in their everyday lives. [NHS England » Green social prescribing](https://www.england.nhs.uk/personalisedcare/social-prescribing/green-social-prescribing/).

* The programme set out to test how to embed green social prescribing in mental health pathways and across integrated care systems to improve mental health and tackle health inequalities. [[41]](#endnote-42)
* Increasing evidence suggests that one of the most efficient ways to manage mental health issues is through physical activity, especially in the natural environment, which is associated with greater feelings of revitalisation, increased energy and decreases in tension, confusion, anger, and depression.
* The benefits of exercise in the natural environment happen almost immediately: only 5 minutes of exposure improves self-esteem and mood, irrespective of gender, age and health status. [[42]](#endnote-43)
* A role of KCC Principal Planning for Health Officer for a 2-year fixed term is a significant step forward to improve access to green spaces for health improvement. E.g. embedding principles of healthy place into the [Kent Design Guide](https://www.kent.gov.uk/about-the-council/strategies-and-policies/service-specific-policies/economic-regeneration-and-planning-policies/regeneration-policies/kent-design-guide)
* A collaboration with Southeastern Trains in 2024 to establish better connections and access to green and blue space in Gravesham. Work focuses on access from Southeastern train stations and a programme of activities run alongside this to encourage interaction with these spaces by those less traditionally able to do so, including those from Lower Socio-Economic Groups [LSEG], culturally diverse communities, women and girls.

KCC has a statutory duty to maintain Public Rights of Way [PROW]. The latest improvement strategy (2018-28), aims to contribute towards more sustainable development, deliver active travel options and provide opportunities for exercise, leisure and open-air recreation.

* The plan looks to address accessibility issues and other barriers that the visually impaired, those with mobility problems and under-represented groups face when using the PROW network. Ibid
* The development of Age Friendly Communities across Kent would be an aid to assessing the degree to which environments in Kent support healthy ageing and physical activity
* Walking is a popular activity for older adults in Kent. Market research for the Kent PROW improvement strategy revealed that the older age groups (55+) found poor maintenance of stiles/gates and surface, overgrown vegetation and difficult terrain the biggest barriers.
* In line with previous Sustrans research, the use of cycle path / tracks was higher amongst males (33%) when compared to females (22%). Sustrans have identified the need to provide cycle paths / tracks separated from traffic to get more women cycling.

## 6.6 Social Prescribing

Health is affected by a variety of factors commonly known as the wider determinants of health [WDH]. These include social, economic, and environmental factors which social prescribing can often help people feel more able to manage. Professionals benefit from knowing that people can receive the support they need which in turn improves wellbeing and reduces service demand. Communities have a better understanding of what activities are available in their locality which makes these easier to get to and be involved in. This makes for more connected and stronger communities.

* [Explore Kent](https://explorekent.org/be-inspired/) is a KCC partnership initiative with public, private and voluntary sector partners that promote and actively encourage Kent’s residents to access, enjoy and benefit from being active in the great natural resources that Kent has to offer.[[43]](#endnote-44)
* Through [Social Prescribing Kent & Medway](https://socialprescribingkentandmedway.uk/), residents benefit from bespoke support to manage health conditions e.g. increased activity often mean people are less reliant upon medication as they become more involved in their local community activities and increase socialisation. Kent & Medway Integrated Care System (ICS) delivers the project to support and improve access to social prescribing across the area.

In 2023, the [Kent and Medway Social Prescribing and Communication Strategy](https://democracy.kent.gov.uk/documents/s122930/App%201.pdf) highlighted there were several directories of services and varying degrees of understanding of where and how to access care and support. It is a major complaint of clinicians and practitioners that finding and making service referrals, is a time-consuming administrative process.

The JOY platform works across the patient journey to deliver non-clinical requests to GPs to Personalised Care Teams for action to primarily support high frequency-higher- intensity service users. The software will augment GP clinical systems [computer patient records], to expedite data capture and making social prescribing referrals. [[44]](#endnote-45)

This will be possible as a service directory of locally available commissioned and non-commissioned marketplace services will be available to professionals make timely referrals. This is important because people are less likely to participate in activities if the time between referrals being made and services being accessed is too long.

This system saw a reduction of 35% in GP appointments in Cambridge and Peterborough ICS. To date, across Kent and Medway, 29 GP practices have agreed to introduce the system into practice in 2025. The sustainability of this work is unknown as it is funded for a limited period.

## 6.7 One You Kent

The [One You Kent](https://www.kent.gov.uk/social-care-and-health/health/one-you-kent) KCC website contains a selection of advice for a range of lifestyle health improvements. E.g. a self-assessment referral form to [Get moving and links to groups for walking and swimming and a range of supportive Apps at Better Health - NHS [[45]](#endnote-46)](https://www.kent.gov.uk/social-care-and-health/health/one-you-kent/get-moving) ￼ and [[46]](#endnote-47), [[47]](#endnote-48)[Are you ready to start moving more in your everyday life? - Everyday Active Kent](https://www.everydayactivekent.org.uk/) [[48]](#endnote-49), [[49]](#endnote-50)

## 6.8 Promotion, Communication and Education

Presently there is no comprehensive, systematic, up-to-date or consistent promotion of the benefits of exercise aimed at older adults. I.e. what exercise options are available with information on the types of activities of most beneficial to them e.g. strength and balance, and why.

* It is recommended that this information is widely promoted especially to targeted inactive groups. E.g. Active Kent now includes a category for ages 50+ beneficial exercise options.

There are a multitude of private and community and voluntary sector organisations providing exercise activities for all ages. It is difficult to maintain a current service directory when services are commissioned on often short-term basis, and there is no commissioning requirement related to registration with a directory of services.

* It is recommended that activities be featured and promoted with targeted aims led by the evidence. E.g. for falls risk reduction, improvement for strength, balance, flexibility, cardiovascular etc.

Whilst efforts are being made to address these issues, e.g. the social prescribing navigation strategy, it remains that there are multiple platforms containing service directories which are not signposting links to each other, and which contain different services and describe these in unhelpful ways. This can cause confusion and frustration to users especially if they have cognitive, physical or sensory impairments.

* It is recommended that there be one public facing focal point of information for physical activity and signposting information, with links to others as appropriate. E.g. Active Kent and Medway.

An ‘Adverse childhood experience’ [ACE], are known to impact on adult mental health. This term is used to describe the cumulative impact of negative childhood experiences which affect the developing brain of a child leading to difficulties in later life. E.g. such impacts can impair an adult’s ability to make changes or process information.

* Seven studies have shown the likelihood and risks of poor outcomes in adulthood from having 2+ ACE as related to physical activity. It remains unknown to what extent.[[50]](#endnote-51) This is important to remember when delivering behavioural change programmes and health promotion messaging.

## 6.9 Health Literacy, Awareness and Promotion

The personal knowledge and competencies that accumulate through daily activities, social interactions and across generations is known by the term health literacy. It is mediated by the structures and availability of resources made available by organisations e.g. ICS. In the USA, health literacy is a stronger predictor of someone’s health status than income, employment status, education level, racial or ethnic group.

* Strategies and interventions are recommended which increase both organisational and personal health literacy be developed, implemented and existing ones be amplified as related to increasing PA in older adults.

A review of intervention type and effectiveness of community engagement strategies tells us that universal interventions have a higher effect size than targeted ones. These are most effective in adults.

* Employment, skills, and training interventions work best for behaviour change.

Active Kent in collaboration with PH and Communication teams, have been sharing information to raise awareness of the positive mental and physical health outcomes from moving more. This has included collaboration on a New Year healthy lifestyles campaign and sharing content and information via the Active Kent social media channels, websites, newsletters e.g., Release the Pressure and One You. AKM Sport Welfare Officers have continued to share information and posters about Release the Pressure with clubs and welfare officers.

Other routes available to raise awareness within the KCC workforce is via corporate channels and the [People Strategy](https://www.kent.gov.uk/__data/assets/pdf_file/0008/141785/The-People-Stratgey-2022-2027.pdf) 2022-27 and, via an Adult Social Care and Health newsletter for staff working directly with families and communities.

## 6.10 Adult Social Care

In compliance with the wellbeing principle of the Care Act [2014], in assessments, staff in adult social care services [ASC] are required to have discussions with clients and carers relating to the use of community facilities, including physical activity.

For example, regular discussions take place with regards to funding of gym memberships for informal carers. Another domain within the Act concerns maintenance and management of nutritional needs and healthy diets.

* These discussions provide an opportunity to include health promotion, IBA-PA to be included in routine care assessments.

The ASC workforce receive training to promote mindfulness for improved mental health, but no other training is undertaken to promote other aspects of population health promotion such as physical activity, maintenance of strength and balance or other modifiable lifestyle risk factors e.g. smoking, alcohol misuse or positive weight conversion.

* It is strongly recommended that ASC develop and include screening and IBA for physical activity and other modifiable lifestyle risks in new client assessments with annual review thereafter as appropriate.
* The workforce should be equipped to have these conversations via appropriate educational training.
* It is recommended that the in-house staff education platform ‘Delta’ for physical education and other lifestyle risks, be reviewed, updated and aligned with learning content for health and care workforces available at: [https://portal.e-lfh.org.uk](https://portal.e-lfh.org.uk/Login). [[51]](#endnote-52)

Direct payments are made to eligible adults and is their personal budget the council will pay towards any social care and support needs as determined by assessment. The proportion and to what extent if any, people in receipt of direct payments are using these towards physical activity is unknown. At the present time there is no mechanism or process to capture this data. If feasible, it is recommended that this be captured as part of the assessment and routine review.

## 6.11 Assistive Technology

Home-based exercise options are attractive to many for many reasons and a variety of telephone apps and wearable technology to facilitate monitoring and health literacy of gait, balance, exercise activity are widely available which can be of assistance to many.

Emerging evidence suggests that both the Falls Management Exercise [FaME] programme and the Otago Exercise Programme [OEP] are successfully being incorporated into digital technologies e.g. exergames, apps, DVDs. [Exercise and keep fit classes for seniors | Age UK](https://www.ageuk.org.uk/services/in-your-area/exercise/) are available in-person across Kent and on the internet <https://youtu.be/Ml9Nba3a8hw>.

Fallsify project [KCC, 2022] was three small pilot projects, in which elderly people receive physical training with the help of a digital tablet training platform called ‘digi rehab’.[link](https://www.digitalhealthlab.nl/nl/fallsify/) Although promising more research and evaluation is required.

RITA, which stands for Reminiscence Interactive Therapy Activities, is an innovative, evidence-based, state-of-the-art digital therapy system used within the Kent and Medway Social Partnership Trust [KMPT], which successfully allows patients to use apps, games, and other leisure activities as part of their recovery. Staff have observed that it could be useful in settings for patients with dementia and that whole bays of patients took part in exercise classes using interactive videos.

To what extent this could be used with people with other severe mental health conditions within hospitals settings would be worth exploring as this group has the greatest level of preventable mortality related to poor physical health.

People with psychological or neurological conditions that are referred by the community or crisis team, who have or may be at risk of a fall, receive a comprehensive falls assessment and support including group exercises. The scale, impact and outputs of this approach is unknown.

## 6.12 Rehabilitation and Enablement Services

Kent Community Health NHS Foundation Trust [KCHFT], provide the Community Rehabilitation services in Kent. These services offer assessment and short-term rehabilitation to help to people to achieve maximum independence in daily living activities, improve memory, concentration, and ability to solve problems, and to remain in the community rather than in long term care or hospital admission.

The service provides short-term rehabilitation to enable patients, where possible, to remain in the community rather than be admitted to hospital or long-term care, and to live as independently as possible.  They have close links with Acute [General/District] Hospitals to ensure patients can continue their rehabilitation in the community following discharge from hospital.

The team can assess for, provide suitable equipment, and home adaptations to increase independence.  They assess and devise individual exercise programmes to improve muscle strength, mobility and balance.  Treatment plans are based on patient-centred goals which are aimed at improving patients’ ability to perform daily activities, such as walking, climbing stairs and self-care.

In recognition of the historical notable variation in the service offers between east and west Kent, work has been done over the last three years to standardize the eligibility, service offer, and processes used within the services. Except for a few limited local variations. It is recommended that further efforts be made to clarify and align service names and functions.

They give advice and information on issues relating to patient safety and self-management e.g. [Steady on your feet: Beat falls, trips and slips](https://www.kentcht.nhs.uk/leaflet/steady-on-your-feet-beat-falls-trips-and-slips/). A summary of rehabilitation related services across Kent is shown below.

**East Kent**

Rehabilitation services.

Telephone: 0300 7900 389 [8am-5pm]**.** East Kent Local Referral Unit. Telephone 0300 123 0915. Monday to Friday, 8am to 10pm.

Acute Response Team *is also known as the* [Frailty Home Treatment Service (east Kent)](https://www.kentcht.nhs.uk/service/frailty-home-treatment-service-east-kent/). Providing individualised home treatment to patients in crisis in east Kent.

**West Kent**

West Kent 0300 123 4081. **West Kent Local Referral Unit.** Telephone 0300 123 1950. Monday to Friday, 8am to 10pm**.** [kcht.LRUwestkent@nhs.net](mailto:kcht.LRUwestkent@nhs.net)

[Urgent Care Team (west Kent) | Kent Community Health NHS Foundation Trust](https://www.kentcht.nhs.uk/service/urgent-care-service/)

Is a nurse led, nursing and rehabilitation care provided to people in their homes to prevent them going into hospital unnecessarily. West Kent only. Available 24 hours daily, every day of the year.

[Home Treatment Service (west Kent) | Kent Community Health NHS Foundation Trust](https://www.kentcht.nhs.uk/service/home-treatment-service/). Providing urgent care for up to seven days to patients in crisis.

## 6.13 Enablement Services

Newly merged contact services from Kent County Council [KCC], provides a ‘one front door’ enablement service. Focusing on Prevent, Reduce and Delay, the support offered ranges between short term intervention plans and streamline the processes for people with overlapping conditions providing all enablement needs to be met within one service.

The service comprises of nine teams working with individuals to help with learning and confidence building e.g. after a fall, to offer short term support to encourage and enable independence. Social care needs are identified for achievement within a 12-week intervention period, and there is no cost for this service. The waiting time for this service is unknown.

* It is recommended that physical activity information and brief advice [IBA] is included in this assessment, with work is in progress to develop this.

Kent area Adult Social Care Support teams are based in both the north and south of Kent.

North Kent areas include Tunbridge Wells, Tonbridge, Sevenoaks, Gravesend, Dartford, Swanley, Sittingbourne, Sheppey, Maidstone east, Maidstone west, West Malling

Faversham, Whitstable. The South Kent team covers Canterbury, Birchington

Dover, Sandwich, Ramsgate, Margate, The Marshes, Folkestone rural, Folkestone town, Ashford north, Ashford south.

## 6.14 Home Adaptation Services

Home adaptations are changes people can make to their home to make it safer, easier to move around and do everyday tasks. Equipment can be bought directly from suppliers, or a care needs assessment can be done to find the recommend the equipment.[[52]](#endnote-53),[[53]](#endnote-54)

Private sector housing teams provide the disabled facility grants for home adaptations and Occupational Therapists conduct home adaptation services. The service is free for children and means-tested for adults.

## 6.15 Carer Support

The Shared Lives service comes under the enablement service umbrella, is a provision service which identifies and support carers. Adults are referred to the Shared Lives service by the social care teams for short breaks or long-term care.

Included in the information to carers are bespoke suggestions of activities including physical activities. These could be several different community services activities based on their needs or wants. Suggestions are based on client preference and what is available locally.

The extent to which chosen activity is related to increasing physical activity is unknown but would be of interest considering the associated benefits to carers who are the backbone support to statutory services. Carers UK report that:

* Caring can have a significant impact on health and wellbeing. 60% of carers report a long-term health condition or disability compared to 50% non-carers
* Over a quarter of carers (29%) feel lonely often or always
* There is increasing evidence that caring should be considered a social determinant of health
* Unpaid carers in England and Wales contribute a staggering £445 million to the economy every day – that is £162 billion per year (Petrillo and Bennett, 2023).
* The value of unpaid care is equivalent to a second NHS in England and Wales, which in 2020/21 received an estimated £164 billion in funding (Petrillo and Bennett, 2023).[[54]](#endnote-55)

# 7. Information Required

## 7.1 Strategy, Pathway and Prevention

It is imperative that this be addressed to systematically improve health outcomes related to increased physical activity. The following lists identify areas for action and instances where data is either missing or inadequate with suggestions for areas of further research.

**Commissioned contracts**

* Data was unrequested within contracts.
* Data requested is omitted during report submission for contract monitoring.
* Some organisations are unable to collect, collate, or submit data on time—or at all.
* Varied data collection methods lead to a lack of comparability.
* Data monitoring outcomes are poorly understood and/or communicated.
* There is a lack of prioritisation—either to ask for or to record data.
* Lack of available data fields (e.g., in primary care clinical systems like GP records).

**No data available within Adult Social Care**

* Physical activity elements within adult social care assessments
* Clients with disabilities
* Kent Enablement Services (e.g., Shared Lives)
* Advice and signposting of clients to physical activity opportunities
* Proportion of direct payments used toward physical activity
* Clients categorized by accommodation type e.g., residential care
* nursing care

**Inadequate data in Health settings**

* Variability in IBA (Intervention and Brief Advice) levels of assessment for physical activity
* No consistent use of agreed data capture codes
* Varied data collection methods leading to lack of comparability
* Data monitoring outcomes are poorly understood and/or communicated

**Data gaps**

* Lack of data for people with disabilities in assessments and health checks
* Lack of data referencing physical activity by accommodation type (e.g., residential care)
* Unknown scale, impact, and outputs of interventions by the Mental Health crisis team for individuals at risk of falls, including group exercises

**More Information Required / Areas for Research**

* The dose-response relationship between physical activity and/or sedentary behaviour and various health outcomes. This is especially important for addressing health disparities in vulnerable communities
* The effect of wider determinants of health (e.g., age, sex, race/ethnicity, socioeconomic status) on:
  + Physical activity outcomes
  + Falls risk reduction
* The impact of having 2 or more Adverse Childhood Experiences (ACEs) on physical activity and adult health outcomes
* Differences in health effects based on types and domains of physical activity:
  + Leisure time
  + Occupational
  + Transportation
  + Household
  + Education
* Sedentary behaviour types and their health effects:
  + Occupational sitting
  + Screen time
  + Television viewing
* The association between physical activity and sedentary time with health outcomes across the life course
* Barriers and enablers for older adults in achieving and maintaining muscle mass
* Health benefits of light-intensity physical activity and breaking up sedentary time with light activity
* The role of poor nutrition and footcare as barriers to physical activity

# 8. Next Steps

## 8.1 Implementation

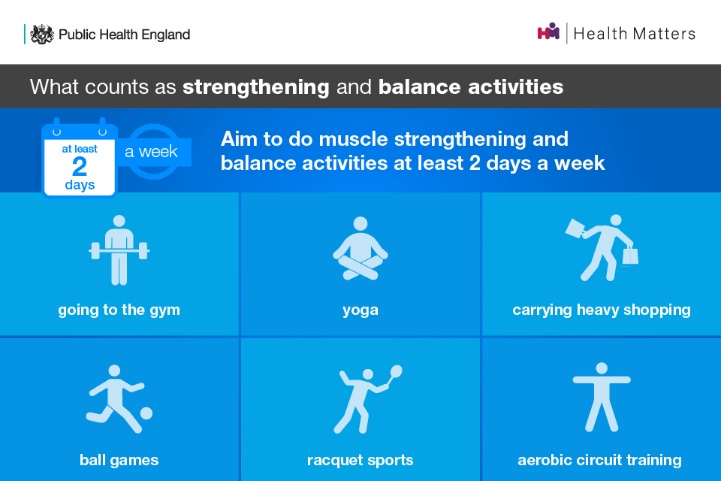
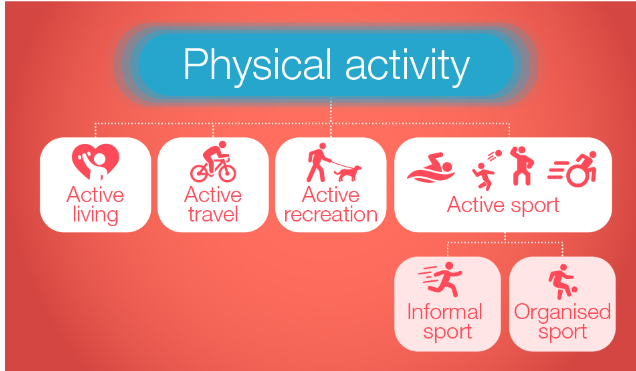
* **There will be a steering group established accountable to an identified governing body to oversee the implementation of these recommendations**
* **A comprehensive and integrated communication and health promotion implementation strategy will be established for the public and professionals.**
* Increasing physical activity will be recognised as the cornerstone of health, care and other allied strategies.
* **Individuals, employers and statutory organisations will understand their roles in reducing health and care service demand through support and interventions to increase population physical activity [in older people].**
* **There will be high levels of effective collaborative working between partners to ensure best use of resources and access to activities for older adults.**
* **Allied workforces will act as advocates and champions for this within their own areas of influence, families and communities, and benefit from supportive working environments and practices.**
* Introduction of mandatory workforce education programmes for physical activity and reporting mechanisms

## 8.2 Metrics and Targets

* **The proportion of health, care and allied workforces trained to do IBA-PA**
* **The proportion of organisations with PA embedded within client and patient assessments**
* **The proportion of older adults with recorded IBA-PA and activity referral**
* **The proportion of strategies which have increasing and enabling PA as a core action within prevention, reduce and delay, and contributing strategies.**
* **The proportion of GPs achieving Active Practice Charter status.**

Appendix

Figure 6: Physical activity guidelines for beneficial activities for older adults



Source: Public Health Matters, 2020

Figure 7: What counts for cardiovascular activity

weekly heart health guidelines to do at least 150 minutes of moderate activity, 75 minutes of vigorous activity, even shorter bursts of very vigorous activity or a combination of moderate, vigorous and very vigorous activity.

Moderate intensity heart exercises include brisk walking, swimming, cycling, hiking, gardening, dancing, active hobbies, housework, carrying heavy loads [e.g. heavy shopping bags].

Source: Public Health Matters, 2020

Table K: Types of activities and how these improve our health

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Activity/Sport | Muscle Function | Balance | Aerobic Capacity | Bone Health |
| Running | ★ | ★ | ★★★ | ★★ |
| Ball games | ★★ | ★★★ | ★★★ | ★★★ |
| Racquet sports | ★★ | ★★★ | ★★★ | ★★★ |
| Aerobics/step training | ★★★ | ★★ | ★★★ | ★★★ |
| Circuit training | ★★★ | ★★ | ★★★ | ★★★ |
| Strength training (gym or home) | ★★★ | 0 | ★ | ★★★ |
| Cycling | ★ | ★ | ★★★ | ★ |
| Static cycling | ★ | NK | ★★★ | ★ |
| Swimming | ★ | 0 | ★ | 0 |
| Aqua aerobics | ★★ | ★★ | ★★ | ★ |
| Yoga | ★★ | ★ | 0 | ★ |
| Tai Chi | ★★★ | ★★★ | 0 | NK |
| Dance | ★ | ★ | ★★ | ★★ |
| Walking | 0 | 0 | 0 (unless brisk) | 0 (unless brisk) |
| Nordic walking | ★★ | ★ | ★ | ★ |
| Bowls | ★ | ★ | 0 | NK |
| Stair climbing | ★★ | ★★ | ★★ | ★★ |
| Heavy housework/gardening/DIY | ★ | ★ | ★ | ★ |

★★★ Strong effect ★★ Medium effect ★ Low effect 0 No effect NK Not known

Source: [Physical Activity and Health - elearning for healthcare](https://www.e-lfh.org.uk/programmes/physical-activity-and-health/), [Accessed 2005]

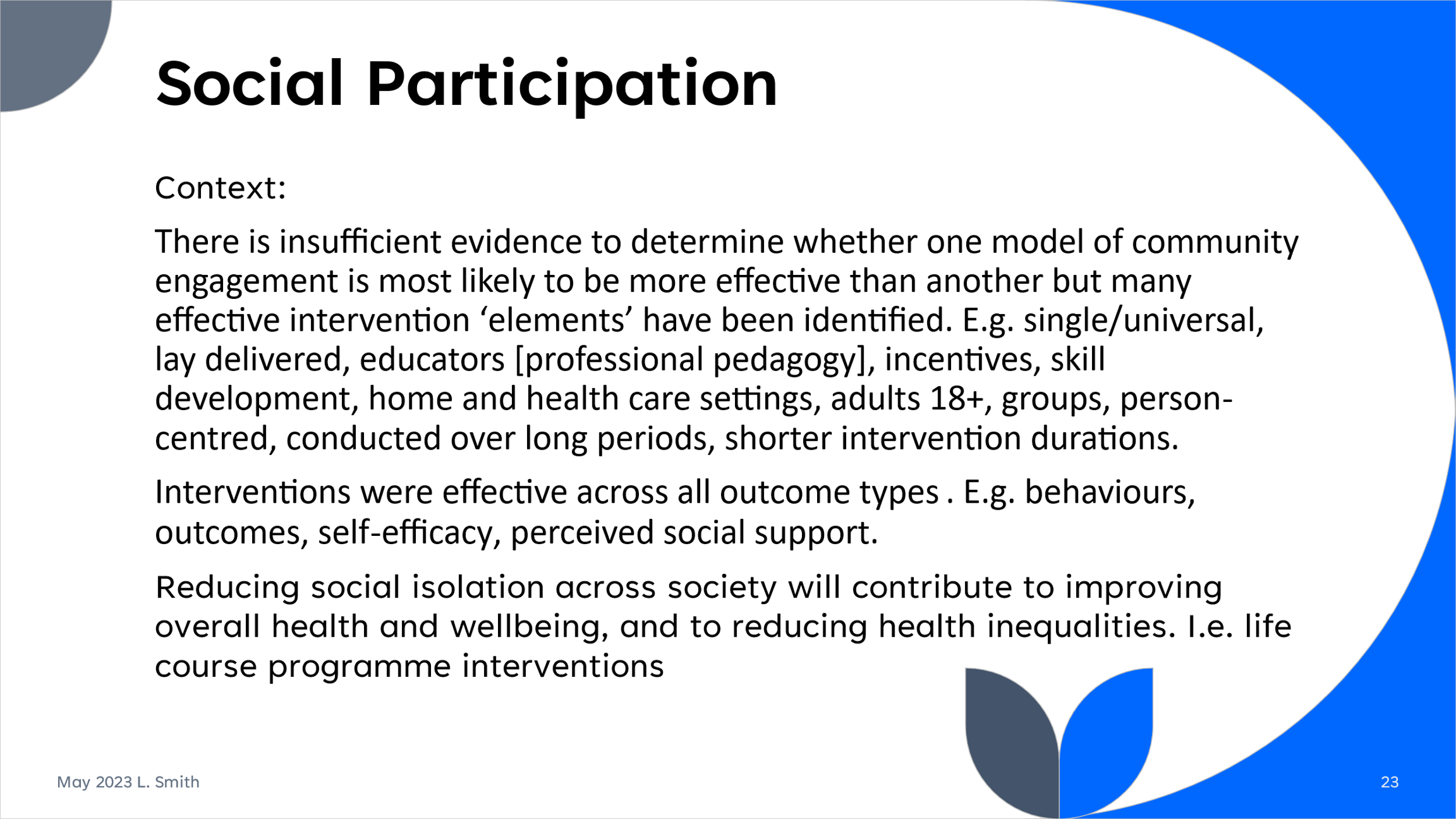
Table L: Evidence review and recommendations for community development approaches

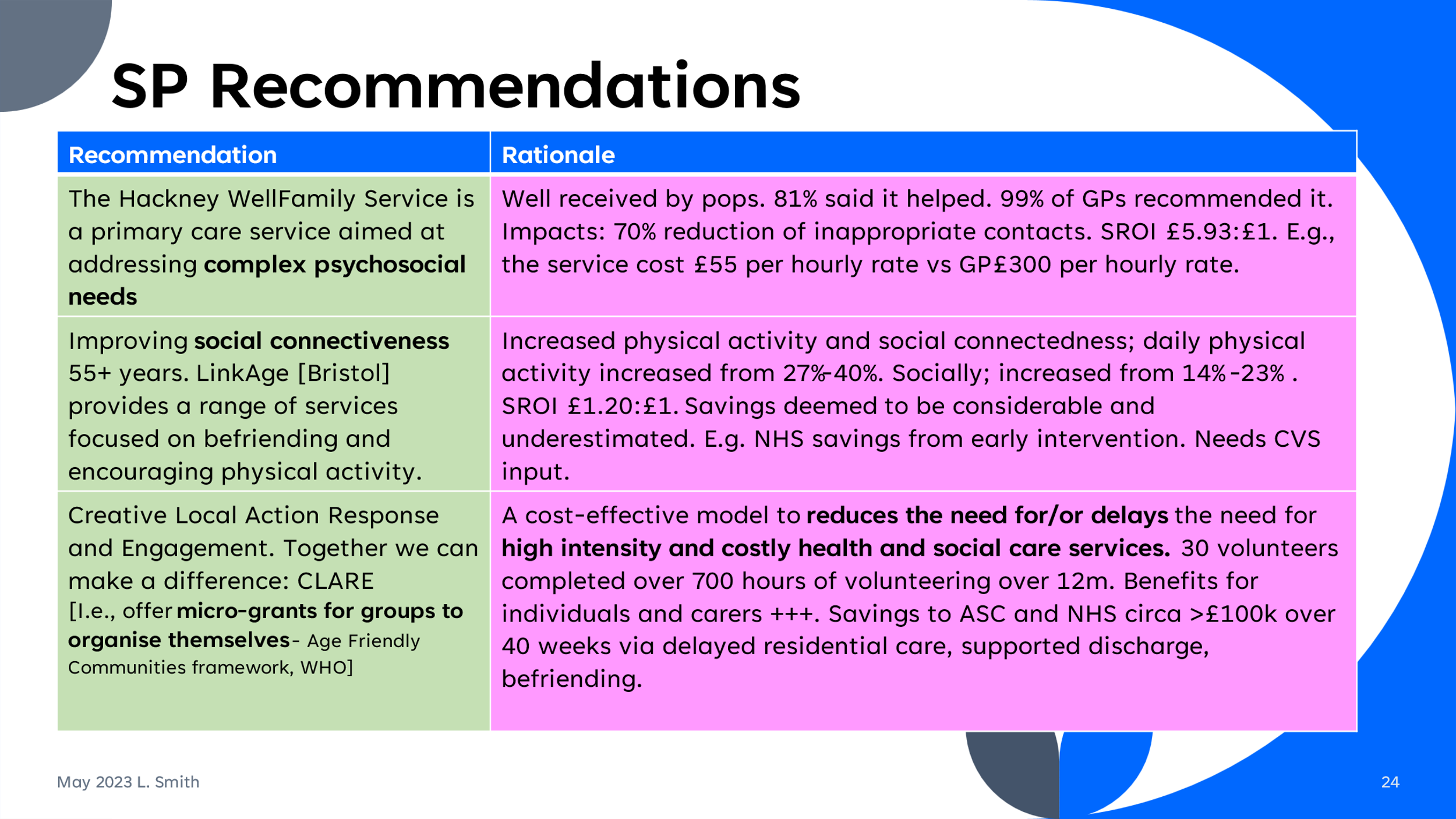
|  |  |
| --- | --- |
| Recommended Interventions | Rationale |
| Volunteer led, group health walks | These improve participant health-related quality of life, cardiovascular fitness, mental well-being, improve social participation in older people and are low-cost to implement (SROI circa £9 return for every £1 invested). |
| Community food growing | Increased fruit and vegetable intake, higher neighbourhood attachment, social cohesion and civic participation. |
| Volunteering in the over 65s | Volunteering improves the physical and mental health of volunteers. The effect is best documented for a reduction in mortality. It supports functional capacity and may reduce depression. |
| Peer led community champions providing health and wellbeing support to local communities. | Improvements across many outcomes including improved self-reported health, increase in participation in physical activity, increased uptake of benefits and other resources and social connectedness. SROI £5-£12 per £1 invested. |
| Multi-component interventions delivered from community hubs | E.g. addressing physical activity and social isolation and targeted towards specific groups (e.g. diabetics, older people) improve health outcomes and decrease healthcare use. |
| Collaborative, from-the-ground-up participatory approaches to priority setting and service developments for specific communities | Outcomes include increased engagement with services, improvements to neighbourhoods, reduction in crime rates, improved health literacy and reduced use of healthcare services. |
| Transport |  |
| Rapid bus transport system | A 14%-point increase in bus share with the potential of reaching a 21%-point increase with additional introduction of offboard ticketing. |
| Advocate for public realm infrastructure improvements. *[PHE spatial planning resource pack*] | Associated with increased mobility, PE activity, reduced BMI, injury, other +ve outcomes. |
| Peak-time AT interventions | Reduce congestion, air pollution |
| Redesignate street parking for bike, mobility scooter lanes, bike parking. *[AT toolkit for LAs, gov.uk].* | Shopping footfalls increase 40% [living streets]; Canada; business footfall up 20%, spend up 16%, return visits up 13%. |
| Adult cycle training / specialised classes for OP | Increase cycling uptake afterwards |
| Large scale capital schemes  *[supplement with journey assist cards, transport buddying for flagship routes]* | Areawide programmes increase cycling up to 6% PA and on flagship routes up to 60% for cycling and 50% for walking |
| Social Participation |  |
| The Hackney Well Family Service is a primary care service aimed at addressing complex psychosocial needs | Well received by pops. 81% said it helped. 99% of GPs recommended it. Impacts: 70% reduction of inappropriate contacts. SROI £5.93: £1. E.g., the service cost £55 per hourly rate vs GP£300 per hourly rate. |
| Improving social connectiveness 55+ years. LinkAge [Bristol] provides a range of services focused on befriending and encouraging physical activity. | Increased physical activity and social connectedness; daily physical activity increased from 27%-40%. Socially, increased from 14%-23%. SROI £1.20: £1. Savings deemed to be considerable and underestimated. E.g. NHS savings from early intervention. Needs CVS input. |
| Creative Local Action Response and Engagement. Together we can make a difference: CLARE programme.  [I.e., offer micro-grants for groups to organise themselves - Age Friendly Communities framework, WHO] | A cost-effective model to reduces the need for/or delays the need for high intensity and costly health and social care services. 30 volunteers completed over 700 hours of volunteering over 12m. Benefits for individuals and carers +++. Savings to ASC and NHS circa >£100k over 40 weeks via delayed residential care, supported discharge, befriending. |
| Housing - quality |  |
| Home improvements to the following:  windows and doors, kitchens, bathrooms, heating systems, wall insulation, loft insulation, electrical systems\* and garden paths targeting older person households. | **39% fewer hospital admissions** for cardiorespiratory conditions and injuries compared to those living in homes that were not upgraded.  **Biggest gains for respiratory conditions** |
| Installing central heating/improving home energy efficiency (all ages) | **Up to £4 worth of health benefits accrued for every £1 spent.** Biggest benefits for respiratory and cardiovascular disease |
| Improving heating and ventilation (children) | 17% movement for children with severe asthma to moderate asthma compared to 3% in the control group.  ICER of £234 per point improvement on the 100-point asthma scale **(this is cost-effective**) |
| Energy efficiency advice and improvements to vulnerable households | GP visits for respiratory conditions decreased by 3.9% in beneficiaries, compared to a 9.8% increase for the control group. |
| Home modifications such as handrails, grab rails, outside lighting, and slip resistant surfaces | Decrease the rate of injuries requiring medical treatment caused by falls at home by 26% per year  SROI for bed days saved is estimated at £5.50 per £1 invested |
| Preventive health care and day-to-day chronic illness support at extra care schemes | 19% of older residents reverted to a ‘resilient’ state from a ‘pre-frail’ state helping to reduce overall NHS costs, with frail residents’ health costs on average reducing from £3,374 to £1,588 per person per year |
| Environment |  |
| Improve access to natural and green spaces with targeted approach and social marketing | Combining physical change to the green space with social marketing for increasing green space use and physical activity are effective and cost effective. Nearly £600 million, which includes £192 million in health benefits. |
| Promoting active travels through walking, cycling and increase access to public transport | Interventions increased levels of cycling and walking. Consistent support for the positive effects on health of active travel over longer periods and distance. Reducing risk of T2D. For  every £ invested there was a return on investment of £4.50. |

Table M: Community development evidence – what works

|  |  |
| --- | --- |
| **Intervention** | **Outcome** |
| Volunteer led, group health walks | Improved cardiovascular [heart] and physical health, mental wellbeing, social connectedness and low cost. |
| Community food growing | Increases healthy eating, neighbourhood attachment and civic participation |
| Volunteering amongst older adults | Reduces mortality of all types by up to one third |
| Peer led community champions providing health and wellbeing support to local communities | Improvements in physical and mental health, health behaviours, weight loss and savings from health and social care avoided Social Return on Investment [SROI] £5 saved for every £1 invested. |
| Multi component interventions delivered from community hubs | Improvements in self-reported health status, clinical measures, and reduction in GP attendances. |
| Collaborative approaches to priority setting and service developments for specific communities | Increased engagement with services, improvements to neighbourhoods, reduction in crime rates, improved health literacy and reduced use of healthcare services. |
| Time banks | Demonstrated SROI but implementation fidelity hard to achieve in practice |
| Reducing the cost of local authority leisure facilities | Increases participation especially in low-income groups but no impact demonstrated on health outcomes |

Figure 8: Evidence review what works for social participation [including activity]





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