

Healthy Weight

Healthy Ageing

Tools to Support Measurement of Physical Activity in Primary Care Settings

Expert Roundtable Report

February 2026

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Acknowledgments

We gratefully acknowledge the valuable contributions of the experts who participated in the roundtable discussion on the use of the physical activity assessment tools in primary care. Their considered reflections, insightful questions, and constructive feedback provided critical perspectives that have informed the development and interpretation of the research findings. The team extends its sincere appreciation for their time, expertise, and engagement throughout the session (please see appendix one for list of attendees).

Roundtable Overview

The Department of Health and Social Care (DHSC) commissioned the NIHR Policy Research Unit in Healthy Weight and NIHR Policy Research Unit in Healthy Ageing to review the suitability of the General Practice Physical Activity Questionnaire (GPPAQ) for assessing physical activity levels in primary care.

GPPAQ is the current recommended tool for identifying individuals who would benefit from a physical activity intervention. A validated assessment tool currently referenced within NHS Health Check national guidance and embedded within existing delivery pathways. GPPAQ is presently the only validated instrument used within this context that categorises individuals across four physical activity levels (inactive, moderately inactive, moderately active, and active), aligning with requirements established within The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. However, policy makers were keen to explore whether it was well utilised, demonstrated adequate validity and reliability, and whether alternative tools may perform better (for more information see our project webpage [here](#)).

To address these questions, the NIHR Policy Research Unit in Healthy Weight and NIHR Policy Research Unit in Healthy Ageing undertook a rapid research project as follows:

- Analysis of secondary data from the Clinical Practice Research Datalink (CPRD) to investigate how GPPAQ is routinely used in general practice.
- An expert-informed rapid review of evidence on the validity and reliability of different physical activity assessment tools suitable for use in primary care in the UK.

The final stage of this work included a virtual roundtable with key experts to:

- review the research findings
- discuss the strengths and limitations of GPPAQ
- assess its validity and ongoing use in primary care, and
- identify gaps to inform the final integrated policy report and recommendations for policy

The following high-level report provides a summary of key discussion points raised in response to the research findings, alongside notes related to policy issues and recommendations.

To conclude this work, we will go on to produce a policy briefing document that draws together the research findings and the roundtable discussion.

Summary of research findings

The use of the GPPAQ in English primary care

Patterns of Use: Analysis of data from the Clinical Practice Research Datalink (a primary care research database) show that GPPAQ is primarily used for high-risk individuals in primary care, with most recordings performed by healthcare assistants and nurses. One in ten adults had a GPPAQ recorded, with higher use among those with overweight, obesity, or pre-diabetes, or registration with practices in socioeconomically disadvantaged areas.

Recording Context: GPPAQ was most often recorded during cardiovascular checks and NHS health checks, with over half of the recordings being repeat assessments. GPPAQ was seldom recorded during new patient appointments.

Associated Actions: In approximately 60% of cases, a relevant intervention or advice code followed a GPPAQ recording, particularly for those classified as inactive, though the effectiveness of these interventions remain unclear.

Limitations and Gaps: There is little evidence on whether the use of GPPAQ leads to changes in physical activity or health status. Whether the costs of recording are justified by health benefits is also unclear.

Rapid Review of Physical Activity Assessment Tools

Tool Comparison: GPPAQ, Exercise Vital Sign (EVS), Physical Activity Vital Sign (PAVS), and IPAQ Short Form were compared. All were feasible, acceptable and generally reliable in identifying inactive individuals. However, all showed poor to moderate validity in assessing overall PA compared with objective measures. GPPAQ was less inclusive for older adults (often underestimating their activity), while PAVS showed lower validity among women and individuals with lower educational attainment, and EVS demonstrated variable accuracy between men and women and across different UK study populations.

Inclusivity: Evidence on inclusivity (the validity of the tool in different population groups) was limited. Some tools performed differently by sex and education level. None of the four tools measured strength, balance.

Potential Improvements to GPPAQ: Modifications to GPPAQ (e.g., GPPAQ-Walk, GPPAQ-Walk Old) improved sensitivity at identifying active older adults but also reduced specificity. Strength and balance measures could be included to ensure a holistic assessment of PA; however, such changes would make the tool longer to administer, which may impact on its use in primary care

Limitations and Gaps: There is a lack of direct comparative studies, limited evidence on inclusivity across diverse populations, and no standard criteria for tool assessment. These are important gaps for future research.

Key discussion points

Although GPPAQ is a validated tool embedded within national guidance and established care pathways, its routine use within integrated care delivery may not be consistent across settings. This highlights implications for policy implementation and service delivery. As such, decisions regarding physical activity assessment approaches are not solely methodological, but are also shaped by existing policy infrastructures, commissioning arrangements, and service delivery requirements.

Alternative tools: Some participants described use of the EVS and PAVS other the GPPAQ because these alternative tools are shorter, can be more sensitive and align with government physical activity guidelines. Moving Medicine use EVS and this is the standard for many hospital electronic patient record systems.

Inclusivity: Concerns were raised about the inclusivity of current tools and approaches, particularly the ability to capture different types of activity across varying functional abilities and occupational roles. It was noted that older and less active individuals are less likely to report having conversations about physical activity, whilst those who are already more active appear more likely to engage in such discussions. In addition, it was highlighted that GPPAQ may not accurately capture occupational physical activity, with some individuals in manual or trade occupations being classified as inactive despite achieving recommended activity levels through their work.

Purpose of assessment: PA assessment is important to identify people who may benefit from intervention and to help promote behaviour change. There were reflections on the impact of interventions following GPPAQ, highlighting the absence of a standardised pathway linking assessment to clear next steps, such as brief advice, referral, or social prescribing. There was uncertainty about whether assessment consistently leads to meaningful behaviour change, recognising that effective follow-up should also consider whether an individual has the capability, opportunity and motivation to increase their physical activity. However, it was noted that where conversations do take place, they often prompt reflection and can lead to attempts to increase activity.

Digital health: There is growing momentum towards digital and device-based measurement of physical activity, including smartphone step counters, wearables and other body-worn sensors. Perceived advantages include greater objectivity compared with self-report measures, alignment with broader digital transformation across the NHS, and their usefulness as practical conversation starters in clinical consultations. However, participants cautioned that this approach may risk widening health inequalities. Smartphone ownership in older and socioeconomically disadvantaged groups may highlight digital exclusion, potentially limiting the reliability and equity of such approaches.

A helpful prompt for discussion: It was acknowledged that measurement needs to be quick and efficient to with short consultation times. This would allow greater

emphasis on an empathetic, personalised discussion, with the assessment tool serving primarily as a prompt for a more meaningful conversation. Crucially, experts stressed that what follows the assessment is most important, as coding or categorisation alone is unlikely to drive behaviour change.

Practice variation: GPPAQ is most commonly used where it is embedded within structured pathways, such as NHS Health Checks and CVD reviews. However, feedback indicated that many practitioners either find it unhelpful or do not routinely use it in practice. Participants noted that incentives are often required to support widespread adoption of tools in primary care. Greater integration into processes such as new patient registration, health checks and long-term condition reviews may increase uptake, though this alone may not ensure meaningful engagement and can make the processes more burdensome for patients.

Policy implications

The group discussed the implications of the findings for policy, emphasising the need for flexible and inclusive tools, better integration with digital health, and greater alignment between primary and secondary care.

Inclusivity and Choice: There was emerging consensus that the key question is not “Which single tool should we use?”, but rather “What set of tools is needed to assess physical activity effectively and inclusively?” Participants advocated for a menu of options that can be adapted to different populations and clinical contexts, rather than reliance on a single standardised tool. This approach was seen as more likely to improve inclusivity, clinician and patient engagement and allow appropriate tailoring of tools to individual circumstance.

Shift towards digital integration: There was broad agreement on the growing role of digital health infrastructure (e.g. the NHS App, smartphones, wearables) in physical activity assessment. Participants noted that patients often find the use of objective measures from smartphones and wearables more engaging and accurate than self-reported questionnaires. However, it was also recognised that device accuracy varies, devices are not always used ‘properly’, integration into clinical systems remains challenging, and not all population groups use digital tools equally. Policy interest in testing wearables within health checks, cardiovascular disease (CVD) pathways and modern service frameworks was acknowledged and this could provide an opportunity for pilot testing.

Data and Implementation: Participants highlighted the importance of separating two distinct policy objectives: **a)** to capture physical activity data at a population level and **b)** to support individualised clinical assessment and behaviour change. Primary care has a broad remit, but resources are primarily directed at individual patient care. Robust population surveillance requires a clear remit and well-resourced infrastructure, which means that primary care may not be the best data source. Conflating these aims risks limiting clarity in policy and implementation. There was agreement on the need to collect actionable data for public health and research purposes, but this was a separate issue to assessment for clinical purposes in primary care settings.

Overall, the central issue identified was not simply the selection of a single, best tool, but clarification of the purpose of physical activity assessment in primary care. Stakeholders emphasised the distinction between population-level data collection and personalised behaviour-change conversations, recognising that different tools may serve different functions. Concerns about inclusivity, digital integration and the limitations of GPPAQ were noted, particularly in the context of an ageing and increasingly digitally enabled population. However, there was broad agreement that measurement alone is insufficient. The quality of the subsequent conversation and intervention remains critical.

Appendix 1: Roundtable Attendees

Chair:

- **Jamie Blackshaw, Physical Activity Policy Lead**
Health Improvement Directorate, Department of Health and Social Care

Attendees:

Experts

- Dr James Sanders, Loughborough University.
- Dr Natasha Jones, Moving Medicine.
- Dr Hussain Al-Zubaidi, Royal College of General Practitioners.
- Suzanne Gardner, Sport England.
- Michelle Turner, Sheffield Hallam University.
- Michelle Roberts, The Richmond Group of Charities.
- Dr Sarah Price, NHS England Public Health.

Department of Health and Social Care

- Anni Bailey, Research Programme Lead – Science, Research & Evidence directorate
- Andrew Black, Research Programme Officer – Science, Research & Evidence directorate
- Joe Smith, Physical Activity Senior Policy Adviser – Health Improvement Directorate
- Emily Jackson, Physical Activity Senior Policy Adviser – Health Improvement Directorate

NIHR Policy Research Unit in Healthy Ageing

- Professor Barbara Hanratty, Newcastle University.
- Professor Chris Todd, University of Manchester.
- Professor Jane McDermott, University of Manchester
- Dr Kimberly Lazo Green, University of Manchester.

NIHR Policy Research Unit in Healthy Weight

- Dr Oliver Mytton, University College London.
- Dr Simon Russell, University College London.
- Disha Dhar, University College London.

Appendix 2: Roundtable Agenda

Roundtable on Tools to Support Measurement of Physical Activity in Primary Care Settings

Date: 13/02/2026, 10am-11.30am

Time	Activity	
10:00	Welcome and Introductions Brief Overview of Project	Jamie
10:15	Presentation Workstream 1 - Analysis of Clinical Practice Research Datalink (CPRD) data	Barbara (HAPRU)
10:25	Questions and Reflections	Jamie/All
10:35	Presentation Workstream 2 - Expert Consultation and Evidence Synthesis	Simon (HWPRU)
10:45	Questions and Reflections	Jamie/All
10:55	Discussion - Do these findings resonate with your experience? Why or why not? - How do these insights relate to policy challenges? - If we could address one or two issues, which would you prioritise in terms of policy impact? - What specific actions are realistic within the next 12 to 24 months?	Jamie
11:25	Round-up of recommendations	Jamie
11:30	Close	