

**PHYSICAL ACTIVITY
IN THE NORTH WEST REGION:
AN AUDIT**

**Commissioned by:
Department of Health North West**



Final Draft
Submitted to DH North West
20 July 2010

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Executive summary

This report was commissioned by the Directorate of Public Health North West to help their understanding of current policy and action on physical activity in the region; to assist the regional physical activity manager in supporting local areas and to provide a basis for future action.

An online questionnaire-based survey was conducted among Primary Care Trusts in the NW region. This achieved a 100% response rate.

Conclusions

The audit found that physical activity is not an independent priority for the majority of the PCTs in the region, and appears in few of the PCTs strategic plans. Just under half the PCTs in the region do not currently have a physical activity strategy.

PCTs have key targets in place around obesity against which they are performance managed. While there is a physical activity target in place through the LAA, this is managed and led by local authorities. PCTs have an important contributory role in achieving this target but their priority is its relationship to obesity.

There are no full-time physical activity leads in PCTs and postholders spend on average up to one day a week on the topic, with the majority also covering work around obesity. These physical activity leads have on average 2 members of staff working on physical activity who they line manage and just over half have some additional support from other colleagues in the PCT.

PCTs are engaging with partners on physical activity. Physical activity is a key theme or a subgroup of a key theme across more than half of the Local Strategic Partnerships, and the majority of PCTs have a representative who sits on the Sport and Physical Activity Alliances.

PCTs use a variety of data sources to inform their strategic planning of physical activity and a range of evidence to inform their commissioning of physical activity interventions.

The vast majority of PCTs are not currently using *Let's Get Moving*, but just over half intend to in the future. There are issues regarding capacity to deliver *Let's Get Moving* training.

Physical inactivity is estimated to cost £17 per person across the region, but PCTs are investing only just over 60 pence per head in the promotion of physical activity.

Recommendations

1. Where possible, in the face of public sector spending cuts, budgets for physical activity should be at least protected at current levels for as long as possible. This will allow for more robust evidence on the impact of the programmes on long-term behaviour change.
2. The time allocated to physical activity across the PCT should be reviewed to ensure that the PCT physical activity leads and other support staff have the capacity to commission and deliver effective programmes.
3. Efforts should be made to review the inclusion of physical activity within the Local Operating Plans of the PCT on an annual basis.
4. Strategies on physical activity should be in place across each local partnership.
5. GPs should be encouraged to promote active lifestyles to their patients using the evidence-based approach set out in Let's Get Moving, which includes the use of the validated General Practice physical activity questionnaire (GPPAQ).
6. Implementing Let's Get Moving and the use of the GPPAQ should be seen as the top commissioning priority for physical activity in primary care as this can provide the overriding framework for a number of associated services.
7. Physical activity leads in PCTs should advocate for physical activity participation as an outcome within the NHS Outcomes Framework.
8. The evaluation component of a programme should be prioritised to ensure evidence of impact and outcomes can be demonstrated, with a minimum agreed allocation of 10% of the total budget.
9. The Standard Evaluation Framework for weight management interventions should also be applied to physical activity interventions across the region.
10. National evidence in the form of NICE guidance and Cochrane reviews be used to inform the development of the physical activity programmes, especially in light of current financial constraints.
11. The profile of physical activity should be maintained across the NHS in the region and the 'useful' aspects of the regional structure built upon to ensure continued support to PCTs and local authorities for this area of work.

Acknowledgements

This research was conducted by Cavill Associates in conjunction with the South East Public Health Observatory

Nick Cavill (Cavill Associates) oversaw the project and edited the report.

Debra Richardson (Cavill Associates) provided input to all stages of the project and drafted sections of the report.

Sergio Chrisopoulos (SEPHO) designed the online questionnaire and analysed the data.

We would like to thank Jackie Brennan from the Department of Health North West for commissioning this report, and for her help throughout the research process. We would also like to thank all the respondents to the survey who gave their time to provide invaluable insight into the promotion of physical activity in the region.

1. Introduction

Physical inactivity is a growing public health problem. In his last annual report as Chief Medical Officer, Professor Sir Liam Donaldson said:

“The benefits of regular physical activity to health, longevity, well being and protection from serious illness have long been established. They easily surpass the effectiveness of any drugs or other medical treatment. The challenge for everyone, young and old alike, is to build these benefits into their daily lives.”¹

The Chief Medical Officer recommends that adults (16 years plus) should aim to accumulate 30 minutes moderate intensity activity on at least 5 days a week². Over 60% of adults in England do not reach this level of activity. Sport England’s Active People Survey 3, which measures the amount of sport and active recreation undertaken, found that adults in the North West are slightly below the national average; 21.4% for the North West and 21.6% nationally. However, within the North West there are large variations in activity levels with many districts well below the national and regional average.

In February 2009, *Be Active, Be Healthy*, the national physical activity plan was launched by the Department of Health. This plan set out how Local Authorities, PCTs and the voluntary sector can work in partnership to improve levels of physical activity in the population as a whole. It established a new framework for the delivery of physical activity aligned with the delivery mechanism for sport for the period leading up to the London 2012 Olympic and Paralympics Games.

Be Active, Be Healthy emphasises the importance of commissioning effective programmes on physical activity, but establishes that decision-making about commissioning is a local responsibility: it is up to each Primary Care Trust, in conjunction with their partners, to decide the nature and extent of physical activity promotion in their local area.

In the NW region, a 2012 Health and Wellbeing Legacy Group has been developed to ensure maximum health and wellbeing outcomes occur through communicating the importance and benefits of health organisations being a significant partner of the 2012 Games. The group is chaired by the Chief Executive Officer of NHS NW.

This report therefore aims to establish the current state of play of physical activity promotion in the region. This report was commissioned by the Directorate of Public Health North West to help their understanding of current policy and action on physical activity in the region; to assist the regional physical activity manager in supporting local areas and to provide a basis for future action.

The report was commissioned prior to the general election in 2010 and finalised in the early days of the coalition government. It is therefore likely that there will be a number of quite radical changes to the public health system in the near future that may have an implication for the promotion of physical activity. It is hoped that the vast majority of the conclusions and recommendations in this report remain relevant for a number of years to come.

2. Aims and objectives of the audit

Aim

To conduct an audit of the strategic commitment and prioritisation of physical activity across the PCTs and Local Authorities in the Northwest region, in order to make recommendations for maximising impact.

Objectives

- To develop an audit tool to review and assess: strategic approach and planning; level of investment; partnership approach and buy-in (including links with professional sports clubs); levels of service provision, operating and commissioning plans; levels of evidence based practice/evaluated practice; workforce capacity and capability, for physical activity by PCTs and their partners; commitment and approach to a 2012 Olympic legacy effect.
- To use this tool to undertake an electronic audit with PCTs, in liaison with Local Authorities, to establish a baseline profile for each local PCT and LA partnership.
- To identify progress and capacity of all North West PCTs to implement either *Lets Get Moving* as a full physical activity care pathway or ensure the PCT is putting in steps to provide a seamless, integrated protocol that supports patients in accessing local physical activity opportunities, delivered by a variety of partners.
- To work alongside the Regional Physical Activity Programme Manager to identify priority areas for service improvement (both geographical, process and or thematic) and identify common issues that can be tackled at a regional level.
- To produce a public-facing overview report that summarises the regional data and provides regional recommendations.
- To produce brief feedback for each PCT based on their responses compared to the regional picture.

3. Methodology

On-line survey

A questionnaire was developed in consultation with the Department of Health North West, based on previous audits conducted in London and the East Midlands.

The questionnaire focused on the planning, commissioning, resourcing, implementation and evaluation of physical activity interventions across each area. Copies are in Appendix II

The questionnaires were converted into an online format and piloted with colleagues and members of the target audiences. Suggested refinements were incorporated into the final questionnaires.

An email was sent to all Directors of Public Health in the 24 PCTs across the North West Region inviting them to take part in the survey. To maximise response the email was sent by the Physical Activity Lead for the region. A copy is in Appendix I.

An e-mail reminder was sent on 3 occasions at weekly intervals. In addition, some non-respondents were contacted by telephone in the final days of the survey, which boosted the response rate.

Response

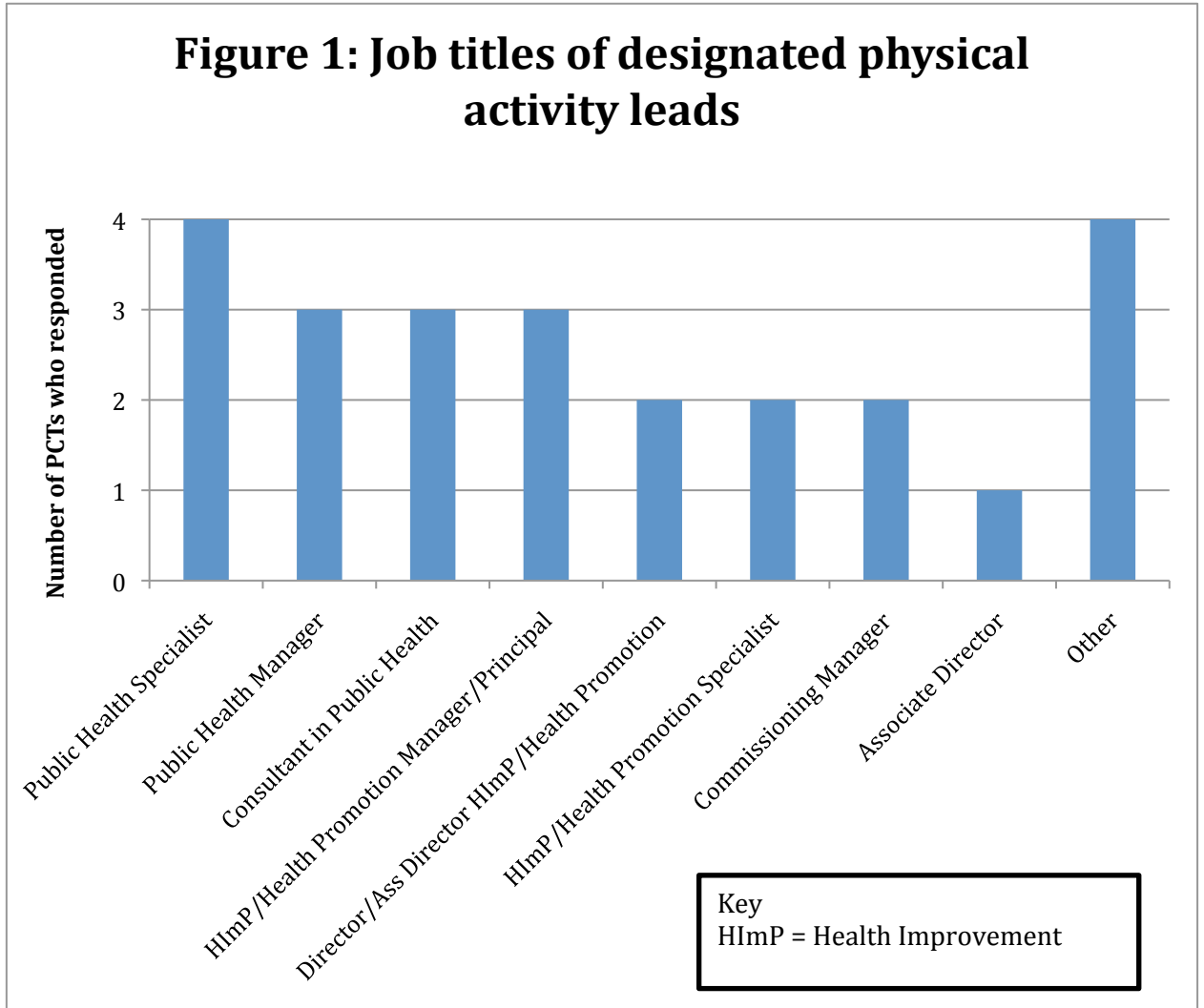
A 100% response rate was achieved for the survey. This compares extremely well to two previous audits, which achieved a 84% and 100% response rate. A separate online survey of Directors of Public Health in England, conducted by Cycling England, achieved a 49% response rate ³.

4. Results

Physical activity capacity

Designated lead person with responsibility for physical activity

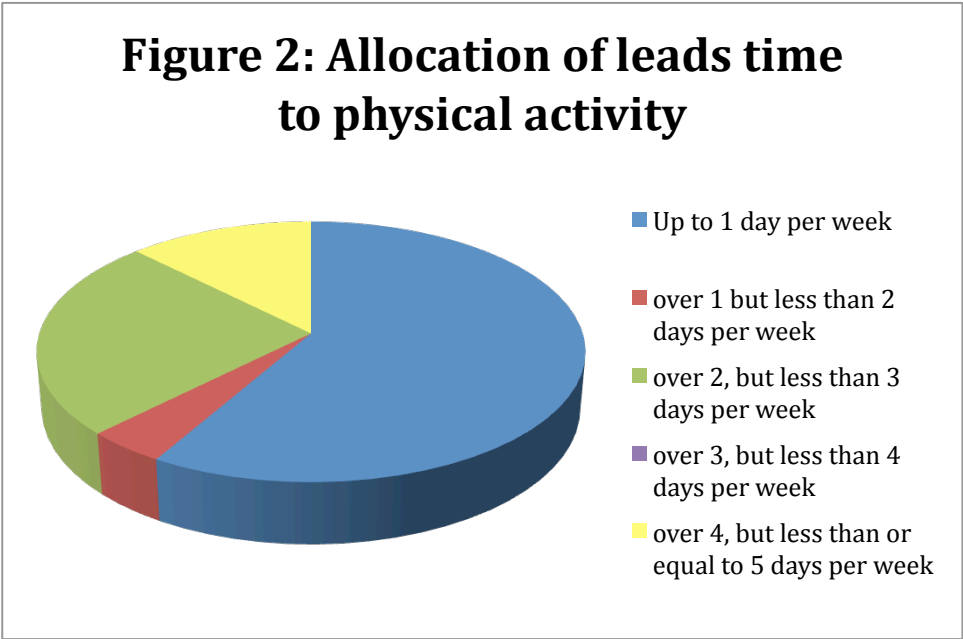
All 24 PCTs currently have a designated lead person with responsibility for physical activity, although their job titles vary as shown in Figure 1:



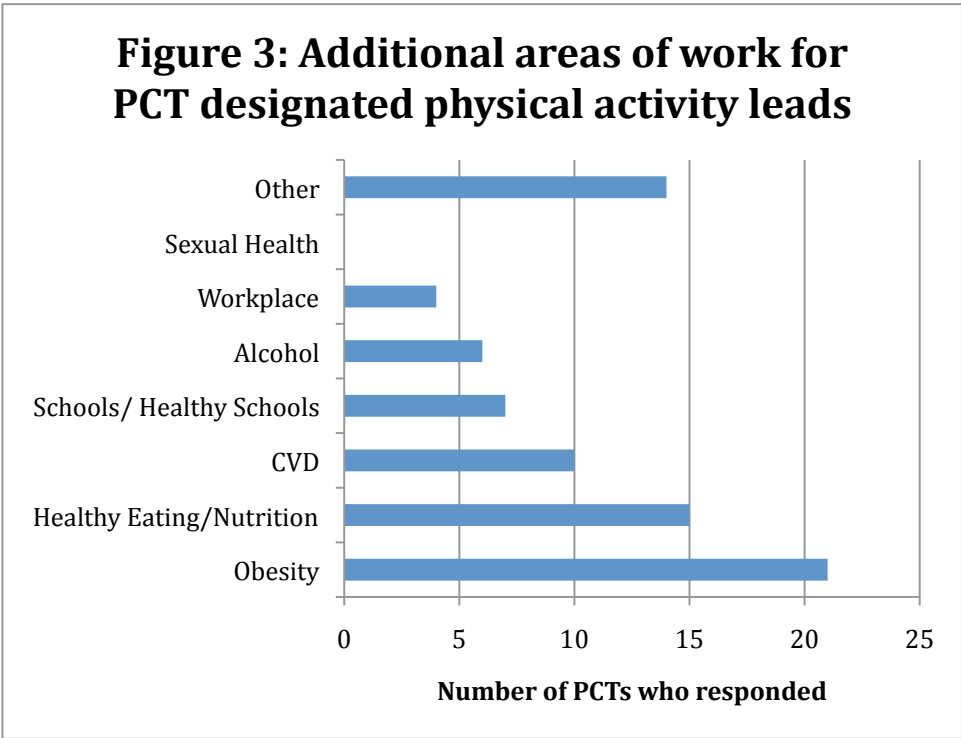
'Other' included:

- Head of Active City
- Head of Health Improvement
- Healthy Weight, Healthy Lives Lead – Public Health
- Public Health Partnership Specialist

All leads responded to say how much of their time is spent on physical activity as shown in Figure 2:



None of the leads spend 100% of their time on physical activity and whilst the actual time allocated to physical activity is varied across the PCTs, the median time spent is up to 1 day per week. Additional work areas covered by PCT physical activity leads are shown in Figure 3:



The additional areas of work covered by the PCT designated physical activity leads was varied, although 21 out of 24 PCT leads also worked on obesity and 15 also worked on healthy eating/nutrition. 'Other' areas were listed by 14 PCTs and whilst there are too many to mention individually 'Partnerships' was cited by 3 PCTs and

Tobacco Control, Health Inequalities, Social Marketing, Transport (including Active Travel) were each cited by 2 PCTs.

With the increased commissioning function held by Health Improvement/Public Health and the tighter budgets, it is not uncommon for Health Improvement and Public Health specialists to cover a range of topic areas. However, it is clear that whilst the time allocated to physical activity does vary across PCTs, as a region the median time allocated is up to 1 day per week. Whilst this may 'peak and trough' this has overall implications for the amount of monitoring PCT leads can do in their role as commissioners of physical activity services and, as such, the amount of support they receive from senior managers and other PCT colleagues is important to help maintain the profile of physical activity.

Additional PCT resource for Physical Activity

23 out of the 24 PCT leads have additional support for physical activity from the PCT.

Fifteen out of the 23 leads oversee staff that work on physical activity. Whilst this varies from 1 to 32 people across the PCTs, on average each lead oversees 2 members of staff. It is unclear whether those line managed by the PCT leads work at a strategic and/or operational level in relation to physical activity and also the time they can allocate to this work area. In addition to this 1 PCT lead is *'in negotiation to secure a partial resource once [they] return from maternity leave'*.

Interestingly, looking purely at job titles it appears that the 2 PCTs leads who oversee the highest numbers of staff are staff who work at a purely operational level in relation to physical activity.

Fourteen PCT leads had additional support from other colleagues in the PCT as follows:

- Senior commissioner for long-term conditions
- Deputy Director of Public Health
- Director of Public Health
- Consultant in Public Health
- Public Health Registrar
- Public Health Manager (Obesity)
- Public Health Worker (workplace & pharmacy campaigns)
- Public Health Associate (Healthy Works Team)
- Drug and Alcohol Action Team Manager
- Officers in Commissioning & Public Health
- Neighbourhood HImP teams
- Health Improvement Specialists/Officers
- Healthy Schools Programme
- Children's and Young People's Trusts
- Physical Activity lead (provider arm)
- Healthy Lifestyle Team (provider)
- Manager and staff of physical activity referral scheme (provider)
- Cycle & Walk for Health leads

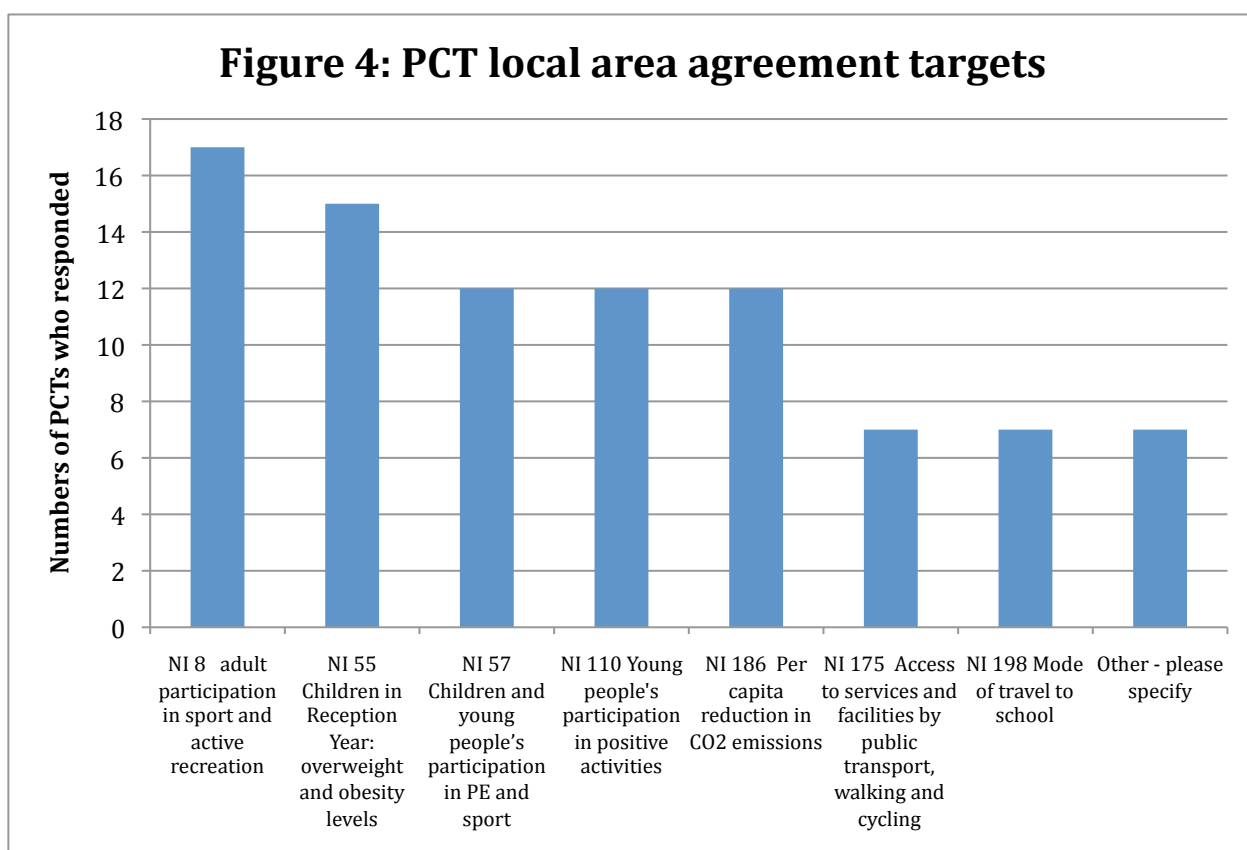
In addition, 1 PCT does not line manage any staff and does not have any other support from the PCT in relation to physical activity.

It is promising to see the additional PCT support on physical activity at both a strategic and operational level, especially given the small amount of time that leads are able to allocate to this work area. Although it is unclear how much time is dedicated to this 'support' it is good to see additional PCT commitment to physical activity. As Public Health now has a predominantly commissioning role, it is imperative that commissioned programmes can be delivered and that the importance of physical activity for health is maintained. Strong partnership working is key to the achievement of this.

PCT Targets

Local Area Agreements

23 PCTs responded to say they were working to 1 or more LAA targets as shown in Figure 4:



The top three most frequently cited LAA targets which PCTs are working towards are NI56: children in Year 6: overweight and obesity levels (21 PCTs), NI8: adult participation in sport and active recreation (17 PCTs) and NI55: Children in reception: overweight and obesity levels (15 PCTs).

PCTs tend to lead on NI55 and NI56 in relation to childhood obesity and due to the clear links between obesity and physical activity it is not surprising that obesity is an

'additional' area of work for 21 of the PCT Physical Activity leads. NI8 is also a key indicator and whilst this is cited as a PCT LAA target, this is often lead and managed through LA, with PCTs having a contributory role.

A range of 'other' LAA targets were listed but the most frequently cited was 'NI 120 all-age all-cause mortality' (4/23 PCTs), followed by 'healthy life expectancy at age 65' (3/23 PCTs) and 'reduction in CVD mortality rate >75' (3/23 PCTs) .

Other targets in relation to physical activity

Sixteen out of 21 PCTs who responded to this question are working towards 'local targets'. Eleven PCTs are working towards 'Vital Signs' which vary across PCT, but with the most frequently cited being 'obesity in children' (6 PCTs) followed by 'all-age, all-cause mortality' (4 PCTs). 'Healthy life expectancy at 65' (3 PCTs) and 'a reduction in CVD mortality rate <75' were cited by 3 PCTs and 4 PCTs are working towards the 'Legacy Action Plan target – 2 million more active'.

It is surprising that 'Vital Signs' are cited by just 11 PCTs given that they link directly to the requirements set out in the NHS operating plan, which PCTs are performance managed against. However, for those 11 PCTs the most frequently cited 'Vital Signs' targets are also listed as LAA targets, allowing for the LAA process and performance management system to be used to achieve multiple gains.

Budgets

Nineteen out of 24 PCTs identified a budget for physical activity in 09/10 and 18 of these also identified a budget for physical activity in 10/11. PCT budgets and costs per head calculations have been made based on mid-2008 population totals (ONS), as indicated in Table I:

Table I: Budgets and cost/head expenditure for physical activity for each PCT

PCT	Population mid 2008 estimates	09-10 budget	10-11 budget	09-10 costs/ head	10-11 costs/head
1 - Ashton, Leigh & Wigan	306,790	1,300,000	1,300,000	4.24	4.24
2 - Blackburn and Darwen teaching	140,673	926,086	926,086	6.58	6.58
3 - Blackpool	141,916	435,500	143,000	3.07	1.01
4 - Bolton	262,781	250,000	250,000	0.95	0.95
5 - Bury	183,140	0	0	0.00	0.00
6 - Central & Eastern Cheshire	454,525	0	0	0.00	0.00
7 - Central Lancashire	453,436	257,405	256,527	0.57	0.57
8 - Cumbria	496,627	0	0	0.00	0.00
9 - East Lancashire	384,500	*	213,000		0.55
10 - Halton and St Helens	297,305	*	*		
11 - Heywood, Middleton and Rochdale	206,338	425,000	440,000	2.06	2.13
12 – Knowsley	150,841	*	*		
13 – Liverpool	434,864	2,500,000	2,400,000	5.75	5.52
14 – Manchester	464,190	300,000	300,000	0.65	0.65
15 - North Lancashire teaching	331,095	180,000	180,000	0.54	0.54
16 – Oldham	219,717	0	0	0.00	0.00
17 – Salford	221,253	140,000	140,000	0.63	0.63
18 – Sefton	275,134	525,611	518,738	1.91	1.89
19 - Stockport	280,998	150,000	140,000	0.53	0.50
20 - Tameside and Glossop	249,645	30,000	0	0.12	0.00
21 – Trafford	212,808	20,000	10,000	0.09	0.05
22 - Warrington	196,206	280,000	280,000	1.43	1.43
23 - Western Cheshire	235,607	0	0	0.00	0.00
24 - Wirral	309,488	215,000	215,000	0.69	0.69
Total	6,909,877	7,934,602	7,712,351		
Mean**		377,838	350,561	1.42	1.27
Median**		215,000	196,500	0.63	0.60

*Boxes which are blank are where PCTs stated that there was a budget, but did not specify an amount.

** Mean and Median calculations exclude those PCTs where budgetary data is not available

Based on these figures, in 2009/10, an estimated £7.9 million was spent on physical activity by PCTs across the North West region. The figure for 10/11 is slightly lower, estimated at just over £7.7 million. Based on these figures, the median spend in 2009/2010 was £215,000 per PCT and predicted median spend, based on allocated budgets for 10/11 is £196,500 per PCT. This equates to a median spend of 63 pence spent per head on physical activity across the Region for 09/10, reducing slightly to 60 pence per head in 2010/11.

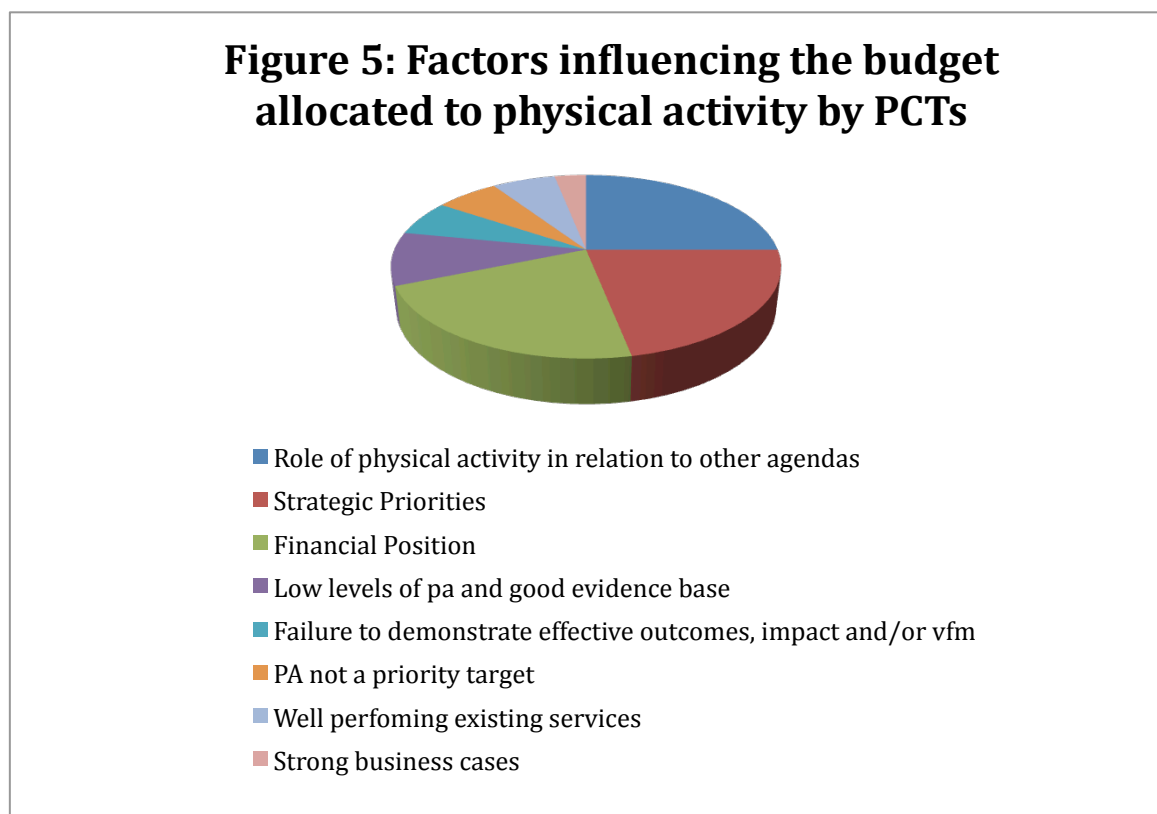
To put this into context, Allender et al ⁴ found that the estimated direct cost of physical inactivity to the National Health Service in the UK is £1.06 billion. This is approximately £17 per head across the UK (based on UK population of 60,975,000, according to the ONS in 2008). Clearly an investment of 60 pence per head falls substantially short of this.

This should, however, be interpreted cautiously as it is based on allocated budgets for 10/11 and total population figures (2008), rather than targeted populations.

Also, 3 PCTs state that other physical activity programmes are funded which are excluded from the budget allocations shown in Table I: for PCT 14 the budget excludes the main physical activity referral service, which is part of a broader contract; PCT 17 funds other physical activity interventions, but not from 'ring-fenced physical activity monies' and PCT 21 provides additional funds for the 'Fit for Life' programme. In addition, PCT 16, which has a £0k budget for both 09/10 and 10/11 states that *'physical activity is funded through Health Improvement but there is no dedicated physical activity budget. Whilst [the] PCT does invest resources in services commissioned, it can't be quantified in this way'*.

Factors influencing PCT budgets for physical activity

A range of factors, positive and negative, were identified as influencing the budgets allocated to physical activity by the PCT, these have been categorised according to the general theme of the response as shown in Figure 5:



The most frequently cited 'positive' influence on the physical activity budget was the 'role of physical activity in relation to other agendas' with obesity cited in 5 out of the 8 responses. Other areas referred to were hypokinetic disease, CVD, Health and health inequalities. 'Strategic Priorities' had 7 responses and included the role of physical activity as a contributor towards a broader priority. 'Low levels of physical activity and good evidence base' was cited on 3 occasions and 'Strong business case' on 1 occasion.

The most frequently cited 'negative' influences on the physical activity budgets was 'Financial Position' (7 responses) which included loss of matched funding, de-investment to re-invest in other priorities, lack of available resources and lower overall allocations. 'Physical activity was not a priority area' on 2 occasions. Failure to demonstrate effective outcomes, impact or value for money was also mentioned on two occasions.

Whether physical activity is considered to be an independent priority rather than absorbed in other agendas, like obesity, is often considered to represent the importance placed on physical activity within a PCT. However, it is clear that given the economic climate the place of physical activity across broad agendas and the weighting attached to the role of physical activity in achieving broader PCT strategic objectives has helped to secure continued funding for physical activity across a number of the PCTs in the region. There is also some independent recognition of the low levels of physical activity, the good evidence base and the need for a strong business case. This appears to have added weight to the 3 PCTs who cited these responses as they also have the largest allocated budgets for physical activity for 10/11.

However, the financial climate has had a detrimental effect on the budget allocated to physical activity for 7 PCTs across the region; through either a reduction in their budget for physical activity compared to their 09/10 allocation or a failure to secure additional investment which has led to the de-commissioning or deferring of physical activity programmes originally planned for this financial year (10/11).

Non-NHS funding

Non-NHS funding for physical activity was stated as being secured for 10/11 by 9 out of 21 PCTs who responded to this question. However, one of these is a lottery bid for £120k to enhance exercise referral programme to support patients with long term conditions that has yet to be confirmed. The detail provided for the non-NHS funding is varied, but where stated the funding organisations are included below:

- Local Authority
- Borough Council
- Local Strategic Partnerships
- NW Healthy Living Network
- Health & Well-Being Thematic Group
- Big Lottery Fund 2008-2012
- Sport England
- Communities for Health
- Working Neighbourhoods Fund

In addition 1 PCT stated that they *'invest in Health Improvement services that manages programmes funded by Non-NHS resources'*.

Budget breakdown

Fourteen PCTs provided a budget breakdown in % terms of the amount spent on staff costs (including overheads), interventions or projects and evaluation. Whilst the

responses were varied the largest median percentage was 77.5% of the total budget which was allocated to staff costs. The median percentage allocated to interventions or projects was 20%, with a median percentage of just 0.5% for evaluation.

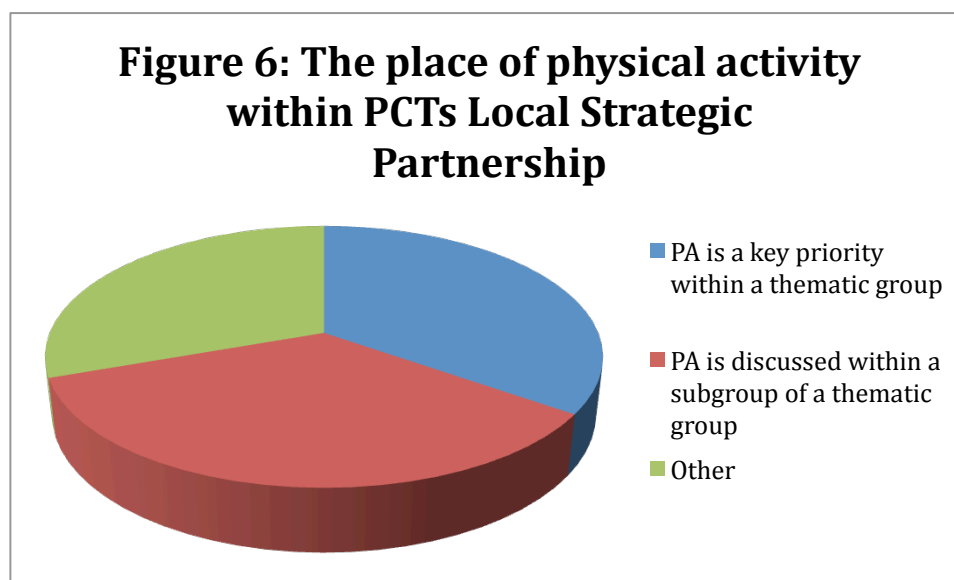
Whilst the budget breakdown varies across PCTs there seems to be a disproportionate amount of spend on staff costs compared to the costs of the intervention and evaluation. This may in part be due to the commissioning role of the PCT and the funding required to run programmes by external agencies. However, it is imperative that this budget breakdown is reviewed to ensure a more even split between staff costs and programme costs, with a minimum allocation of 10% for evaluation.

Overall, the budgets aligned to physical activity across the PCTs in the region are varied and as such this carries with it a range of views on whether the investment in physical activity is sufficient. However, physical inactivity hits many agendas, not just health and PCTs on their own are not solely responsible for commissioning physical activity services. Indeed, sixteen out of 24 PCTs stated that they currently jointly fund physical activity programmes with other agencies, organisations or individuals.

Partnerships

Local Strategic Partnerships

The consideration of physical activity within the LSP is through a range of avenues as shown in Figure 6:



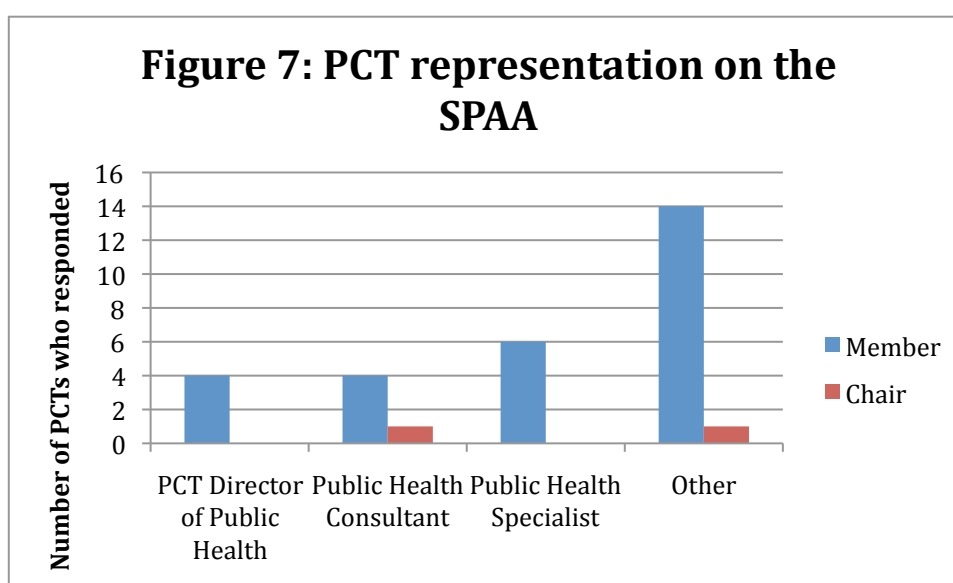
Eight out of 23 PCTs who responded stated that 'physical activity is a key priority within a thematic group' and a further 8 PCTs said that 'physical activity is discussed within a subgroup of a thematic group'. Seven PCTs identified 'Other Comments'; five of these listed the Sport and Physical Activity Alliance as the place where physical activity is considered specifically:

‘Our SPAA is being refreshed and the PE and Sports group feeds into this along with a number of other groups’; ‘Somewhat complexbut generally managed by the SPAA which has an unclear relationship to the LSP’; ‘SPAA – representation from all thematic groups’.

In addition, ‘SHAPE Board.. part of LSP. Health and well-being have 2 key priorities and one is CVD [including physical activity]’; ‘public health partnership (physical activity) - partnership is sub group of thematic group - healthy communities and older people’ and ‘physical activity is a key priority for the partnership as a whole’.

Sport and Physical Activity Alliances – Public Health representation

All 24 PCTs responded, with 5 PCTs having more than one representative on the SPAAs, as shown in Figure 7:



Two PCT representatives, 1 Public Health Consultant and 1 ‘Other’: Senior Public Health Specialist, act as the chair of the SPAA’s. Twenty eight PCT representatives are members of the SPAA’s, with Public Health Specialists representing the largest group (6 PCTs) followed by Public Health Consultants (4 PCTs) and Directors of Public Health (4 PCTs).

Out of the 14 ‘Other members’, PCT representation was from the following:

- Assistant Director of Public Health (3 PCTs)
- Public Health Manager (2 PCTs)
- Senior Public Health Specialist (Physical Activity lead) (1 PCT across 2 SPAA’s)
- Locality Health Improvement Specialist (1 PCT across 6 SPAA’s)
- Head of Active City (1 PCT)
- Lifestyles lead (1 PCT)
- Health Improvement Specialist (1 PCT)
- Healthy Weight, Healthy Lives Lead (Physical Activity)

Public Health Associate (Physical Activity and Nutrition)
Health Improvement Manager
Physical Activity Specialist

Three of the PCTs do not currently sit on the SPAA's for a range of reasons: 1 SPAA is currently being re-launched; 1 PCT is reviewing their membership and for 1 PCT there is no SPAA in place to support due to Local Authority re-organisation.

Strategies and Plans

Physical activity strategies and rationale

Thirteen PCTs have a physical activity strategy that is either in place or being developed or updated. Out of these, 3 PCTs said they have produced a PCT physical activity strategy/plan, 4 PCTs are either developing or reviewing their physical activity strategy; 4 PCTs are contributing to a partnership strategy on physical activity which is currently being developed or updated and 2 PCTs have contributed to an existing partnership strategy.

Ten PCTs responded to explain why they had not produced a physical activity strategy:

- 5 PCTs said that 'it is included in other policies'
- 1 PCT said that 'we haven't got around to it yet'
- 1 PCT said that "there are too many other areas to work on"
- 1 PCT said that 'it is not a high enough priority'
- 2 PCTs said 'other'

The 'other' reason given by both PCTs was that physical activity it is embedded in broader strategic plans. One of these PCTs also added that, *'[Whilst physical activity is included in the PCTs broader corporate plans, a physical activity] strategy needs to be developed at SPAA level within partnership arrangements'*.

Reference to physical activity in other strategies

The strategic documents produced by the 23 PCTs who responded, and the inclusion of physical activity within these, are shown in Table II:

Table II: PCT strategies and references made to physical activity.

Plan	Number of PCTs produced plan	physical activity referred to in the plan
Adult Obesity Strategy/Plan	19	18
Childhood Obesity Strategy/Plan	18	17
Local Operating Plan	15	13
World Class Commissioning	14	8
Cardiovascular Disease Prevention Strategy/Plan	10	8
PCT Travel Plans	9	9
Workplace Health Strategy/Plan	9	7
Falls Prevention Strategy/Plan	8	9
Mental Health Strategy/Plan	8	8
NHS Health and Wellbeing Plan	7	7
Physical Activity Strategy/Plan	3	3
Carbon Reduction Plan	6	5
Sustainable Communities Strategy	6	5
NI8 Plan	4	3
2012 Olympic/Legacy Plans	3	3
Diabetes Prevention Strategy/Plan	2	2
Other	1	2

The most frequently produced strategies are in relation to adult obesity (19/23 PCTs), followed closely by strategies on childhood obesity (18/23 PCTs). Physical activity is included in all but one of these plans for both adult and child obesity. The most striking issue is that only 14 PCTs have produced World Class Commissioning (WCC) plans and just 8 of these refer to physical activity. In addition to this, only 15 PCT leads state that their PCTs have produced Local Operating Plans (LOPs) and 13 of these leads state that they refer to physical activity. Whilst physical activity is included in many of the plans produced, there appears to be a lack of recognition of the importance of physical activity at a strategic level.

Whilst it is surprising that only 14 PCTs have produced WCC plans, which are mandatory, other PCTs may have taken the WCC principles and included these within the PCTs strategic plan, as was shown to be the case in a review of another region. There is a similar situation with the LOPs as whilst only 15 PCTs state they have been produced, discussion with the regional physical activity lead confirmed that, *'all PCTs had to complete a LOP to be signed off by the Strategic Health Authority.... and I [the regional lead].. read, commented and RAG rated all 24 PCTs on the Lets Get Moving requirements'*. Given this there appears to be a lack of awareness by some PCT physical activity leads of the PCTs broader strategic and operational documents, and the place of physical activity within these. It is unclear why this situation has arisen, but one that needs to be addressed to ensure the positioning of physical activity across the PCT is clear.

In terms of the references made to physical activity, the WCC plans represent the PCTs broader strategic plans which often span over a number of years. These plans tend to reflect high level priorities rather than detailed interventions; the detail tends to be contained within the LOPs which are the 'delivery plans' of the PCTs.

Whilst the prioritisation of physical activity within the strategic plans is likely to remain the same, the annual refresh of the LOPs presents an opportunity to present new data and information in relation to physical activity, in a bid to maintain or increase investment in this area.

The predominance of the development of strategies on obesity reflects the overall current priority that this topic receives across the PCTs in the North West. Obesity is a LAA target for 21 out of 23 PCTs in relation to Year 6 overweight and obesity and for 15 out of 23 PCTs in relation to Reception level overweight and obesity. Obesity is also a vital signs target for 6 PCTs and the second most frequently cited policy issue which drives the commissioning of physical activity for PCTs in the North West and an area of work covered by 21 of the PCT physical activity leads. Whilst there are only 3 PCT physical activity strategies which have been produced, this is misleading as a further 4 PCTs are either developing or reviewing their physical activity strategy; 4 PCTs are contributing to a partnership strategy on physical activity which is currently being developed or updated and 2 PCTs have contributed to an existing partnership strategy.

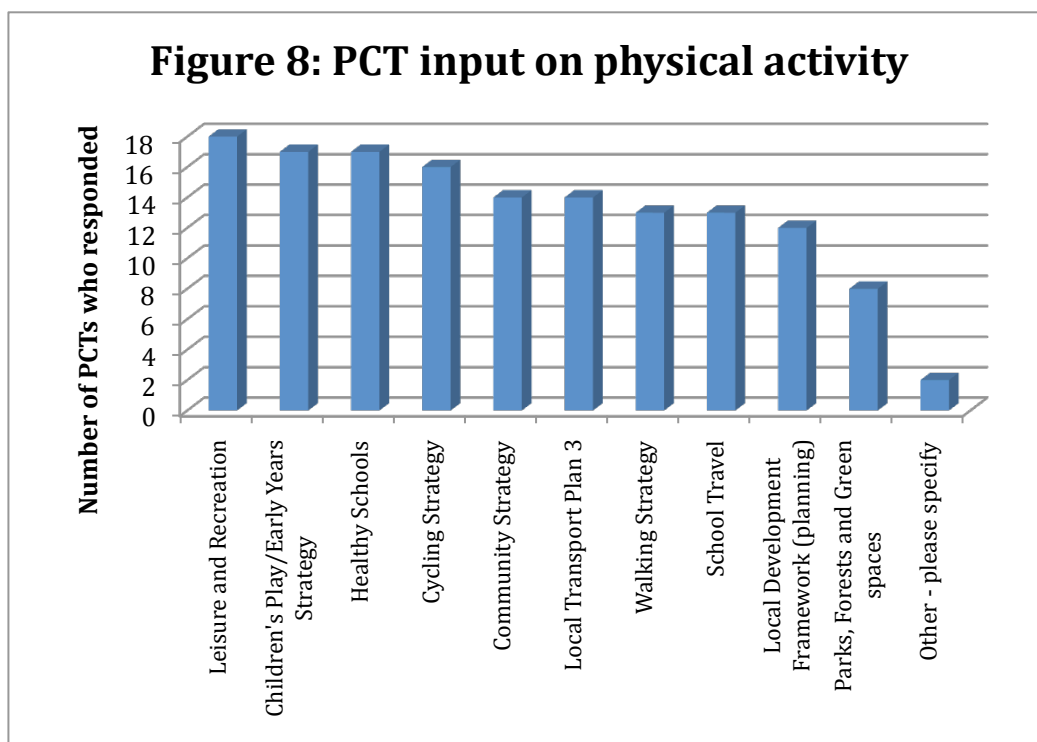
Two PCTs responded to 'Other strategies/plans'. For 1 PCT this covered a number of additional policies that are under development including the mental health strategy and the PCT travel plan and which also 'refer to physical activity'. They also referred to their role in *'Influencing the Sports and Physical Activity Alliance Action Plan to address health inequalities at a district level'*. In addition, 1 PCT just responded to 'refer to physical activity' as physical activity is included in the Corporate Strategic Plan, but the lead was *'...unsure whether this has been produced'*.

Three PCTs provided additional comment: 1 PCT referred to a 'multi agency healthy lifestyles plan' and 1 PCT referred to a 'Dementia care pathway currently being developed' although it is unclear what the time-scale is for these plans and whether they include physical activity. 1 PCT also stated that some of the strategies they have included are *'currently being written'*.

For those PCTs who do not currently have a physical activity strategy which they have developed or contributed towards, it is promising to see the inclusion of physical activity in broader PCT strategies, recognising the role that physical activity has to play in the prevention and management of a range of conditions. However, this does not replace the benefits that can be gained through an overarching physical activity strategy developed either by the PCT or in partnership, to ensure the co-ordination and continuation of physical activity programmes especially in times of financial pressures.

PCT input on physical activity across other strategies/plans

All 24 PCTs have helped to develop or influence the physical activity component of the following local policies or strategies as shown in Figure 8:



Eighteen out of 24 PCTs across the region have helped to develop or influence the physical activity component of the 'Leisure and Recreation' strategies. This is the most frequently cited contribution by PCTs. In addition:

- 17 PCTs have contributed to the 'Children's Play/Early Years Strategy'
- 17 PCTs have contributed to the 'Healthy Schools Policy'
- 16 PCTs have contributed to the 'Cycling Strategy'
- 14 PCTs have contributed to the 'Community Strategy'
- 14 PCTs have contributed to the 'Local Transport Plan 3'
- 14 PCTs have contributed to the 'School Travel plans'
- 13 PCTs have contributed to the 'Walking Strategy'
- 12 PCTs have contributed to the 'Local Development Framework'
- 8 PCTs have contributed to the 'Parks, Forest and Green spaces strategy'
- 2 PCTs responded to 'Other policies/strategies'

Two PCTs responded to 'Other policies/strategies with general statements, 1 PCT re-emphasised their joint partnership working, *'we work in close collaboration with Council colleagues in transport, planning, environmental health and parks and share values and aims'* and 1 PCT said that *'the PCT as a commissioning organisation has not been involved in these [with the exception of the community strategy]'*.

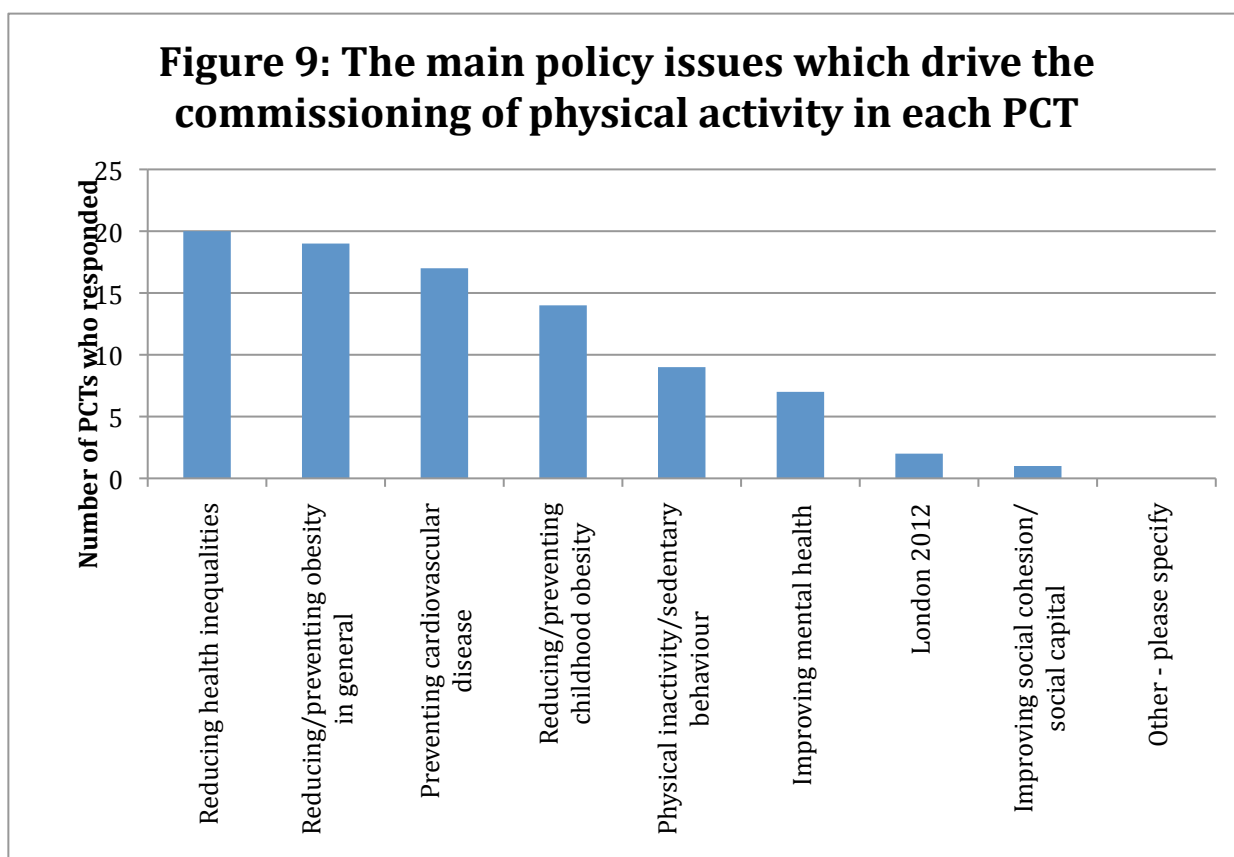
The support provided by PCTs in the development of 'Leisure and Recreation' strategies is extremely important in ensuring that physical activity and health maintain a profile across a broader strategy. An earlier review showed that where there was a broad leisure and recreation strategy the number of references to physical activity was low compared to the references made to 'sport'. Where there was a dedicated joint physical activity strategy there was a much greater focus on everyday activity and health gain.

It is promising to see the range of strategies and plans which the PCT has looked to influence or develop in relation to physical activity; this recognises not only the value that partners place on the PCTs input into these areas, but also the recognition by PCTs of the range of benefits of physical activity across other joint agendas.

Whilst it is unclear what influenced the PCTs contribution to some of these policies it may, in part, be due to the government priorities at that time and the profile of that work in relation to both obesity and physical activity.

Policy Issues in relation to the commissioning of physical activity

There are a range of policy issues which drive the commissioning of physical activity by each PCT, as shown in Figure 9:



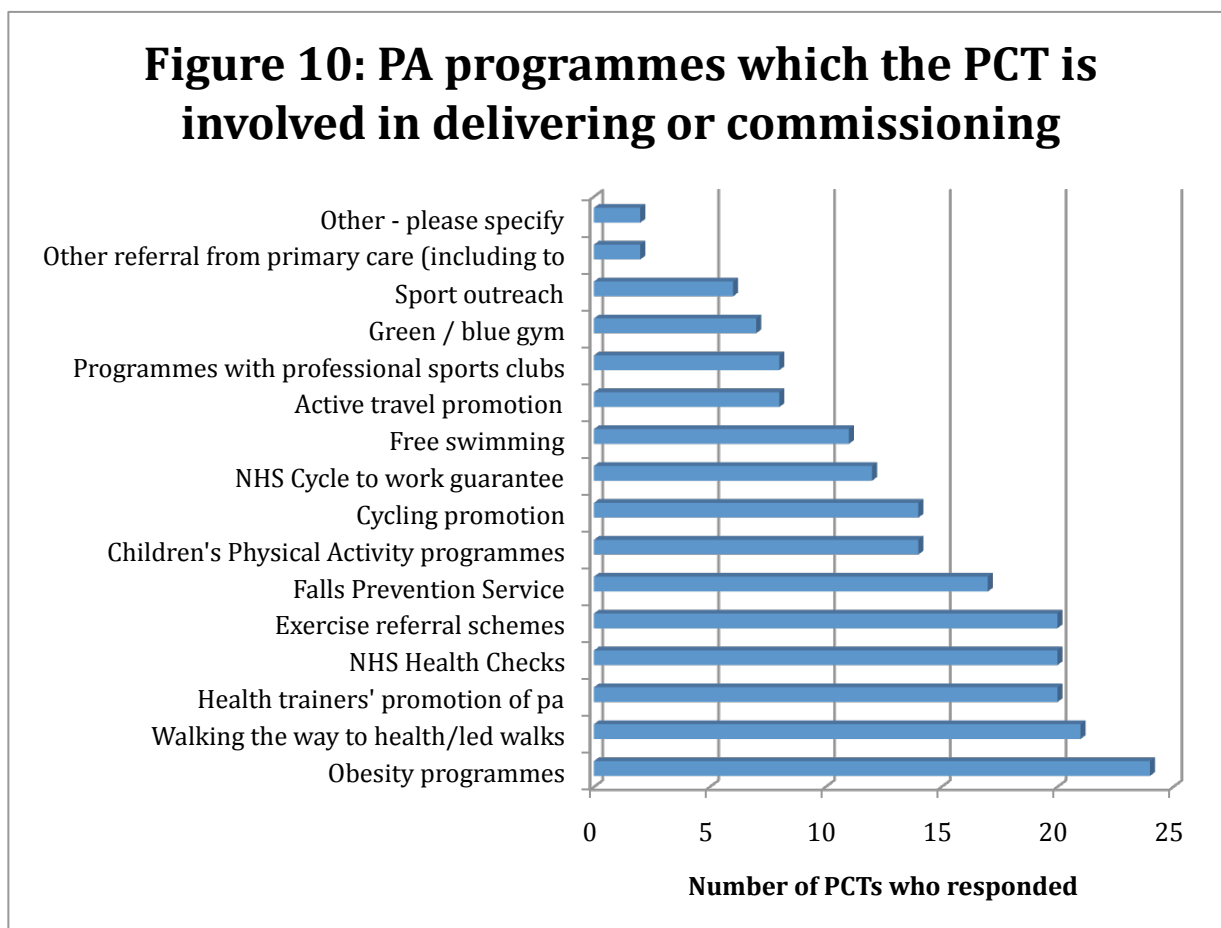
The top three policy issues which were most frequently cited by PCTs were: 'reducing health inequalities' (20/24 PCTs); 'reducing/preventing obesity in general' (19/24 PCTs) and 'reducing/preventing cardiovascular disease (17/24 PCTs - check). In addition, fourteen PCTs identified 'reducing/preventing childhood obesity; 9 identified 'physical inactivity/sedentary behaviour', 7 'improving mental health'; 2 London 2012 and 1 'improving social cohesion/social capital'. No 'other' policy issues were identified.

Obesity therefore represents the second and fourth most frequently cited policy area to drive the commissioning of physical activity. This is not surprising given 21 of the PCT physical activity leads also cover obesity and in addition, the LAA targets

around obesity (NI56 and NI55) were cited as the first and third most common LAA targets that PCTs in the North West are working towards.

Physical activity programmes

All 24 PCTs said that they provide or commission a range of physical activity services in their local areas as shown in Figure 10:



The most popular interventions which all 24 PCTs in the North West region are involved in providing or commissioning are Obesity interventions. Walking programmes are another popular intervention (21/24 PCTs), followed closely by 'Health Trainers promotion of physical activity', 'NHS Health Checks' and 'Exercise Referral schemes' (20/24 PCTs).

'Falls Prevention' is also popular with 17/24 PCTs and 'Childrens Physical activity programmes' and 'cycling promotion' with 14/24 PCTs. Half of the PCTs across the region also support the 'NHS Cycle to work guarantee' and 11/24 PCTs support 'Free swimming'. 'Active Travel promotion' and 'programmes with sports clubs' are also supported by 8/24 PCTs. While 'Green/Blue gyms' is supported by 7 PCTs, 'sport outreach' by 6 PCTs and 'other referral from primary care – including to counselling services' by 2 PCTs. Additionally 2 PCTs stated 'other' programmes as '*supported funding the refurbishment of sports facilities*' and '*community cardiac rehabilitation*'.

All 24 PCTs are involved in providing or commissioning 'obesity interventions' and at a strategic level obesity in general is the second most commonly stated 'driver' for the commissioning of physical activity services, with childhood obesity coming out fourth. Whilst only 21 PCT leads cover 'obesity' specifically, the other 3 leads have staff they line manage who can support this work being commissioned.

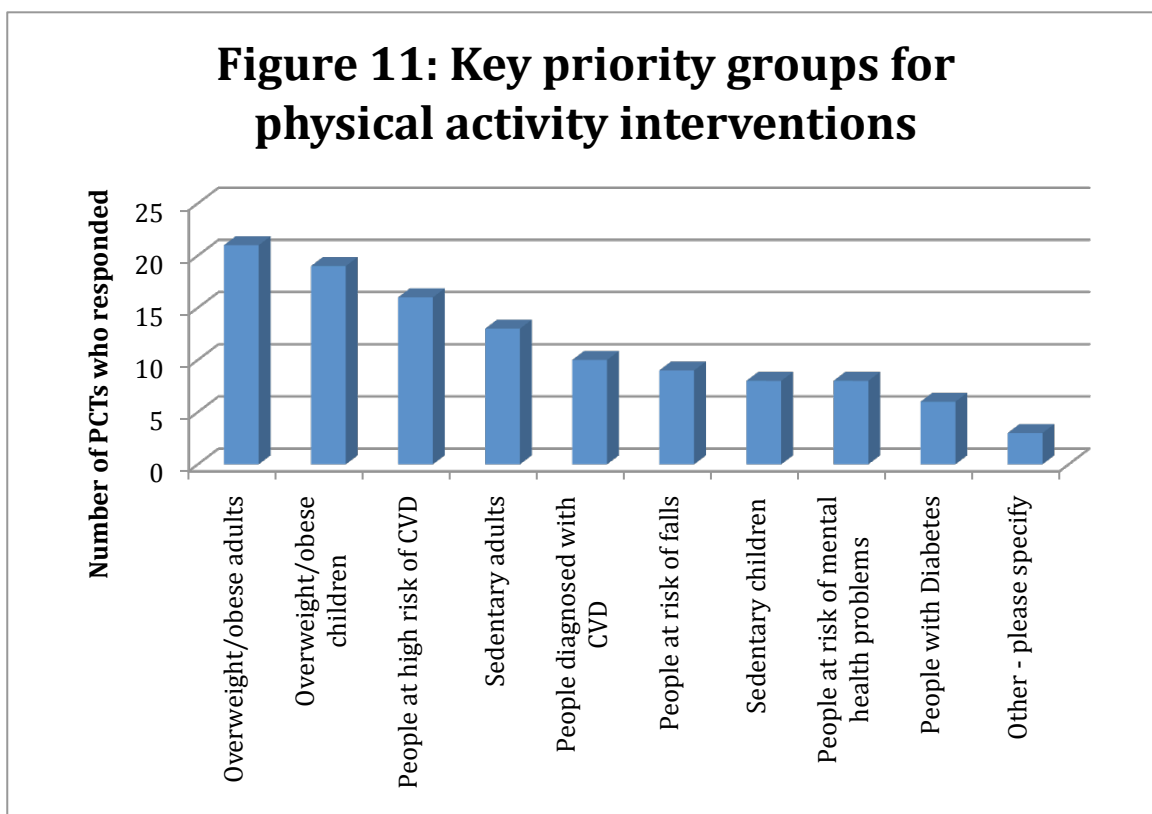
'NHS Health Checks' are also another important deliverable for PCTs and it is good to see that physical activity is being integrated into this work across 20/24 PCTs in the region. Linking physical activity into these broader requirements is imperative if physical activity is going to receive the focus and profile it deserves in primary care.

It is also promising to see the promotion of physical activity through Health Trainers across 20/24 PCTs. Whilst the ideal scenario is for Health trainers to address all health issues, including physical activity, this is often not the case.

It is, however, interesting to note that walking programmes are supported by 21/24 PCTs and exercise referral schemes by 20/24 PCTs. Although the Dept of Health continues to support such schemes, NICE guidance recommended commissioning exercise referral and walking programmes only when they form part of a controlled research trial. Natural England, the organisation responsible for the development and delivery of the national health walks programme, have taken this on board and are evaluating their health walks programme. However, PCTs should still be encouraged to review the programmes in place and ensure stringent monitoring and evaluation is in place.

Key priority groups

These physical activity programmes are aimed at the following key target audiences as shown in Figure 11:



Overweight/obese adults are the most frequently cited key priority group by 21 out of 24 PCTs in the region, with overweight/obese children cited by 19 PCTs.

Sixteen PCTs identified 'people at high risk of CVD' as a key priority groups, whilst 13 PCTs identified 'sedentary adults' and 10 PCTs 'People diagnosed with CVD'. 'People at risk of falls' were identified by 9 PCTs, 'sedentary children' by 8 PCTs and 'people with diabetes' by 6 PCTs. 'Other' priority groups were identified by 3 PCTs as follows:

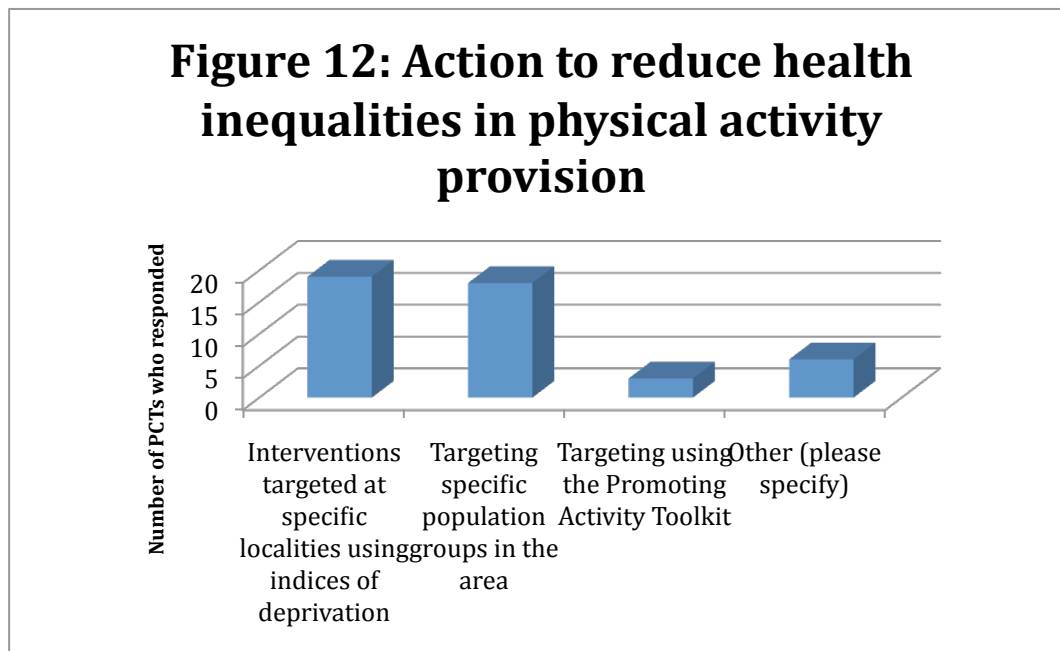
- People in the most deprived 20% Super Output Areas
- All groups
- Anyone at risk of ill health (prevention); those living in deprived areas

The top two cited priority groups in relation to obesity are as expected, given that all 24 PCTs provide or commission obesity interventions. However, given that 17 out of 24 PCTs are involved in commissioning or providing a 'Falls Prevention Service' it is surprising that only 9 PCTs identified 'people at risk of falls' as a priority group.

Interesting to note that only 2 PCTs reference 'people in deprived areas', yet addressing inequalities is the most commonly cited policy area which drives the commissioning of physical activity across the region. However, the need to address inequalities in health often underpins the selection of target groups and or localities, and as such it may not necessarily be pulled out as a discrete area of work. This appears to be the case for PCTs in this region as shown in Figure 12.

Reducing health inequalities through physical activity

There is a range of action being taken to reduce health inequalities in physical activity provision across PCTs, as shown in Figure 12:

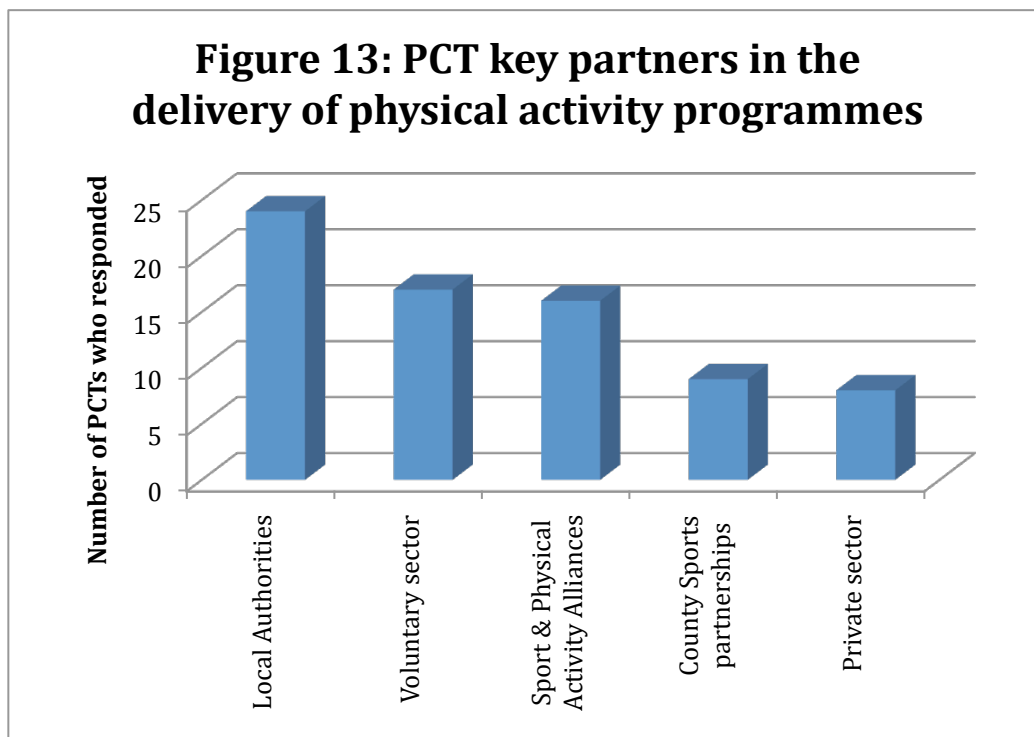


The most common course of action taken by 19 out of 24 PCTs is to target physical activity interventions at 'specific localities using indices of deprivation'. Eighteen out of 24 PCTs 'target specific population groups in the area' and 3 PCTs 'target using the Promoting Activity Toolkit'. Out of these, 13 PCTs target using both 'indices of deprivation and population groups, 2 of which also use, *'Active People Survey Data in a neighbourhood format to determine adult need'* and *'social marketing approaches and local and national audience segmentation'*. Three PCTs use all three approaches to targeting.

In addition, 1 PCT states that, *'using the physical activity toolkit and other tools is an aspiration we hope to build on in coming years'* and 1 PCT who does not identify any method of targeting states that a *'health needs assessment [is] being undertaken'*. Two PCTs also indicate that programmes and teams are in place in areas of highest deprivation, although the mechanism for the targeting is unclear.

Key partners for delivery

PCTs identified a range of key partners for the delivery of the physical activity programmes, these are shown in Figure 13:

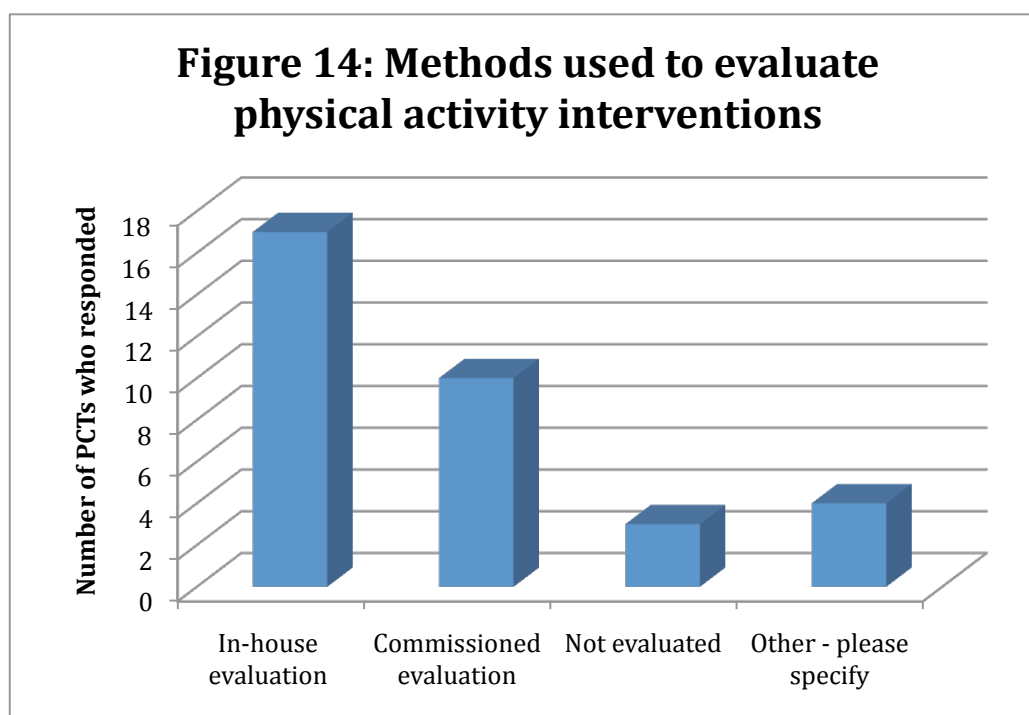


All 24 PCTs cited Local Authorities as key partners; the voluntary sector were cited by 17/24 PCTs followed closely by the Sport and Physical Activity Alliances cited by 16/24 PCTs. Nine PCTs cited the County Sports partnerships and 8 PCTs cited the private sector.

It is promising to see that all PCTs recognise the importance of Local Authorities as providers of physical activity services. However, whilst 16 PCTs cite SPAAs as partners in delivery, 21 PCTs actually have representatives who sit on the SPAAs: 19 PCTs have representatives who are members and 2 PCTs have representatives who chair the SPAAs. However 1 PCT did say that they didn't feel that the 'SPAAs *had clout locally*', which may influence the broader perception of them as delivery partners.

Evaluation

PCTs use a range of methods to evaluate the physical activity projects that are commissioned or delivered as shown in Figure 14:



The most popular method of evaluating physical activity projects, identified by 17/24 PCTs, is through 'In-house evaluation' conducted by the PCT. 'Commissioned evaluation', conducted independently, is used by 10 PCTs and 3 PCTs stated that the physical activity programmes are 'Not evaluated'.

Four PCTs responded to 'other' as follows:

- 'Get Active Study [in addition to in-house evaluation and commissioned independent evaluation]'
- No method identified but states that '*commissioned services are audited*'
- No method identified but states that '[evaluation is through a] *partnership approach*'
- '[commissioned evaluation is just] *for key interventions eg, free swimming*'

Nine out of the 17 PCTs who conduct 'in-house evaluation' and 2 of the PCTs who use 'commissioned evaluation' use only these methods as their mechanism to evaluate.

Whilst the rationale for the choice of evaluation methods is unknown it is likely that the choice of 'in-house evaluation' is influenced by the budget available. Whilst the precise budgets for evaluation was not stated, 14 PCTs indicated an approximate budget breakdown in terms of the percentage of the total budget allocated to evaluation. This showed a variance of 0-20%, although only 1 PCT indicated 20%, 6 indicated 1-5% and 7 PCTs allocated no budget to evaluation. As such the median spend on evaluation is just 0.5% of the total budget across these 14 PCTs. Whilst evaluation of physical activity programmes is in place, in most cases, there is, limited budget for this. This is likely to impact on the quality of the evaluation which can be conducted and therefore the impact and outputs that can be demonstrated. The PCTs across the region, however, stated that they need the evidence, short and long term, to maintain investment in this area and that where there was little or no evidence they would commission a study to provide this. However, in reality this

will only be achieved through a full review of the budget breakdown and specifically the amount allocated to evaluation.

15 PCTs out of 23 who responded have used the Standard Evaluation Framework, published by the National Obesity Observatory.

Monitoring of long-term behaviour change

Sixteen out of 23 PCTs who responded said that they monitor long-term behaviour change in the physical activity programmes that the trust commissions/delivers. Seven PCTs do not monitor long-term behaviour change, although the rationale for this is unclear, this may be influenced by the budget allocated to evaluation.

Change4Life

22 out of 24 PCTs are linking into the Change4Life programme in relation to physical activity. Examples of the links being made were provided by 12 PCTs as follows:

- 10 PCTs link into the Change4Life material and branding, although one PCT stated that the, *'[local] council has a problem with using Change4life brand as they see it as conflicting with their own ...brand'*
- 1 PCT has a Change4Life steering group which *'works towards co-branding and highlighting campaigns'*
- 1 PCT links into the Change4Life market segmentation data

Let's Get Moving

Current usage and intention

Only 3 out of 24 PCTs are currently using the Lets Get Moving physical activity care pathway. Twenty PCTs are not using the pathway and 1 PCT doesn't know if they are using it or not.

Out of the 20 who are currently not using the pathway, 14 do intend to use this in the future, 1 PCT does not intend to use in the future and 6 PCTs don't know if they will use it in the future.

Capacity to deliver

Twenty one PCTs out of twenty four have staff trained in delivering motivational interviewing interventions.

Ten PCTs out of twenty two have staff trained to deliver Module 1 of the 'Let's Get Moving' training. Only five PCTs out of twenty one have staff trained to deliver Module 2 of the 'Let's Get Moving' training.

Let's Get Moving was developed based on NICE evidence in relation to brief interventions and a successful feasibility study led to its inclusion in the NHS Operating Plan 2010/11. As this is the only specific physical activity intervention referred to in the plan, it is imperative that this is prioritised by PCTs and that staff and budgets are re-aligned to ensure there is capacity to deliver across each PCT area.

General Practice Physical Activity Questionnaire (GPPAQ)

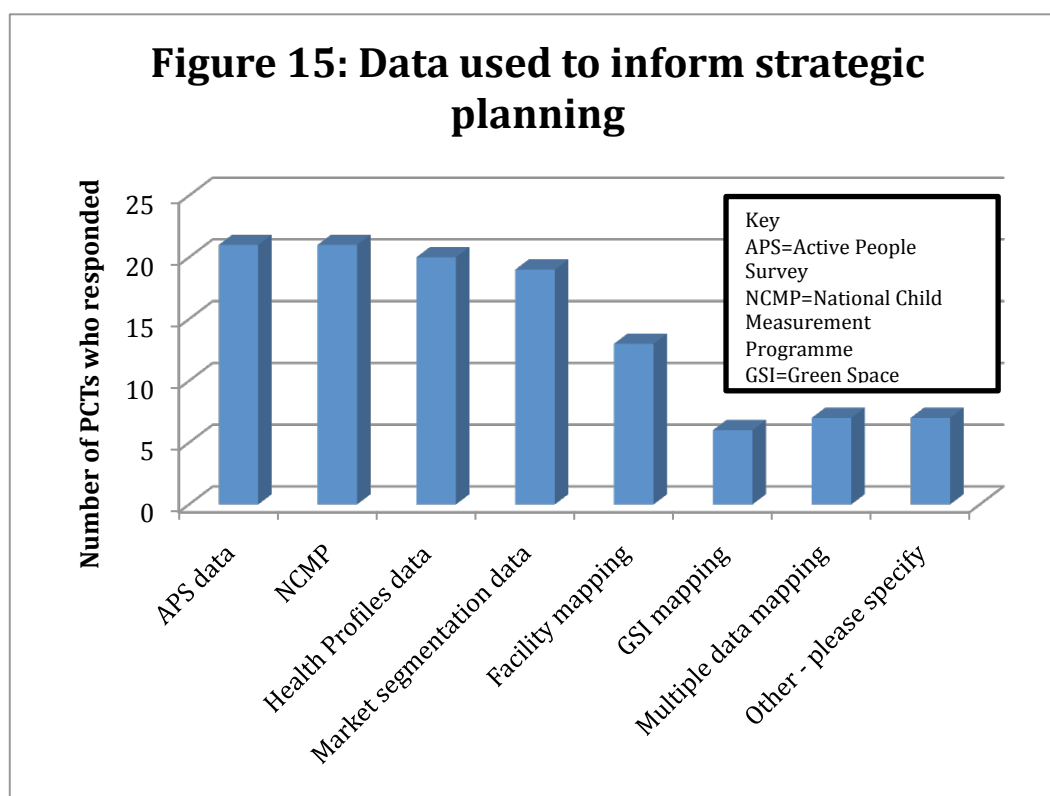
Five out of 23 PCTs who responded said that 'some' of their GP practices routinely screen their patients using the GPPAQ. In addition, 8 PCTs said that 'none' routinely screen and 10 PCTs did not know whether their practices use GPPAQ.

This is related to the above issue, as the GPPAQ is a validated tool and a core component of *Let's Get Moving*. Without screening patients using a tool such as the GPPAQ, it is unlikely that GPs are offering appropriate physical activity services.

Research

Data used to inform strategic planning

There is a range of data used to inform the strategic planning of physical activity across PCTs, as shown in Figure 15:



The Active People Survey and the NCMP are both used by 20 out of the 24 PCTs to inform their strategic planning of physical activity.

Health Profile data is used by 20 PCTs to ensure programmes help to tackle health inequalities and the use of market segmentation data by 19 PCTs supports this.

Facility mapping is identified by 13 PCTs, Multiple data mapping by 7 PCTs and Green space infrastructure mapping by 6 PCTs.

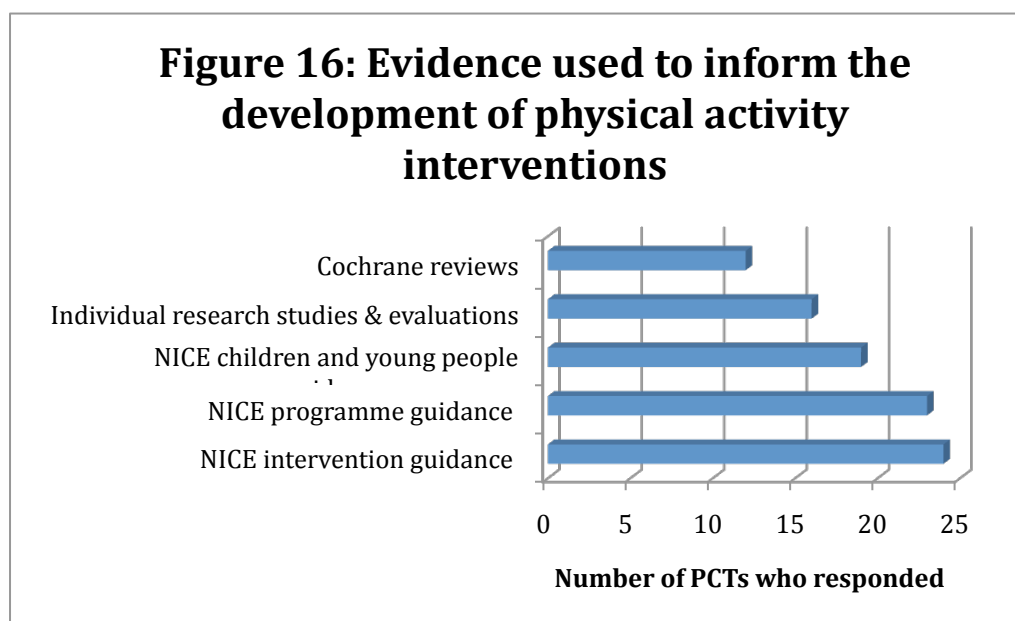
Seven PCTs listed 'other' data used to inform strategic planning, as follows:

- 3 PCTs identified 'local health/lifestyle survey data'
- 3 PCTs identified 'Needs Assessment', one of these was the 'Joint Strategic Needs Assessment'
- 2 PCTs identified the '5 hour offer survey'
- 1 PCT identified the adult obesity 'Quality and outcomes Framework (QoF)'
- 1 PCT identified 'GP data'

It is not surprising that the Active People Survey (APS) and the NCMP data are the most frequently used data sources to inform the PCTs strategic planning. The NCMP data is used to show progress against NI55 and NI56, both of which are key targets for over half of the PCTs in the NW region. The Active People Survey data is still acknowledged as the only measure for Physical Activity and one which measures progress for the LAAs and the achievement of NI8. Whilst this is often managed through the LA rather than the PCT, the PCTs have a contributory role in the achievement of this target through the programmes they commission. The LA are key partners in the delivery of these programmes across all 24 PCTs.

Evidence used to inform programme development

There is a range of evidence used by PCTs to inform their commissioning of physical activity interventions, as shown in Figure 16:



All 24 PCTs responded to say they use the NICE intervention guidance (brief interventions; exercise referral; pedometers and walking/cycling) to inform the development of physical activity programmes. Following closely is the NICE programme guidance (physical activity and the environment) used by 23 PCTs; 19 PCTs use the NICE children and young people guidance; 16 PCTs use 'Individual research studies and evaluations' and 12 PCTs use the Cochrane reviews.

Sixteen out of 24 PCTs use 'individual research studies and evaluations' as evidence to inform the development of physical activity interventions. However, this evidence is not used in isolation as all of these PCTs also use the NICE intervention guidance and NICE programme guidance; 12 of the 16 use the NICE guidance for children and young people and 9 of the 16 use the Cochrane reviews. Given the importance placed on addressing health inequalities, PCTs are listening to the needs of their local populations in addition to the evidence coming through national guidance.

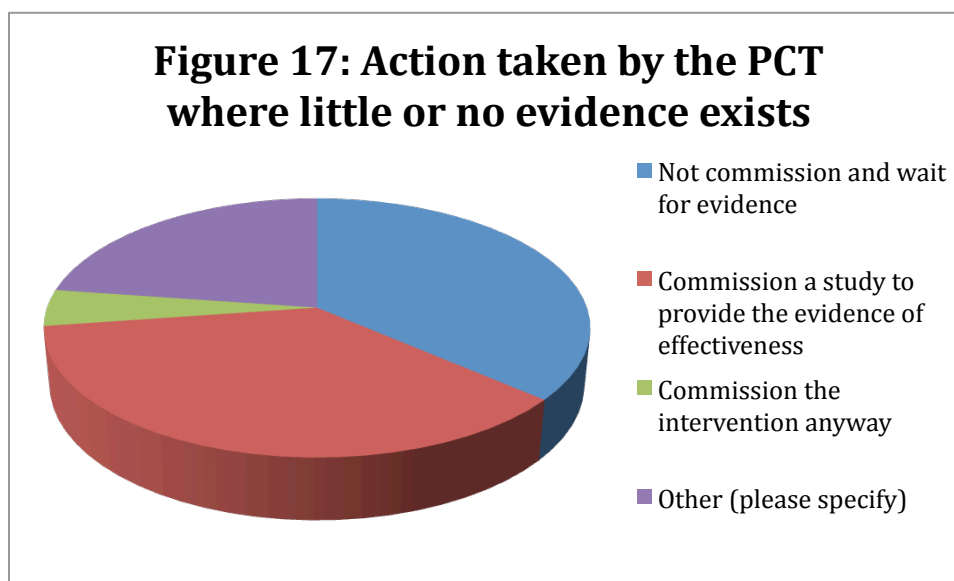
It is good to see the use of robust evidence and guidance in the development of physical activity programmes. However, 20 out of the 24 PCTs continue to fund exercise referral schemes, 21 out of 24 fund walking programmes and 14/24 fund cycling programmes: which were only recommended by NICE if part of a 'properly designed and controlled research study to determine effectiveness'⁵. It would be interesting, therefore, to look at the design of these programmes, specifically the evaluation component, given the median budget allocated for evaluation across the 14 PCTs who responded is just 0.5%.

In addition to the use of the evidence to inform programme development, it is promising to see that the PCTs across the region have provided physical activity input into a range of strategies, some of this input which would not previously have

been considered appropriate, for example in the Local Development Framework and the Local Transport Plan 3. The PCTs recognition of their contribution on physical activity into these areas has without doubt been helped by the strength of the evidence provided by documents like the NICE programme guidance (physical activity and the environment).

Importance of evidence in the commissioning of programmes

Where there is little or no evidence, PCTs take a variety of steps as shown in Figure 17:



8 out of 22 PCTs who responded said they would ‘not commission and wait for evidence’; 8 also said that they would ‘commission a study to provide the evidence’ and 1 PCT said they would ‘commission the intervention anyway’.

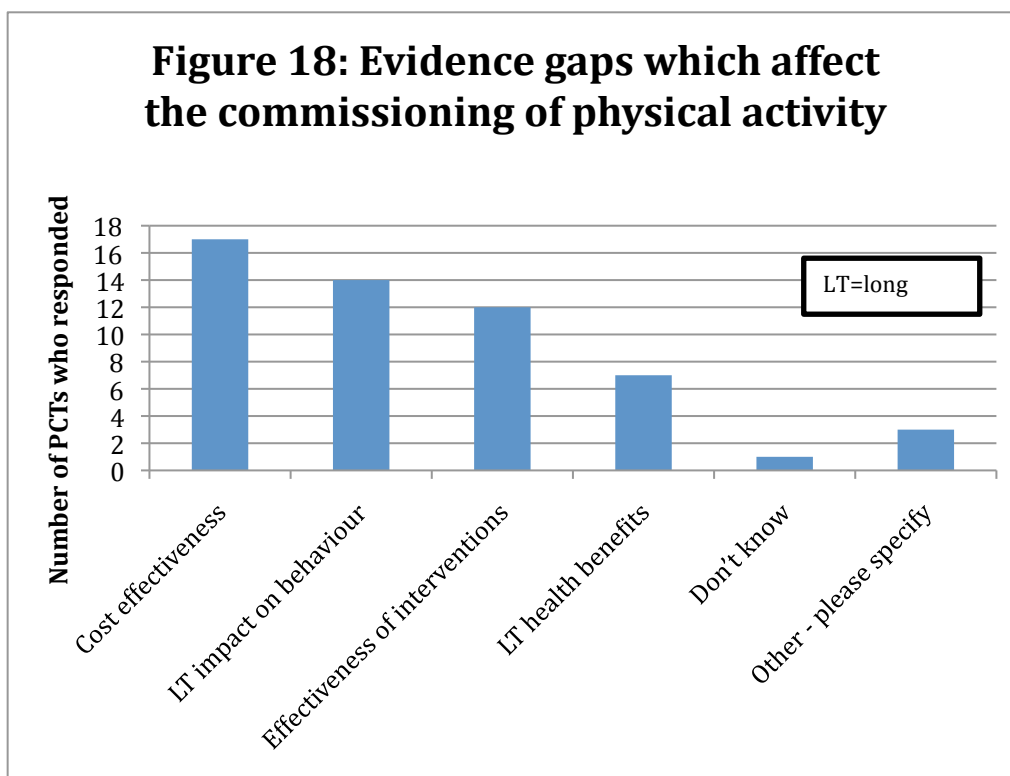
‘Other’ action taken was listed as follows:

- 2 PCTs build evaluation into commissioned activity
- 1 PCT would *‘pilot using the best available evidence’*
- 1 PCT would *‘commission interventions as pilots and ensure evaluation’*
- 1 PCT would *‘commission the service based on local agreement’*

In this financial climate, the need for evidence to support the development of interventions is evident. On the other hand, it is promising to see that for some PCTs innovation is not being stifled as they suggest that where there is little or no evidence they would *‘commission to provide the evidence...’*. In reality, however, they would need to increase the allocation of the budget for evaluation, beyond the 0.5% current median allocation across 14 of the PCTs, in order to make this a realistic and plausible option.

Evidence gaps

PCTs identified a range of evidence gaps which affect the commissioning of physical activity, as identified in Figure 18:



The most frequent response, cited by 17 out of 22 PCTs who responded, was 'cost effectiveness of interventions'. 'Long-term impact on behaviour' was also mentioned by 14 of the 22 PCTs. Lack of evidence on 'effectiveness of interventions' was cited by 12 PCTs and lack of evidence on 'long term health benefits' by 7 PCTs.

3 PCTs responded to 'Other', as follows:

- *'Lack of commissioning capacity'*
- The length of time the benefit realisation will take - *'building a cash releasing business case is hampered not by effectiveness or cost effectiveness, but that the benefit willbe medium if not long term'*
- *'I am not sure that lack of evidence is the reason for not commissioning, it is more the case that other medical interventions have priority'*

Factors that would help PCTs to increase the commissioning of physical activity

- Physical activity as a PCT vital sign
- National 'must do' targets which PCTs/LA's are monitored on
- Greater knowledge/evidence around 'Return on Investment'
- Economic modelling and linking into demand for secondary care
- Further evidence on cost effectiveness and value for money
- Ringfenced funding/more funding and resources to commission services
- Ringfenced funding for Let's Get Moving pathway implementation
- Assistance in steering/embedding Let's Get Moving at practice level without high training costs
- Enhanced QoF incentives for GP's
- Internal prioritisation

- A full evaluation of physical activity programmes to strengthen the evidence base
- Further evidence on effectiveness
- Stronger evidence to demonstrate the links between physical activity and other health issues, eg maintenance of smoking cessation
- Evidence to show that physical activity interventions will achieve better health outcomes than other existing health service interventions
- Strong business cases that show the impact of physical activity on other health priorities, eg, unscheduled care
- Links made to current policy levers
- Capacity of providers to deliver services

Regions

Aspects of the Structure PCTs find useful

17 PCTs responded indicating the aspects of the regional structure they find useful, categorised as follows:

- 6 PCTs said 'updates: policy, knowledge and interventions'; 2 of these specifically referred to the 'physical activity e-updates'
- 5 PCTs said 'networking and sharing of knowledge and working practices through workshops/seminar updates'
- 4 PCTs said 'NW Physical activity forum'
- 3 PCTs said 'links to DH and national/regional policy and opportunities'
- 2 PCTs said 'communication and support from the regional physical activity lead'
- 1 PCT said 'Greater Manchester Public Health Network' and 'Greater Manchester Health Facilitator Network'
- 1 PCT said 'Greater Manchester Healthy Weight leads'
- 1 PCT said 'special marketing programmes at regional or Greater Manchester level'

How Region could better support PCTs

- Strategic Health Authority to set a vital sign for physical activity
- Benchmarking programmes being delivered in terms of effectiveness
- Research and evaluation, specifically to further develop the evidence base
- Further resources to effectively commission
- A forum for exercise referral leads to share good practice, learn and develop
- Set up physical activity working groups, using the Champs model around healthy weight.
- Expansion of social marketing work
- Evidence reviews for physical activity and cost effectiveness summary
- Inclusion of PCTs in all regional discussions with CSP's
- Regional events to showcase good practice
- Increase pressure on PCTs to prioritise physical activity
- Regional colleagues visiting PCTs and providing critical friend support

- Funding to come with initiatives that region want rolling out, eg, Let's Get Moving
- Core things that all SPAA's should be implementing on health
- Enable partnerships between PCTs in order to jointly commission evaluations and contribute to the evidence base
- Shadow PCT representatives to gain an understanding of local issues and provide support

Other Key Issues in the commissioning or provision of physical activity?

- Clear governmental support beyond Change4Life is required that will assist in embedding physical activity as a vital component of health improvement
- Need to ensure a continued high profile for physical activity as old and new priorities emerge
- Robust QALY data is needed as competition for funding increases from areas with stronger evidence base.
- Review of cardiac rehabilitation and the location of phase IV is required.
- Strengthening of evidence base, nationally and locally
- Variety of commissioners and providers for physical activity is problematic. Co-ordinating and influencing this is not always easy. If the NHS tries to assume a lead role the expectation is that they will provide the majority of the funding, but this is not possible. A list of approved physical activity providers would be helpful.
- Issues around boundaries between commissioners and providers, SPAA's are the obvious place to resolve but little clout locally so whilst physical activity is recognised in meeting health and other important priorities, no-one wants to assume responsibility to pay for it.
- Local area priorities differ across the patch
- Physical activity has been primarily considered alongside the healthy weight agenda, potential to build on this with increased collaboration on physical activity between LA and PCT.
- Need to explore opportunities to work with voluntary and community sector through joint commissioning arrangements.
- Commissioning and provision of physical activity can only be done effectively in partnership
- More links with planning, transport and policy around impact of infrastructure
- Lots of issues re-commissioning would like to discuss further
- Helpful to have one website eg NOO that has a section on physical activity which shows impact of interventions on health and cost savings
- Need better evidence of cause and effect

5. Conclusions

The overriding conclusion from this audit is that physical activity is not an independent priority for the majority of the PCTs in the region, and appears in few of the PCTs strategic plans. However, it has maintained its profile across the region through the links to broader agendas, especially around obesity.

PCTs have key targets in place around obesity against which they are performance managed. While there is a physical activity target in place through the LAA, this is managed and led by local authorities. PCTs have an important contributory role in achieving this target but their priority is its relationship to obesity. All the PCTs in the region are involved in providing or commissioning 'obesity interventions' and overweight/obese adults and overweight/obese children are the top two 'key priority groups' for the physical activity interventions commissioned by PCTs.

In order to secure physical activity as an independent priority there needs to be a discrete PCT physical activity target in place, ideally a Vital Sign. This would, however, need to be at either Tier 1 or Tier 2 level, requiring PCTs to report progress. It would be imperative that this was closely aligned to the Active People Survey data and the Legacy Action Plan target, to prevent any confusion and to enable PCTs to continue to work in partnership across their local areas. It is essential that any new target is not seen as purely a PCT target.

Just under half the PCTs in the region do not currently have a physical activity strategy. However, it is promising to see the inclusion of physical activity in broader PCT strategies and PCT input on physical activity in the strategies of partner agencies, such as in the Local Development Framework and the Local Transport Plan 3.

While physical activity was only included in a small number of PCTs strategic plans, it was included in 13 out of the 15 Local Operating Plans, the 'delivery' aspects of the PCTs broader strategic plans. The prioritisation of physical activity within the strategic plans is likely to remain the same, however, the annual refresh of the LOPs presents an opportunity to present new data and information in relation to physical activity, in a bid to maintain or increase investment in this area.

There are no full-time physical activity leads in PCTs and postholders spend on average up to one day a week on the topic, with the majority also covering work around obesity. These physical activity leads have on average 2 members of staff working on physical activity who they line manage and just over half have some additional support from other colleagues in the PCT. Having a strong focus on physical activity within the PCT is invaluable in ensuring the development of targeted physical activity programmes and to ensure that the health agenda is given equal consideration to the broader sport and performance agenda. This is especially the case with the publicity and support surrounding 'London 2012', although this and the Legacy Action plan target does not appear to be a physical activity driver for the majority of the PCTs across the region.

PCTs are engaging with partners on physical activity. Physical activity is a key theme or a subgroup of a key theme across more than half of the Local Strategic Partnerships, and the majority of PCTs have a representative who sits on the Sport and Physical Activity Alliances. PCTs are also being acknowledged as important contributors to the physical activity component of broader strategies both across the PCT and across partner organisations, with 18 out of 24 PCTs contributing to the Leisure and Recreation strategy. Local authorities, the voluntary sector, the Sport and Physical Activity Alliances and the Private sector have a clear delivery role compared to the predominant commissioning role now seen across Public Health. Although it is unclear who the current 'Private sector' providers are it is important that professional sports clubs are utilised for the range of resources and services they can offer to enhance the physical activity opportunities in a local area.

PCTs use a variety of data sources to inform their strategic planning of physical activity and a range of evidence to inform their commissioning of physical activity interventions. It is good to see the use of robust evidence and guidance in the development of physical activity programmes. However, 20 out of the 24 PCTs continue to fund exercise referral schemes, 21 out of 24 fund walking programmes and 14/24 fund cycling programmes, all of which were only recommended by NICE if part of a 'properly designed and controlled research study to determine effectiveness'⁵. Whilst national evaluation is taken place around health walks, it would still be interesting, to look at the design of these programmes, especially the evaluation component.

While it is disappointing that the vast majority of PCTs are not currently using *Let's Get Moving*, just over half intend to in the future. Whilst most PCTs have staff trained in delivering motivational interviewing interventions, just under half of the PCTs have staff trained to deliver Module 1 of the *Let's Get Moving* training and just under a quarter have staff trained to deliver Module 2. Very few GPs across the region use the validated General Practice Physical Activity Questionnaire (GPPAQ); a fundamental aspect of *Let's Get Moving*. The roll out of *Let's Get Moving*, and the use of the GPPAQ should, however, be seen to be a major priority. *Let's Get Moving* is based on NICE evidence in relation to brief interventions and is specifically mentioned in the NHS Operating Plan for 2010-11. As *Let's Get Moving* begins to be embedded with the NHS, it is likely that stand-alone exercise referral schemes will either be incorporated into the care pathway, or will be decommissioned.

In the long run, investment in physical activity makes sound economic sense: increasing physical activity is likely to lead to significant reductions in public expenditure on conditions including obesity and cardiovascular disease. Physical inactivity is estimated to cost £17 per person across the region, but PCTs are investing only just over 60 pence per head in the promotion of physical activity. However, in the current economic climate PCTs in the region have, on the whole, done well to maintain a similar level of investment from 09/10 to 10/11. In addition over half of the PCTs jointly fund programmes and so the total investment in physical activity across partnerships is likely to be significantly higher than this.

A wide range of aspects of the regional structure were found to be useful by 17 out of the 24 PCTs across the region, but especially the 'updates: policy, knowledge

and interventions' and networking and sharing of knowledge and working practices. Without a doubt this level of structure is felt to be extremely important in helping to support and interpret national policy into local implementation. The loss of the regional physical activity lead post may lead to subsequent disinvestment by PCTs as the perception of the importance of this area may be diminished.

The recent publication of the NHS White Paper outlined a major overhaul of the NHS which will see the abolition of PCTs, a consortia of GPs commissioning services and a new public health system in local government. This will bring with it new challenges, but also opportunities. It is imperative, however, that the agenda of inactivity and its clear links to poor health outcomes are recognised and prioritised across these new structures and services.

6. Recommendations

1. Where possible, in the face of public sector spending cuts, budgets for physical activity should be at least protected at current levels for as long as possible. This will allow for more robust evidence on the impact of the programmes on long-term behaviour change.
2. The time allocated to physical activity across the PCT should be reviewed to ensure that the PCT physical activity leads and other support staff have the capacity to commission and deliver effective programmes.
3. Efforts should be made to review the inclusion of physical activity within the Local Operating Plans of the PCT on an annual basis.
4. Strategies on physical activity should be in place across each local partnership.
5. GPs should be encouraged to promote active lifestyles to their patients using the evidence-based approach set out in *Let's Get Moving*, which includes the use of the validated General Practice physical activity questionnaire (GPPAQ).
6. Implementing *Let's Get Moving* and the use of the GPPAQ should be seen as the top commissioning priority for physical activity in primary care as this can provide the overriding framework for a number of associated services.
7. Physical activity leads in PCTs should advocate for physical activity participation as an outcome within the NHS Outcomes Framework.
8. The evaluation component of a programme should be prioritised to ensure evidence of impact and outcomes can be demonstrated, with a minimum agreed allocation of 10% of the total budget.
9. The Standard Evaluation Framework for weight management interventions should also be applied to physical activity interventions across the region.
10. National evidence in the form of NICE guidance and Cochrane reviews be used to inform the development of the physical activity programmes, especially in light of current financial constraints.
11. The profile of physical activity should be maintained across the NHS in the region and the 'useful' aspects of the regional structure built upon to ensure continued support to PCTs and local authorities for this area of work.

References

1. Department of Health 2009 Annual Report of the Chief Medical Officer; London, 2010.
2. Department of Health At least five a week: evidence on the impact of physical activity and its relationship to health; London, 2004.
3. Cavill, N.; Rutter, H.; Hill, A., Action on cycling in primary care trusts: results of a survey of Directors of Public Health. *Public Health* 2007, 121 (2), 100-5.
4. Allender, S.; Foster, C.; Scarborough, P.; Rayner, M., The burden of physical activity-related ill health in the UK. *J Epidemiol Community Health* 2007, 61 (4), 344-8.
5. National Institute of Health and Clinical Excellence Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise; London, 2006.

Appendix I: Invitation E-mail to PCTs

Dear All

Please find attached a letter which outlines our request for PCTs to complete a brief online physical activity audit. The questionnaire is designed to be completed by the most senior person in charge of commissioning physical activity in each PCT. It should take around 20 minutes to complete. The link to the questionnaire is in the letter.

The information supplied will be included in a report about the commissioning of physical activity services in the NW which will be shared with PCTs but individual responses will not be identified.

Please ensure it is completed by 14th June 2010 and thank you for your cooperation.

Best Wishes

Jackie Brennan

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North West

(JACKIE BRENNAN)

Direct Line: 0161-952-4289
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Department of Health North West
13th Floor
City Tower
Piccadilly Plaza
Manchester
M1 4BE

Date : 27th May 2010

Dear *Director of Public Health*

Subject: NW Regional Physical Activity Audit

It is still a regional priority to increase physical activity levels, decrease sedentary behaviour, contribute towards achieving a 2012 legacy target of 2 million people more active by 2012 and achieve a 2012 health and well-being legacy for the NW.

DH Northwest has commissioned Cavill Associates to carry out a brief audit of NW Primary Care Trusts, which will identify the current baseline of physical activity delivery within the NHS in this region. This regional overview of the strategic commitment, available resources, capacity and types of interventions to promote physical activity at the local level will provide key intelligence for DH Northwest and NHS Northwest as regional roles change. It will enable assessment and prioritisation to identify areas for support and ensure the most effective practices and processes are in place in a tough financial climate.

A final written report will provide a regional profile and overview and make recommendations to support future local delivery. It will be shared with all PCTs but will not indicate individual PCT responses. This audit will therefore provide local areas with a tool to benchmark their own approaches and priorities to increasing physical activity and identify what support might be needed from the current regional structure or any future intermediate tier.

The audit may also provide local areas with an opportunity to offer and or receive peer support when dealing with challenging issues and provide opportunity to work collaboratively with other local areas for example within a County Sport Partnership network.

I would welcome your support in ensuring that the most appropriate member of your staff completes this audit by **14th June 2010** by accessing this link: <http://www.surveymonkey.com/s/2XKV7BT>

Yours sincerely

A handwritten signature in blue ink that reads 'Jackie Brennan'.

Jackie Brennan
Regional Physical Activity Programme Manager
Department of Health, North West

Appendix II: Online Questionnaire

Physical activity audit in the North West

1.

Thank you for agreeing to complete this questionnaire. This audit aims to establish what action is being taken by Primary Care Trusts (PCTs) and their local authority partners in the North West to promote physical activity. The audit is being conducted by the [South East Public Health Observatory](#) and [Cavill Associates](#), on behalf of the Department of Health North West.

The questionnaire is designed to be completed by the most senior person in charge of commissioning physical activity in each PCT. It should take around 20 minutes to complete.

The information you supply will be included in a report about the commissioning of physical activity services in the North West, and individual respondents will not be identified.

To complete the questionnaire you will need information about budgets, projects and staffing on physical activity in your PCT. As many physical activity services are delivered in partnership with local authorities, your response should represent the views of both you and your local authority partner. You may want to complete the questionnaire together, or to discuss the questions in advance.

We would be grateful for your responses by **14 June 2010**.

Thank you.

* 1. Are you the physical activity lead for the PCT?

- Yes
- No (If no, please ensure this questionnaire is now completed by the person who has lead responsibility in your PCT for the commissioning of physical activity services)

* 2. Please select your PCT

3. Please select your job title

- Associate Director
- Commissioning Manager
- Consultant in Public Health
- Director/Associate Director of Health Improvement / Health Promotion
- Health Improvement / Health Promotion Manager / Principal
- Health Improvement/ Health Promotion Specialist
- Public Health Manager
- Public Health Specialist
- Other (please specify)

2.

Physical activity audit in the North West

4. As the physical activity lead, how many days of your time are allocated to physical activity?

- Up to 1 day per week
- over 1 but less than 2 days per week
- over 2, but less than 3 days per week
- over 3, but less than 4 days per week
- over 4, but less than or equal to 5 days per week

5. What other areas do you work on?

- Obesity
- Cardiovascular disease
- Healthy eating/nutrition
- Alcohol
- Sexual health
- Workplace
- Schools/healthy schools
- Other (please specify)

6. Is there anyone else in your PCT who supports work on physical activity ?

- No
- Yes

If yes please specify

7. Do you oversee any staff who work on physical activity?

- Yes
- No

If yes, please state how many whole-time equivalents and their job titles in the box below

Physical activity audit in the North West

8. Which local area agreement targets is your PCT working towards?

- NI 8 adult participation in sport and active recreation
- NI 55 Children in Reception Year: overweight and obesity levels
- NI 56 Children in Year 6: Overweight and obesity levels
- NI 57 Children and young people's participation in PE and sport
- NI 110 Young people's participation in positive activities
- NI 175 Access to services and facilities by public transport, walking and cycling
- NI 186 Per capita reduction in CO2 emissions
- NI 198 Mode of travel to school
- Other - please specify

9. Which other targets in relation to physical activity are you working towards?

- Legacy Action Plan target - 2 million more active
- Local targets
- Vital signs (if yes, which ones?)

10. Where is Physical Activity considered within your LSP ?

- PA is a key priority within a thematic group
- PA is discussed within a subgroup of a thematic group
- Other/ Additional comments

Physical activity audit in the North West

11. Who from the PCT sits on the Sport and Physical Activity Alliances (SPAA)?

	Chair	Member
PCT Director of public health	<input type="radio"/>	<input type="radio"/>
Public Health Consultant	<input type="radio"/>	<input type="radio"/>
Public Health Specialist	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

(Please specify)

3.

12. Did your PCT have a budget for physical activity in the last financial year, 2009/2010?

- No
 Yes

If yes, Please state how much this budget was for 2009/10

13. Has your PCT allocated a budget for physical activity in the current financial year, 2010/2011?

- No
 Yes

If yes, please state how much this budget will be

14. Does your PCT currently jointly fund physical activity programmes with other agencies, organisations or individuals?

- No (go to Q16)
 Yes (go to Q15)

15. If 'yes' please state:

1. Name of the programme	<input type="text"/>
Other funding agencies	<input type="text"/>
Total budget allocated to the programme	<input type="text"/>
2. Name of the programme	<input type="text"/>
Other funding agencies	<input type="text"/>
Total budget allocated to the programme	<input type="text"/>
3. Name of the programme	<input type="text"/>
Other funding agencies	<input type="text"/>
Total budget allocated to the programme	<input type="text"/>

4.

16. Of the total budget identified in the previous questions, what percentage is spent on -

Staff Costs (including overheads)

Interventions or projects

Evaluation

17. What if anything has influenced the budget allocated to physical activity by the PCT?

18. Has your PCT secured any non-NHS funding for physical activity for this financial year, 2010/2011?

No

Yes

If yes - please state the purpose/source/amount/period of time for non-NHS funding received for physical activity

Physical activity audit in the North West

19. Has your PCT

a) produced any of the following plans or documents in the last two years?

b) and do they refer to physical activity?

	a) produced?	b) refer to physical activity?
2012 Plans (Olympics/Legacy Action Plan)	<input type="checkbox"/>	<input type="checkbox"/>
Adult Obesity Strategy/Plan	<input type="checkbox"/>	<input type="checkbox"/>
Carbon Reduction Plan	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular Disease Prevention Strategy/Plan	<input type="checkbox"/>	<input type="checkbox"/>
Childhood Obesity Strategy/Plan	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Prevention Strategy/Plan	<input type="checkbox"/>	<input type="checkbox"/>
Falls Prevention Strategy/Plan	<input type="checkbox"/>	<input type="checkbox"/>
Local Operating Plan	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Strategy/Plan	<input type="checkbox"/>	<input type="checkbox"/>
National Indicator 8 Plan	<input type="checkbox"/>	<input type="checkbox"/>
NHS Health and Wellbeing Plan	<input type="checkbox"/>	<input type="checkbox"/>
PCT Travel Plan	<input type="checkbox"/>	<input type="checkbox"/>
Physical Activity Strategy/Plan	<input type="checkbox"/>	<input type="checkbox"/>
Sustainable Communities Strategy	<input type="checkbox"/>	<input type="checkbox"/>
Workplace Health Strategy/Plan	<input type="checkbox"/>	<input type="checkbox"/>
World Class Commissioning Plan	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Other - please specify

5.

20. If your PCT has not produced a physical activity strategy/plan what is the main reason?

- We just haven't got around to it yet
- There are too many other areas to work on
- We don't have the staff
- It is included in other policies
- It is not a high enough priority
- There is not enough evidence of what works
- Other - please specify

21. Has your PCT helped to develop or influence the physical activity component of the following local policies or local strategies? If yes, please select

- Children's Play Strategy / Early Years Strategy
- Community Strategy
- Cycling Strategy
- Healthy Schools
- Leisure and Recreation
- Local Development Framework (planning)
- Local Transport Plan 3
- Parks, Forests and Green spaces
- School Travel
- Walking Strategy
- Other - please specify

Physical activity audit in the North West

22. Is the PCT involved in providing or commissioning physical activity services through any of the following? If yes, please select

- Active travel promotion
- Children's Physical Activity programmes
- Cycling promotion
- NHS Cycle to work guarantee
- Exercise referral schemes
- Falls Prevention Service
- Free swimming
- Green / blue gym
- Health trainers' promotion of physical activity
- NHS Health Checks
- Obesity programmes/interventions
- Other referral from primary care (including to counselling services)
- Programmes with professional sports clubs
- Sport outreach
- Walking the way to health/led walks
- Other - please specify

6.

23. Who are your key partner agencies for the delivery of the physical activity project(s) above?

- County Sports partnerships
- Local Authorities
- Private sector
- Sport & Physical Activity Alliances
- Voluntary sector
- Don't know

24. Who are the key priority groups for the physical activity interventions that your PCT commissions/delivers? Please select a maximum of three.

- Sedentary adults
- Sedentary children
- Overweight/obese adults
- Overweight/obese children
- People with Diabetes
- People diagnosed with CVD
- People at high risk of CVD
- People at risk of falls
- People at risk of mental health problems
- Don't know
- Other - please specify

25. How do you evaluate the physical activity projects that are commissioned/delivered?

- In-house evaluation (conducted by the PCT)
- Commissioned (independent) evaluation
- Not evaluated
- Don't know
- Other - please specify

26. What action is being taken to reduce health inequalities in physical activity provision in your PCT area?

- Interventions are targeted at specific localities using indices of deprivation
- Targeting using the Promoting Activity Toolkit
- Targeting specific population groups in the area
- Other (please specify)

7.

27. Is your PCT currently using the 'Let's Get Moving' physical activity care pathway?

- Yes
- Don't know
- No

28. If your PCT is *not* currently using the 'Let's Get Moving' physical activity care pathway, does it intend to?

- Yes
- No
- Don't know

29. Do you have staff trained in delivering motivational interviewing interventions?

- Yes
- No

30. Do you have staff able to deliver module 1 of the 'Let's Get Moving' training?

- Yes
- No

31. Do you have staff able to deliver module 2 of the 'Let's Get Moving' training?

- Yes
- No

8.

32. Have you used the Standard Evaluation Framework published by the National Obesity Observatory?

- Yes
- No
- Don't know

33. Do your PCT's physical activity programmes monitor long-term behaviour change?

- Yes
- No
- Don't know

**34. What do you see as the main policy issues that drive the commissioning of physical activity within your PCT?
(Please Choose the top three)**

- Reducing health inequalities
- Reducing/preventing obesity in general
- Reducing/preventing childhood obesity
- Preventing cardiovascular disease
- Improving mental health
- Improving social cohesion/social capital
- Physical inactivity/sedentary behaviour
- London 2012
- Other - please specify

35. What data do you use to inform strategic planning?

- Active People Survey data
- Facility mapping
- Green Space Infrastructure mapping
- Health Profiles data
- Market segmentation data
- Multiple data mapping
- National Childhood Measurement Programme data
- Other - please specify

9.

36. What type of evidence do you generally use to inform the development of physical activity interventions?

- NICE intervention guidance (brief interventions; exercise referral; pedometers and walking/cycling)
- NICE programme guidance (physical activity and the environment)
- NICE children and young people guidance
- Cochrane reviews
- Individual research studies and evaluations
- Other - please specify

37. Where there is little or no evidence of effectiveness on a specific physical activity intervention, do you?

- Not commission and wait for evidence
- Commission a study to provide the evidence of effectiveness
- Commission the intervention anyway
- Other (please specify)

38. What are the main evidence gaps that affect the commissioning of physical activity services across your PCT? Please select all that apply.

- Lack of evidence of effectiveness of interventions
- Lack of evidence on long term health benefits
- Lack of evidence of long-term impact on behaviour
- Lack of evidence on cost effectiveness
- Don't know
- Other - please specify

39. What would help your PCT increase the commissioning of physical activity services?

10.

40. Do any of your GP Practices routinely screen their patients using the General Practice Physical activity questionnaire (GGPAQ) ?

- Yes all do
- Most do
- Some do
- None do
- Don't know

41. Are you linking physical activity work to Change4Life?

- Yes
- No
- Don't know

Please provide examples

42. What aspects of the regional structure do you find useful?

43. How could the region support you better?

44. Are there any other issues in relation to the commissioning or provision of physical activity that you would like to raise?

