PHYSICAL ACTIVITY PROVISION
IN THE EAST MIDLANDS REGION:
AN AUDIT

Commissioned by:
Department of Health East Midlands

Final Version

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Executive summary

• This report was commissioned by the Directorate of Public Health East Midlands 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 stimulate future action.

• The audit objectives were:
  o To review available strategic documents
  o To conduct an online audit of PCTs and partners
  o To conduct interviews with PCT physical activity leads
  o To compare current provision against need and make recommendations for future investment and delivery
  o To produce a template for a business case that PCTs and their partners can use to advocate for future investment needs.
  o To review available data to assess progress towards nationally agreed indicators and targets.

• The review found that the promotion of physical activity does not seem to have a high priority within delivery agencies in the region, especially within Primary Care Trusts. It has a relatively low status in strategic documents, and is allocated a relatively low level of financial and human resources compared to other lifestyle behaviours.

• There are no full-time physical activity leads in PCTs, as postholders only spend on average one day a week on the topic. These physical activity leads have few if any staff, and control small budgets.

• Physical inactivity is estimated to cost £17 per person across the region, but PCTs are investing only just over £1 per head in promotion of physical activity.

• PCTs do appear to be engaging with strategic partners on a wide range of issues linked to physical activity, including leisure, recreation, education and transport. Key to this are the county/city sport and physical activity partnerships, which provide a focus for action, and tend to have higher levels of staffing and budgets than PCTs.

• London 2012 does not appear to be a driver for action: none of the strategic documents mentioned the Olympics, and in discussion few physical activity leads referred to the Legacy Action Plan.

• There is an inconsistent approach taken to indicators such as NI8, and a need for more firm and consistent indicators. It appears that in 5 or 6 PCTs in the region, the NI8 target for physical activity will not be reached by 2012.

• It is encouraging that the vast majority of PCTs in the region are intending to implement the Let’s Get Moving care pathway. This should be seen to be a major priority, as it is specifically mentioned in the NHS Operating Plan for 2010-11.
**Recommendations**

1. PCTs in the Region should be urged to give a far greater priority to the promotion of physical activity as an independent lifestyle behaviour within their commissioning plans and establish formal commissioning arrangements across physical activity partnerships.

2. 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.

3. Efforts should be made to ‘make the case’ for physical activity to the PCT executive team, supported by the Region, to ensure that the broader role of physical activity in achieving the PCT’s long term strategic priorities in relation to both prevention and treatment, is acknowledged.

4. Partnership strategies on physical activity should be in place across each PCT, with clear links between the plans of City and County Physical Activity partnerships.

5. Implementing *Let’s Get Moving* 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.

6. Physical activity leads within PCTs should increase their focus on working to influence other policy areas, by emphasising the multifaceted role of physical activity in achieving multiple agendas and embed it within service provision. Examples include: NHS health checks; use of the General Practice physical activity questionnaire within primary care; weight management services; other lifestyle issues such as smoking cessation.

7. Physical activity leads in PCTs should review their sole focus on achieving NI8, and also advocate for a new Tier 1 or 2 Vital Sign for physical activity against which the PCT should be managed.

8. The evaluation component of programme should be prioritised to ensure evidence of impact and outcomes can be demonstrated. The Standard Evaluation Framework for weight management interventions should also be applied to physical activity interventions across the region.

9. National evidence in the form of NICE guidance and Cochrane reviews should be used to inform the development of the physical activity programmes, especially in light of the financial constraints.
Acknowledgements

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

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

Cathy Mulhall (SEPHO) designed the online questionnaire and analysed the data.

We would like to thank Sarah Quilty (nee Bowles) from Directorate of Public Health East Midlands for commissioning this report, and for her help throughout the research process. We would also like to thank all the respondents to the survey and interviewees 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.”

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 week. Over 60% of adults in England do not reach this level of activity.

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 East Midlands region as a whole, activity levels are similar to the national average: 21.6% are classed as active in the East Midlands compared to 21.3% nationally. However within the East Midlands there are large variations in activity levels with many districts well below the national and regional average. There is a great wealth of physical activity opportunities taking place in the region however it is unsure how many new initiatives/provision would be needed in order for achieve the increase in the numbers required to access physical activity opportunities.

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 East Midlands 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.
2. Aims and objectives of the audit

Aim
To audit the current provision of physical activity services in the East Midlands Region, in order to make recommendations for maximising impact.

Objectives
The original objectives for the project were adapted due to the availability of local data. Revised objectives are summarised below:

- To review available strategic documents to assess commitment to physical activity promotion within develop a methodology for a needs assessment, which can be applied to PCTs and local partnerships.
- To conduct an audit of PCTs and partners to assess the investment, partnership buy-in, strategic planning, levels of service provision, levels of evidence based practice/evaluated practice, workforce capacity and capability, for physical activity.
- To conduct interviews with PCT physical activity leads to enrich the data from the audit.
- For each local partnership compare current provision against need and make recommendations for future investment and delivery, including work force plans, and where new national initiatives should take place.
- Produce a template for a Business Case that PCTs and their partners can use to advocate for future investment needs.
- To review available data to assess progress towards nationally agreed indicators and targets.
3. **Review of Strategic Documents**

This section outlines the work done to review key strategic documents on physical activity in the region. This was done to understand the stated commitment to the topic, before investigating the issue in more detail with frontline staff.

**PCTs/NHS**

**Strategic Commissioning Plans**

All PCTs are required to produce strategic commissioning plans, and with the advent of the World Class Commissioning (WCC) programme in 2008 there is a clear need for PCTs to monitor their performance against the WCC competencies. Some PCTs have responded with the development of ‘World Class Commissioning Plans’ whilst others have incorporated the progression through these competencies within existing strategies.

**Local Operating Plans (LOPs)**

These are mandatory, and are the more detailed plans in which PCTs set out how the priorities defined in their strategic plans are reflected in operational projects.

The 2010/11 LOP represents the final year of the three year national LOP cycle.

**Links to Physical Activity**

There is no mandatory requirement for PCTs to invest in physical activity provision or to set targets for increasing levels of physical activity within their population. However, it is likely that many PCTs will respond to the evidence for the benefits of physical activity and drivers such as increasing obesity and show support to the achievement of National Indicator 8, by establishing programmes or projects in their localities. These should be reflected in the PCTs strategic plans and local operating plans.

**County/City Sport and Physical Activity Partnership Strategies/Plans**

These plans represent the key priorities of the local partnership for the delivery of physical activity and sport, based on the needs of their local populations and the achievement of key targets including the Legacy Action Plan and National Indicator 8. In many cases the plans have developed in partnership with a range of relevant agencies.

**Methods**

A request for PCT strategic commissioning plans, LOPs for 09/10 and 10/11 and city/county sport and physical activity partnership strategies was made at the start of this review.

However, the PCT commissioning plans, the LOPs for 10/11 and some of the City/County Sport and Physical Activity Partnership strategies proved difficult to access in the timeframe for this report. Given this, where the commissioning strategy was not readily
available the search was extended to the PCTs core strategy and the LOPs for 09/10 were taken as the ‘direction of travel’ for PCTs in relation to physical activity. The available city/county physical activity partnership plans were reviewed, although these had varied timelines for their implementation and one required updating. For the partnership with no strategy, other relevant strategies were considered.

Through a combination of information received from the regional lead, physical activity leads and website searches, the following plans were obtained:

- LOPs for 09/10 for all 9 PCTs;
- LOP for 10/11 for 2 PCTs
- Strategic plans for 7 of the PCTs. Two of these were specific to commissioning: 1 World Class Commissioning Plan (09-14) and 1 Commissioning and Investment Strategy (08-13); five were broader Strategic documents: PCTs 5-year strategic plans (09-14).

In addition, 7 city/county sport and physical activity partnership plans were obtained: 1 covering 08-11; 1 covering 08-12; 3 covering 09-13; 1 covering 09-20 and 1 covering 05-10 (which is now considered out of date). A ‘Be Active, Be Healthy Briefing Paper’ was also considered for 1 partnership as their strategy was in a draft format. For 1 partnership with no overarching strategy their on-line strategic framework for physical activity, NI8 Action plan (08-11) and Healthy Weight Strategy (09-11) were considered, where appropriate.

The PCT Local Operating Plans and Strategic plans along with the city/county physical activity partnership strategies were reviewed in detail. The main aim of this analysis was to establish the priority that each PCT and partnership had established for the commissioning of physical activity within its published plans.

The PCT plans were reviewed for the following:

- whether physical activity was an independent priority;
- references made to physical activity compared to other lifestyle behaviours;
- details of specific physical activity initiatives;

The Physical Activity Partnership Strategies were reviewed for the following:

- The prioritisation and focus on physical activity
- Partnership working with the PCT and other organisations

Results

PCT Strategic Plans and Local Operating Plans

The Prioritisation of Physical Activity

The prioritisation of physical activity within PCT operational and strategic plans was considered for each of the plans, as detailed in Figure 1:
Physical Activity was identified as an independent priority within just one Local Operating Plan (LOP) for 09/10; however it is unclear where physical activity sits within the broader strategic framework for this PCT as the strategic plans were not available. Physical activity was not considered an independent priority within any of the remaining plans.

In 6 out of 7 of the Strategic Plans, 5 out of 9 of the LOPs for 09/10 and 1 out of 2 of the LOPs for 10/11, physical activity was most frequently referenced as a mechanism to achieve a range of agendas including in some instances, obesity alongside other agendas, for example, cardiovascular disease, cardio-pulmonary disease and falls prevention. Physical activity was referenced as a priority alongside obesity/diet in 1 strategic plan, 2 LOPs (09/10) and 1 LOP for 10/11.

One PCT did not reference physical activity in the LOP. However, in discussion the PCT lead stated that physical activity was aligned to the obesity work and ‘a formal recommendation for 10/11 [had been made] for the inclusion of physical activity and objectives to show support for the work led through the sport and physical activity partnerships with respect to Nl8’.

Across the 7 strategic plans and corresponding LOPs the prioritisation of physical activity is the same, with the exception of 1 PCT where physical activity is referenced as working to achieve multiple agendas in the strategic plan, but specifically prioritised alongside diet within the LOP for 09/10.

LOPs are the ‘delivery’ plans of the PCTs broader strategic plans, which often span across a number of years. The prioritisation of physical activity within the strategic plans is therefore 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, where
this exists from local and national evaluation, in a bid to maintain, increase or re-invest in this area.

**Comparison of Lifestyle Behaviours**

The total number of times that a range of lifestyle behaviours were mentioned in the 7 strategic plans, all 9 LOPs for 09/10 and 2 LOPs for 10/11 were counted and combined for each PCT. Simply mentioning a behaviour is clearly not a sign of commitment to an issue by the PCT, but it does give a rough idea of the importance attached to each topic.

**Figure 2**

![Median number of references made to each lifestyle behaviour within PCT Plans](image)

The median number of mentions for physical activity is 28 compared to 89 for smoking, 85 for alcohol, 27 for sexual health (including Chlamydia) and 4 for healthy eating/diet. Generally across the plans the links between physical activity in relation to the obesity agenda are made. As such, the references made to obesity/healthy weight have been reviewed. The median value for obesity was 72, which is still some way of the 89 references made to smoking, but higher than the number of references made to physical activity and the other lifestyle behaviours.
Types of Physical Activity Programmes

Through the Strategic plans and the LOPs, all 9 PCTs commission or support the development of physical activity programmes for both the prevention and management of a range of conditions across their local populations. However, within the plans, 2 of the PCTs clearly prioritise physical activity programmes aimed at prevention.

Detail in relation to specific physical activity interventions was included in 5 out of the 7 strategic plans; 6 of the LOPs 09/10 and the 2 LOPs for 10/11. Whilst the level of detail contained in the plans was varied, the five interventions most frequently referred too across the combined review of strategic plans and LOPs for each PCT are:

- exercise referral type programme (6 out of 9 PCTs);
- Health Trainers (5 PCTs);
- schools work on physical activity (including extended schools; healthy schools) (5 PCTs);
- falls prevention programmes (3 PCTs);
- walking/active transport (2 PCTs).

However, 8 out of 9 PCTs also made direct reference to physical activity in the development of care pathways and programmes to support obesity in children and families clearly showing the increased prioritisation of obesity against physical activity.

Within the 2 LOPs for 10/11 the prioritisation of physical activity had not changed, although there were changes to the referencing of specific physical activity programmes. Within 1 LOP the physical activity programme referenced changed from a general physical activity programme: free swimming to the development of care pathways and weight management services; showing once again a clearer steer towards the obesity agenda. Within the other LOP there was an expansion of the programmes referenced, to include, alongside other new programmes, the commissioning of the Let’s Get Moving physical activity care pathway.

This is the only reference made to Let’s Get Moving within all the plans reviewed. However, Let’s Get Moving was the only physical activity intervention to be specifically referenced in the NHS Operating Framework for 2010-11: the strategic document on which PCTs base their LOPs. Whilst it is not possible to comment on the content of all the 10/11 LOPs, the survey did indicate that the 8 PCTs who were not currently using Let’s Get Moving intended to do so in the future. It is, therefore, highly likely that this would be included as a new programme of work in the LOPs for 10/11.

Physical Activity Budgets

One PCT, whose strategic plan was not available, referred to a specific physical activity budget in their LOP 09/10. Whilst this was the only reference to a specific physical activity budget made in all the plans reviewed, 3 strategic plans refer to budgets for broader areas of work which physical activity contributes towards and 2 of the LOPs 09/10 referred to an overall allocation for health improvement with one stating that, ‘Physical
activity programmes will be evaluated during 2010/11 with the commissioning intention to invest further in 2011/12’.

2012 Olympics

None of the 7 strategic plans, 9 LOPs for 09/10 and 2 LOPs for 10/11 made any reference to the London 2012 Olympics.

County/City Sport and Physical Activity Partnerships Strategies

Focus of Partnership Plans

Out of the 7 partnership plans reviewed, 5 of these focused on physical activity alone and 2 focused on both physical activity and sport. The 1 partnership with no overarching strategy also focused on physical activity in the plans submitted.

The 5 plans which focused on physical activity alone had a greater number of physical activity specific priorities than was evident in those plans which also addressed sport and three of these had strong links and clear reporting lines to the PCT. One of these refers to the PCT Local Operating framework as a delivery mechanism for some of this work.

The 2 plans which focused on both sport and physical activity had a broader approach set within a predominantly sport dominated framework.

Comparison of terminology and focus

Six plans had the detail necessary for this comparison to be made: 4 focusing on physical activity and 2 focusing on physical activity and sport. There were also distinct differences in the number of mentions of ‘physical activity/exercise’, ‘health’, ‘sport’ and ‘London 2012’ depending on the focus of the plans. As for the PCT plans, simply mentioning a topic area is clearly not a sign of commitment to an issue, but it does give a rough idea of the importance attached to each of these, as shown in Figure 3 below:

Figure 3

Median number of 'mentions'

<table>
<thead>
<tr>
<th></th>
<th>Physical Activity focused plans</th>
<th>Sport and Physical Activity focused plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>London 2012</td>
<td>250</td>
<td>300</td>
</tr>
<tr>
<td>Sport</td>
<td>400</td>
<td>450</td>
</tr>
<tr>
<td>Health</td>
<td>150</td>
<td>200</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>
The physical activity focused plans mentioned ‘physical activity/exercise’ on more occasions than the combined sport and physical activity focused plans, with median values of 198.5 and 165.5 respectively. The physical activity focused plans mentioned ‘sport’ and London 2012 on fewer occasions, with median values of 129.5 and 0.5 respectively, than the sport and physical activity focused plans with a median value of 200.5 for mentions of ‘sport’ and a median value of 3 for mentions of ‘London 2012’.

All of the plans identified ‘Health’ as a key outcome; however in the physical activity specific plans there were a higher number of references made to ‘Health’ than in the Sport and Physical Activity focused strategies, with median values of 74 and 39 respectively. For 3 of the 5 physical activity focused plans, the links to health were explicit within the document: 2 of these referenced the LOP as a clear delivery mechanism for the strategies, 1 of which also listed the NHS as the lead organisation for the physical activity partnership plan.

Organisations listed as Partners within the Plans

All 7 partnerships referred to the Primary Care Trusts who cover their areas as key partners in the development of their plans. Four of these, including the partnership that submitted broader plans in relation to Healthy Weight and NI8, also referred to other ‘key partners’. Whilst the range of ‘other’ partners varied, all 4 partnerships referred to the County/City Council; and the Physical Activity/Sports Partnership for the City/Council as key partners in both the development and delivery of the plans.

One of the plans where key partners were not identified developed their plan to provide a strategic lead for leisure services and prioritise actions that they would deliver as requested by partner agencies. This is therefore a leisure driven and delivered plan and whilst the aim of the plan is to act upon local leisure priorities, the level of joint ownership of the plan and priorities is unclear.

Audit of Primary Care Trusts and Local Authorities

Methods: online surveys

Two questionnaires were developed: the first was aimed at physical activity coordinators in NHS Primary Care Trusts, and was developed in consultation with Department of Health East Midlands, based on a previous audit conducted in London.

A modified version of this questionnaire was then developed for City/County Sport and Physical Activity Partnerships.

Both questionnaires focused on the planning, commissioning, resourcing, implementation and evaluation of physical activity interventions across each area. Copies are in Appendix V and VI.

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 introductory email was sent to all designated Physical Activity leads in the 9 PCTs across the East Midlands Region. To maximise response the email was sent by the Physical Activity Lead for the region. A copy is in Appendix I. For the 3 Cities and the 5 County Sport and Physical Activity Partnerships (or their equivalent) the physical activity lead for the region discussed the audit with them individually.

An e-mail inviting the Physical Activity leads to complete the questionnaire was sent; initially to the PCT leads and then to the lead for the CSPAPs. Copies are in Appendix II and III.

One e-mail reminder was sent. In addition, some non-respondents were contacted by telephone in the final week of the survey, which boosted the response rate.

**Methods: semi-structured interviews**

Interviews were conducted with the Physical Activity lead for each of the 9 PCTs, once they had completed the online survey.

The interviews enabled additional information to be collected regarding the place of physical activity within broader PCT strategic plans and also provided an opportunity to follow up on queries that were raised through the online survey responses. The standardised introduction and discussion guide for the semi-structured interview is in Appendix IV.

Interview notes were sent back to the interviewee in each PCT for their approval.

Interviews were not conducted with the physical activity lead for the CSPAPs or Cities, although follow up telephone calls were conducted where clarification of survey responses was required.

**Response**

A 100% response rate was achieved for both surveys. For the City/County Sport and Physical Activity Partnership survey, 9 partnerships completed the survey, as two partnerships serving different purposes came to light into one of the areas.

This compares extremely well to a previous audit, which achieved a 84% response rate and a separate online survey of Directors of Public Health in England, conducted by Cycling England, which achieved a 49% response rate.³

A 100% response rate was achieved for the follow up interviews with each PCT, and approval of the interview notes was confirmed by 7 of the 9 PCTs.
4. **Results: Primary Care Trusts**

**Designated lead person with responsibility for physical activity**

All 9 PCTs currently have a designated lead person with responsibility for physical activity, although their overall job roles vary with 4 Health Improvement Principals, 3 Public Health Managers, 1 Public Health Specialist and 1 Health Improvement Team Manager.

All leads responded to say how much of their time is spent on physical activity as shown in Figure 4 below:

**Figure 4**

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 1 day per week. Seven of the PCTs predominantly work strategically on physical activity and 2 work both strategically and operationally.

In discussion, 7 out of the 9 leads stated that physical activity is not a priority area in its own right, but part of a broader area of work, predominantly obesity. However, even within obesity one PCT felt that it was increasingly difficult to prioritise as ‘… we are doing what we can, but there are not huge wins’. Only 2 of the leads identified physical activity as an independent priority for their PCT and one PCT felt that, *the strong partnership working had helped to maintain the momentum of the work and funding streams around physical activity*. 
The 2 PCTs where physical activity sits as a discrete area are the PCTs where the leads spend the most amount of time on physical activity; both spending over 3 but less than 4 days a week.

However, there appears to be real issues with capacity to work on physical activity, especially for 7 of the 9 PCTs, where physical activity sits as part of a broader agenda around obesity. Across these PCTs, the overall time spent on physical activity varies between 0.5 and 2.5 days a week, depending on the other areas covered by the lead. For example, the lead for ‘PCT 3’ works full time on Healthy Weight and as such half their time is spent on physical activity and half on nutrition and healthy eating programmes. This is compared to the lead for PCTs 8 and 9 who works full time across 2 PCTs on a range of issues including physical activity for 0.5 days/week each. In addition to this, one lead is new to physical activity and has been in post just 3 months and another lead is covering physical activity since the physical activity specialists left early 2010.

In discussion, none of these 7 PCT leads felt there would be any change to the amount of time allocated to physical activity, although one lead who works one day a week on physical activity felt that, ‘... this is not really enough time given all the work aligned to this agenda’. One suggestion was that the only way this would be increased was if there was a specific physical activity target which the PCT was performance managed against.

Additional PCT resource for Physical Activity

Six of the PCT physical activity leads do not oversee any staff that work on physical activity. The remaining three physical activity leads line manage 1 member of staff each: 1 full time and 1 worked 1 day a week across 2 PCTs. One of these posts is at risk due to possible budget cuts.

However, in discussion, there were other staff who were listed as supporting and/or monitoring the physical activity work through other broader agendas as follows:

- Public Health Development Manager
- Partnership Manager
- Head of Partnerships
- Public Health Consultant
- Strategist
- Public Health Specialists

It is clear that PCTs hold a predominantly strategic commissioning function in relation to physical activity, and as such there is now limited operational work driven through Public Health. Specialist Health Promotion Services who in the past have taken on a more operational role in relation to physical activity, no longer form part of the PCT and where they still exist, they now form part of provider services. As such, they would still be required to bid for any work commissioned out through the PCT. This Commissioning/Provider split was raised as something that directly impacted on the number of people working on physical activity at a PCT level. One PCT used to have a Physical Activity, Health Promotion Specialist, but when Health Promotion moved to provider services there was a re-focus to reflect strategic priorities and this dedicated health improvement physical activity post was lost. Another PCT had 2 dedicated
physical activity specialists, but these were not recruited into when the post holders left early 2010.

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 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.

Commissioning

Only one of the PCTs stated that they jointly commission physical activity services with the Local Authority.

In discussion there was some uncertainty over what constituted a joint commissioning arrangement. Seven out of the eight PCTs who did not feel that their PCT jointly commissions physical activity, identified funding arrangements between organisations but did not feel they constituted a formal joint commissioning arrangement. For example, three PCTs suggested that they work jointly with local authorities, but the PCT commissions and the Local Authority delivers. Two PCTs co-fund specific programmes and posts when it relates to priority areas, and whilst there is not a joint commissioning budget for physical activity, ‘...commissioning decisions are [still] considered jointly, but all funding comes from the PCT’. One PCT did not foresee any changes to the current system of commissioning physical activity. Although 1 PCT also said that they would like to move towards a ‘more formal joint commissioning arrangement with the Local Authority or County Sports Partnership’.

This lack of a formal joint commissioning arrangement, with a dedicated budget, could put some programmes at risk, especially if one or more of the funding agencies withdraws their funding. Indeed one PCT stated that although indicative funding was allocated to some programmes delivered through LA’s, these were at risk if a second wave of budget cuts was requested.
Targets

Seven out of nine PCTs state they are working towards a ‘physical activity target’, defined as shown in Figure 5 below:

Figure 5

All 7 of the PCTs working towards a physical activity target, refer to the Local Area Agreement targets (LAA), 6 of these referred to specific indicators: all 6 refer to National Indicator 8\(^1\) in relation to 16+ participation in sport and active recreation. However, 5 of these state their role as a contributory role towards this target, as this target is managed predominantly through the Local Authorities. Three PCTs referred specifically to National Indicator 55\(^2\) and National Indicator 56\(^3\) around childhood obesity, which they lead on.

For 4 of the 7 PCTs the Local Area Agreement targets are the only ‘physical activity target’ they are working towards. Out of the remaining three, in addition to the LAA targets, one lists ‘vital signs’ and two PCTs list the Legacy Action Plan (LAP) target of 2 million more active and ‘local targets’, as ‘physical activity’ targets which they are working towards. The 2 PCTs who list the LAP target state that the mechanism for this is the Active People Survey data which is the data also being used to show progress against NI8 the indicator of measure for LAA’s. Although 1 PCT stated, ‘.. there is an assumption that changes to the Active People Survey means programmes must be working, but we are really unclear which programmes are making the greatest contribution’.

1 NI8 is the percentage of the adult population (age 16 years and over) in a local area who participate in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks (equivalent to 30 minutes on 3 or more days a week). (ref)
2 Obesity in primary school age children in Reception
3 Obesity in primary school age children in Year 6
The two PCTs who do not have a specific target for physical activity do, however, state that they support the work of the Local Authorities in achieving NI8, but they don’t see this as a PCT target.

In discussion, it was clear that whilst 6 PCTs list NI8 as a target for physical activity to which they contribute, only 2 of these are aware of the numbers of people they would need to attract to their programmes, in order to impact on this target. In addition, one PCT is working on a gap analysis to look at how programmes are performing and where the gaps are in reaching the numbers needed for the NI8 target. Overall, there needs to be a more focused approach by all partner agencies, including PCTs to understand the numbers they need to attract to their programmes in order to impact on NI8.

One PCT referred to Vital Signs as a ‘physical activity target’, although, there is currently no Vital Signs target in relation to physical activity, only broader targets of which physical activity plays a contributory role.

However, a target specifically on physical activity is something that 7 PCTs feel would be beneficial, as it would help to increase the profile of physical activity and help to secure senior level buy-in. A lack of a target can be interpreted as ‘non-essential’ work. However, the two remaining respondents suggested that ‘a physical activity target for PCTs would not help as lots of the physical activity work [around prevention] sits outside the NHS’. They did not feel that the PCT should be taking a lead in this area as, ‘physical activity programmes should be in place before they [people] reach the NHS’.

Overall it appears that without a physical activity target for PCTs, this will never receive the same priority as other areas of Public Health with a target, like smoking and alcohol. One PCT suggested that in terms of targets which hold the greatest weight, ‘Vital Signs’ are the main priority for PCTs, as they link directly to the requirements set out in the NHS operating plan. Given this it would seem an ideal place for a physical activity target to sit, although it was emphasised by 1 PCT that this must be at Tier 1 and Tier 2 level, as these require PCTs to report back progress. However, this would need to be 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 this new target is not seen as purely a PCT target.

**Budgets**

Eight out of the nine PCTs identified a budget for physical activity in 09/10 and all nine PCTs identified a budget for physical activity in 10/11. Five PCTs had also secured non-NHS funding for physical activity for 10/11, from the following sources:

- Football League
- Sport England
- Local Authority
- Exercise Referral (3 responses)
- LAA
- Local Authority
- Department for Transport
PCT budgets and costs per head calculations have been made based on mid-2008 population totals (ONS), as indicated in Table I below:

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

<table>
<thead>
<tr>
<th>PCT</th>
<th>Pop (1000)</th>
<th>2009-10 proposed budget £000</th>
<th>2010-11 proposed budget £000</th>
<th>2010-11 best case budget** per head £000</th>
<th>2009-10 best case budget per head £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>685.10</td>
<td>832</td>
<td>810</td>
<td>810</td>
<td>£1.21</td>
</tr>
<tr>
<td>2</td>
<td>685.00</td>
<td>450</td>
<td>450</td>
<td>450</td>
<td>£0.66</td>
</tr>
<tr>
<td>3</td>
<td>294.70</td>
<td>285</td>
<td>600</td>
<td>600</td>
<td>£0.97</td>
</tr>
<tr>
<td>4</td>
<td>727.90</td>
<td>700</td>
<td>560</td>
<td>560</td>
<td>£0.96</td>
</tr>
<tr>
<td>5</td>
<td>292.40</td>
<td>403</td>
<td>388</td>
<td>388</td>
<td>£1.38</td>
</tr>
<tr>
<td>6</td>
<td>239.20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£0.00</td>
</tr>
<tr>
<td>7</td>
<td>699.80</td>
<td>1824</td>
<td>1900</td>
<td>1900</td>
<td>£2.61</td>
</tr>
<tr>
<td>8</td>
<td>664.20</td>
<td>165</td>
<td>0</td>
<td>165</td>
<td>£0.25</td>
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<tr>
<td>9</td>
<td>112.20</td>
<td>20</td>
<td>0</td>
<td>20</td>
<td>£0.18</td>
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<tr>
<td>Total</td>
<td>4,400.50</td>
<td>4,679.00</td>
<td>4,708.00</td>
<td>4,893.00</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td></td>
<td>519.89</td>
<td>523.11</td>
<td>543.67</td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td></td>
<td>403.00</td>
<td>450.00</td>
<td>450.00</td>
<td></td>
</tr>
</tbody>
</table>

* PCTs 3 and 4 identified joint budgets for physical activity and nutrition. This analysis assumes 50% of the joint budget for PCT 3 and 70% of the joint budget for PCT 4 allocated to physical activity.

** assuming all PCTs either keep the same budget for physical activity as previous year or have the budget agreed, as stated in the 2010/11 intentions

Based on these figures, in 2009/10, an estimated £4.67 million was spent on physical activity across the East Midlands region. The figure for 10/11 is slightly higher, estimated at just over £4.7 million across 7 PCTs with a ‘best case scenario’ figure of approximately £4.9 million. These figures represent commissioning intentions rather than confirmed budget. However, based on these figures, the median spend in 2009/2010 is £403,000 per PCT and predicted median spend, based on the confirmation of spending intentions, as stipulated in the ‘best case scenario’ is £450,000 per PCT, in 2010/11. This equates to £1.06 spent per head on physical activity across the Region for 09/10, with a higher value of £1.11 per head allocated on physical activity across the Region for 10/11 based on the ‘best case scenario’.

To put this into context, Allender et al 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). As such the £1.06 investment per head in physical activity across the East Midlands region for 09/10 falls substantially short of this. Even when the wide variance across PCTs is taken into account, the median investment on physical activity is still only £1.54 (09/10) and estimated median for 2010/11, based on the ‘best case scenario’ is £0.77 (10/11).
This should, however, be interpreted cautiously as it is based on estimated budgets and total population figures (2008), rather than targeted populations.

In discussion, for 09/10, PCTs 4 and 5 stated that the figures provided represented the budget specifically aligned to discrete physical activity initiatives in place, but it did not include budget aligned to broader programmes of work, where physical activity is one element. As such the total PCT expenditure on physical activity is likely to be higher. However, whilst the ‘best case scenario’ figure for 2010-11, shows an increase in overall budget, 7 of the 9 PCTs anticipated that the confirmed budget would be much lower than the 2010-11 intention, on the cost savings that PCTs are being asked to make across all services, including Public Health, over the 10-11 financial year and also through re-directing budgets where programmes are not demonstrating their effectiveness. ‘Some small [physical activity] programmes have been funded by the PCT for a long time but there is limited evaluation in place and as budgets are tighter, it’s likely that their funding will be withdrawn’. However, it was made clear that de-commissioning occurs because of a lack of evidence of effectiveness rather than not valuing physical activity.

One PCT lead felt it was not necessarily just about the amount of budget available on Physical Activity, but how that money is being spent, ‘I don’t feel it (physical activity) needs more money, but we do need an audit of how money is being used and re-direct resources if required’

Another PCT lead said that, ‘Some key programmes do not require budgets – some are around ensuring quality standards, so it is not all about money available, it’s about complete resources’.

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. Certainly, one PCT invests more into other areas of Health Improvement that ‘fix’ people, for example, Chlamydia screening, falls, alcohol, smoking and felt that ‘people [senior PCT managers] are not convinced that obesity work [which includes physical activity] will make a difference as elements are out of the PCTs control, ie design of local areas...

However, physical inactivity hits many agendas, not just health and PCTs on their own should not feel solely responsible for commissioning physical activity services. One PCT stated that, ‘... at times the PCT feels it ... is seen [purely] as a funding agency... [but it is more than that] ... it is about engaging partners, influencing etc’.

**Strategies and documents**

The strategic documents produced by PCTs and the inclusion of physical activity within these, are shown in Table II:
Table II: PCT strategies and references made to physical activity.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Number of PCTs produced plan</th>
<th>physical activity included in the plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Class Commissioning</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Local Operating Plan</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Physical Activity Strategy/Plan</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2012 Olympic/Legacy Plans</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>NI8 Plan</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Adult Obesity Strategy/Plan</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Childhood Obesity Strategy/Plan</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Cardiovascular Disease Prevention Strategy/Plan</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Diabetes Prevention Strategy/Plan</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Falls Prevention Strategy/Plan</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mental Health Strategy/Plan</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Workplace Health Strategy/Plan</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>PCT Travel Plans</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

No ‘Other’ plans were identified. One PCT said that all strategies produced are joint strategies with the City Council and other partners. A further 2 of the PCTs stated that some of the documents listed were joint documents produced in partnership with the Local Authority. The leads suggested that all the plans produced included physical activity, with the exception of 2 World Class Commissioning, 1 Local Operating Plan, and 1 Workplace Health Plan. However, whilst the responses stated that 7 PCTs produced WCC plans, these are not always discrete plans, but embedded within broader strategic plans. Out of the 7 broader plans reviewed, only 1 referred to physical activity as an independent priority.

4 PCTs stated they had a Physical Activity Strategy. In discussion all added that these were joint strategies with either the LA and or County/City Sports Partnership, which they had contributed towards. In addition 1 PCT was currently involved in the development of a joint physical activity strategy.

The 4 PCTs who had not produced a physical activity strategy gave the following reasons:

- 3 PCTs said that Physical activity is included in other broader policies (2 in obesity and 1 in CVD prevention plan)
- 1 PCT said that physical activity was not a priority and whilst the PCT has previously worked to the partnership strategy this is now out of date.
One of the PCTs where physical activity was included within CVD prevention rather than a discrete strategy also added that they do also have the City sport and leisure services strategy and ‘all physical activity programmes go ahead anyway’. They also added that there is a mis-perception that there is nothing happening on physical activity as there is no overarching strategy. However, whilst they felt that there may be some resistance to developing a PCT physical activity strategy due to the time that this would take and its inclusion in other PCT documents, the PCT acknowledged that a joint physical activity strategy would help to bring all their work together in a co-ordinated way.

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, especially for those PCTs who do not currently have an overarching physical activity strategy. However, this does not replace the benefits that can be gained through an overarching physical activity strategy to ensure the co-ordination and continuation of physical activity programmes especially in times of financial pressures.

**PCT input on Physical Activity into Broader Strategies**

PCTs provided physical activity input into a range of strategies, led by their partner agencies, as listed below:

- All 9 PCTs provided input into ‘Healthy Schools Policy’
- 6 PCTs provided input into the ‘Community Strategy’
- 6 PCTs provided input into the ‘Local Transport Plan’
- 4 PCTs provided input into the ‘Local Development Framework (planning)’
- 4 PCTs provided input into ‘Leisure and Recreation Strategy’
- 3 PCTs provided input into the ‘Children’s Play Strategy’
- 1 PCT provided input into ‘School Travel Policy’
- 1 PCT provided input into the ‘Walking Strategy’

Input provided into ‘other’ strategies was as follows:

- Children’s PE Strategy and other policies and strategies in relation to children and young people
- Community strategies at tier 1 and tier 2 level

One PCT said that whilst they were asked to input into partner strategies they were rarely asked to input into broader PCT strategies, possibly reflecting the priority and awareness of the important role that physical activity has in the broader health agenda and the achievement of broader targets.
Data used to inform strategic planning

There is a range of data used to inform strategic planning of physical activity across PCTs, as shown in Figure 6 below:

Figure 6

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

Health Profile data is used by 8 PCTs to ensure programmes help to tackle health inequalities and the use of market segmentation data by 7 PCTs supports this.

Local research, in the form of lifestyle surveys, also informs the planning of interventions for 2 PCTs.

The Active People Survey (APS) is still acknowledged as the only measure for Physical Activity and one which measures progress for the LAAs. This is despite 2 PCTs identifying their dissatisfaction with the APS, due to the data collection methodology and the lack of inclusion of active travel and other everyday activities.

Commissioning/Delivery of Physical Activity services

Eight out of 9 PCTs said that they provide or commission physical activity services in their local areas. The range of programmes they commission are shown in Figure 7:
The most popular interventions are Obesity interventions and Health Trainers promotion of physical activity. Exercise referral schemes are another popular intervention along with walking programmes, both commissioned by 7 of the PCTs. Cycling programmes are commissioned by 4 of the PCTs with 2 PCTs specifically commissioning Active travel promotion.

Three PCTs commission ‘other referral from primary care’ (including to counselling services) for physical activity; Falls Prevention Services; Sports Outreach and Free swimming with 2 PCTs commissioning green/blue gym programmes.

‘Other’ included:
• Inclusive Fitness Initiative accessibility accreditation scheme
• Wheelchair sports
• Run in England
• Physical activity as part of a lifestyle service
• Physical Activity campaign
• Health referral
• Jogging Promotion
• Phase IV Cardiac rehabilitation

In discussion, those PCTs who stated they support ‘free swimming’ added that while this is offered through Local Authorities and funded through central government, the funds are not always sufficient to cover the total costs and ‘top up’ funding is provided by the PCT.
Seven of the PCTs stated that some of these programmes were at risk in 2010/11 due to financial pressures. Those interventions which were new and those were evidence was lacking were considered to be more at risk.

It is not surprising that ‘obesity interventions’ are commissioned by 8 of the 9 PCTs as at a strategic level, physical activity sits under the heading of obesity for 7 of these and obesity is also the most commonly stated ‘driver’ for the commissioning of physical activity services.

Health Trainers also initially received separate funding and whilst the ideal scenario is for Health trainers to address all health issues, this is often not the case and it is therefore promising that physical activity is being discussed.

It is interesting that exercise referral schemes and healthwalks have been commissioned across 7 PCTs. Although the Dept of Health continues to support such schemes, NICE guidance recommended commissioning exercise referral and healthwalks schemes only when they form part of a controlled research trial. Exercise referral type programmes are also the most frequently mentioned intervention in the analysis of PCTs strategic plans and LOPs. PCTs should, therefore, be encouraged to review the programmes in place and ensure stringent monitoring and evaluation is in place.

Only 1 PCT is currently using the Lets Get Moving physical activity care pathway, although the remaining 8 PCTs intend to use this in the future.

8 out of 9 PCTs are linking into the Change4Life programme in relation to physical activity.

**Target audiences**

These physical activity programmes are aimed at the following key target audiences:

- Sedentary adults (8/9 PCTs)
- Sedentary children (7/9 PCTs)
- Overweight/obese children (7/9 PCTs)
- Overweight/obese adults (6/9 PCTs)
- People at high risk of CVD (5/9 PCTs)
- People diagnosed with CVD (1/9 PCTs)
- People at risk of mental health problems (1/9 PCTs)

Sedentary adults are the most frequently cited target group across PCTs in the region, despite Physical Activity predominantly sitting within the obesity agenda.

**Partner agencies**

PCTs identified a wide range of agencies as key partners for the delivery of physical activity programmes as follows:

- All PCTs identified the local authority and/or county council as a key partner.
- 7/9 PCTs identified County Sports and Physical Activity partnerships, or equivalent, as key partners
• 6/9 PCTs identified the voluntary sector as key partners
• 2/9 PCTs identified the private sector company as key partners
• 1/9 PCTs identified Practice based commissioning groups as key partners

Evaluation

PCTs use a range of methods to evaluate the physical activity projects that are commissioned or delivered as shown in Figure 8 below

**Figure 8**

*Methods used to evaluate Physical Activity interventions*

- Monitoring, eg, numbers taking part
- In-house Evaluation
- Commissioned Evaluation
- None

• 7 PCTs use ‘monitoring’ eg numbers taking part
• 5 PCTs use ‘in-house evaluation’
• 4 PCTs use ‘commissioned evaluation’
• 1 PCT does not commission any physical activity programmes.

In discussion, the main reason, cited by all PCTs, for the choice of evaluation methods was available budget or in some cases a ‘lack of budget assigned specifically to evaluation’. Whilst the precise budgets for evaluation was not clearly stated, further discussion identified the median spend across the 5 PCTs at approximately 10%. Whilst the median budget for the 5 PCTs is 10%, the variance is between 0-24%. Budgets that fall below 10% are below the amount ‘recommended’ for evaluation. The remaining 4 PCTs do not have a budget for evaluation although they do conduct evaluation ‘in-house’ but this is not specifically costed out.

1 PCT suggested their choice of evaluation method was also based on ‘historical ways of evaluating’. The 1 PCT who does not evaluate stated that this was simply because the PCT does not commission any physical activity programmes and therefore the onus for evaluation lies with the funding agencies.

4 PCTs said that they monitor long-term behaviour change in all the physical activity programmes that the trust commissions/delivers. 1 PCT is only monitoring long term
behaviour change in 1 programme, which has a specific budget attached to evaluation. 4 PCTs do not monitor long term behaviour change due to a lack of a designated budget. Whilst evaluation of physical activity programmes is in place, in most cases, there is, as indicated above, varied budgets for this, which is likely to impact on the quality of the evaluation which can be conducted. PCTs, however, stated that they need the evidence, short and long term, to maintain investment in this area and some PCTs are de-commissioning on the basis of a lack of evidence. One PCT said, ‘.. we want quick wins and what can help over a 12-month period’.

Use of Evidence

There is a range of evidence used by PCTs to inform their commissioning of physical activity interventions as shown in Figure 9 below:

Figure 9

It is interesting that so many PCTs use the NICE intervention guidance to inform the development of physical activity programmes, especially when 7 out of the 9 PCTs continue to fund exercise referral schemes and 5 out of the 9 fund walking programmes: both of these were only recommended by NICE if part of a ‘properly designed and controlled research study to determine effectiveness’.

A combination of survey responses and follow up discussion revealed a wide range of evidence gaps. The most frequent responses, cited by 8 out of the 9 PCTs, were ‘cost effectiveness of interventions’, specifically around reducing health inequalities, COPD, unscheduled care and CVD for 1 PCT and ‘clinical outcomes extending beyond public health for another PCT. ‘Long-term impact on behaviour’ was also mentioned by 8 of the 9 PCTs. Lack of evidence of effectiveness of interventions was also cited by 5 PCTs and lack of evidence on long term health benefits by 4 PCTs.
In the absence of available evidence, 5 out of 9 PCTs said they would ‘not commission and wait for evidence’; 3 out of 9 PCTs said they would ‘commission a study to provide the evidence’ and 1 PCT said they would ‘commission the intervention anyway’.

Further discussion identified that budget constraints and the increased need to be able to show the impact of a programme led to PCTs waiting for evidence to become available until they commission. This was especially the case for new programmes. 1 PCT identified that existing programmes would be under more scrutiny now in terms of being able to show that they are effective.

5 PCTs have used the Standard Evaluation Framework, published by the National Obesity Observatory. An additional 2 PCTs are placing this as a requirement in the new service specifications for weight management services.

**Influential Policy Issues in the commissioning of physical activity**

There are a range of policy issues influencing the commissioning of physical activity as shown in Figure 10:

**Figure 10**

All 9 PCTs identified ‘reducing/preventing obesity in general’ as a key policy issue, with 7 of these also citing ‘reducing/preventing childhood obesity’. 8 identified ‘preventing cardiovascular disease’; 7 identified ‘physical inactivity/sedentary behaviour’, 5 identified ‘reducing health inequalities’; 4 ‘improving mental health’; 1 ‘improving social cohesion/social capital’ and 1 ‘London 2012’.

‘Other’ policy issues were:
- Cardiovascular disease (treatment)
- Cardiopulmonary disease
- Cost effectiveness
• Equality and diversity

However, while all 9 PCTs identified ‘reducing/preventing obesity in general’ as a key policy issue which drives the commissioning of physical activity services in PCTs, only three PCTs referred to the obesity indicators (NI55 and NI56) as key targets to show progress in this area in relation to children and young people. This could be because NI55 and NI56 are not considered to be physical activity targets, but obesity targets. Only one PCT referred to London 2012 as a key policy issue yet three PCTs refer to this within their strategic plans or LOPs, also this may have not translated into a priority area.

**What would support PCTs to increase the commissioning of physical activity?**

• Increased evidence, eg, health economics data including cost effectiveness, long term impact
• Benchmark matrix for physical activity which requires progress to be measured
• Need to show impact or risk decommissioning. Executive teams want to see population level effects for limited investment
• Clear commissioning guidance for adults and children and young people
• A ‘change in culture’ in the leisure sector towards a more holistic approach, offering realistic activity choices across population groups
• A change in the perception of Primary Care regarding their role in the promotion of Physical Activity
• Quick impacts, within same financial year, and cost savings and short term goals
• National targets and ringfenced funding
• QoF targets for primary care around the identification and recording of patients physical activity.
• Impact of physical activity on clinical data, not just health gain, but impact on services on a short term basis (within a 12 month period) and a long term basis

**Additional Support**

**Nationally**

• Guidance on how to measure physical activity across specific interventions and modelling of physical activity.
• Guidance on assessment of unit costs of physical activity
• Health economics and cost effectiveness beyond QUALYs
• Cost savings and impact on broader PCT targets including acute services.
• Translation of risk levels into real monetary impacts, ie Physical Inactivity is an independent risk factor for CHD, what does this actually mean and over what period of time?
• International comparisons
• Welsh assembly work on exercise referral
• Adult weight management – commissioning guidance
• Modelling and return on investment

**Regionally**

• Guidance on use of KPI’s for physical activity
• Support on evaluation
• PCTs to inform agenda of regional meetings to ensure PCT ownership and key issues of concern are being addressed: 1 PCT doesn’t attend regional meetings as agenda too packed, suggest more workshops on key issues.
• National Policy updates and dissemination of tools/resources
• Evidence and sharing of good practice, policy updates
• Signposting for those new to physical activity
• PCT specific guidance
• Guidance on what should be commissioned based on evidence
• Critical friends
• Expert contact
• Apply pressure to Executive teams to work on physical activity
5. Results: County/City Sport and Physical Activity Partnerships

Designated physical activity lead

The survey was completed for all 9 partnerships by the ‘designated lead person with responsibility for physical activity’. However, in discussion it was suggested that for some partnerships there is not one lead, but leads for topics within physical activity and sport; where this was the case a judgement call was made by the chair of the partnership regarding the most appropriate person to complete the survey.

All ‘leads’ responded to say how much of their time is spent on physical activity with eight out of 9 stating that they spend ‘over 4, but less than or equal to 5 days’ per week on physical activity. One lead spends over 2 but less than 3 days per week on physical activity. All work at both a strategic and operational level, with the proportion of time allocated to each varying between 20-90% at a strategic level and between 10-80% at an operational level. However, 7 out of 9 Partnership leads spend more than 50% of their time working strategically, with the median for strategic working at 75%. This compares to only 2 partnership leads spending over 50% working at an operational level, with a median for operational work of just 25%.

There is much more of an operational role in relation to physical activity for the physical activity leads of the partnerships than was evident across the PCTs leads. However, this is not surprising as PCT leads who work in Public Health and Health Improvement cover a range of topic areas, and as such it is not feasible for them to have substantive operational roles in relation to one area. In addition to this, the structure and function of Public Health as mainly commissioning organisations reduces the likelihood of any capacity of PCT staff to work operationally.

Additional resource for physical activity

In 7 out of the 8 Partnerships who responded, the physical activity leads oversee staff who work on physical activity. Five of the seven specified the number of staff, which totalled 21 and their job titles which included: 7 people working specifically on exercise referral and 4 people working with older people to increase their activity patterns.

Time allocated to Physical Activity across the Partnership Board

Physical activity leads for four of the partnerships gave an indicative figure for the total time spent working on physical activity by all members of the partnership board of between 0.25 person days per week and 10 person days per week. The operational versus strategic split for this work was varied, with one partnership identifying that 100% of the work of the partnership is strategic, one partnership 80% strategic, 20% operational while the other 2 had a larger operational role of 80% compared to 20% strategic and 60% operational compared to 40% strategic.
In terms of the numbers of people who work across the entire partnership on physical activity, five leads responded with numbers ranging from 4 to 42. Job titles were widespread but can be divided (roughly) into:

- Physical Activity and Health Posts (including Exercise Referral)
- Sports Development
- Sport Specific Development Officer/Co-ordinator (including posts working with disabled people)
- Holiday/Event Co-ordination
- Volunteers
- Public Health and Health Improvement

The largest group represented, as indicated by the Partnerships, are those in ‘Physical Activity and Health’ posts, which includes both strategic and operational posts.

The Partnership Structure

Current Members

All 9 Partnerships responded through the survey and/or further discussion as shown in Figure 11 below:

![Figure 11](image)

All of the Partnerships identified Primary Care Trusts and Local Authorities as members of the physical activity partnership. In addition, National Governing Bodies and Voluntary/3rd sector organisations are also represented on 7 of the partnerships with Private/Commercial organisations represented on 5 of the partnerships.

‘Others’ listed were as follows:
Various departments within the county council, eg, Adult services, transport, education
School sports partnerships
Play England
Further/Higher Education
Sport England
National Parks
Schools
Sustrans
Dance4
Government Office
Police
Youth Offending Service
Locally Elected Councillors

No organisations have withdrawn from any of the partnerships.

**Reporting/Governance Structure**

Five of the Partnerships stated that they report to a senior board as indicated in Table III below:

**Table III: Reporting Lines from Partnership.**

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Reports to:</th>
</tr>
</thead>
</table>
| 1           | • Service team for Sport reports to Partnership Board  
• Specific projects report to other groups which include: Culture and Sport Chief Officers partnership; Health and Well-Being Board; physical activity Champions group (subgroup of Health and Well-Being Board)                                                                                 |
| 2           | • NHS  
• Sport England  
• Department of Health  
• County Council  
• National Governing Bodies  
• LAs – where appropriate                                                                                                                                                                                                                                                                                 |
| 4           | • Sport Board which reports back to Sport England and Government Office                                                                                                                                                                                                                                                                     |
| 5           | • Sport Partnership  
• LAA Culture Board  
• LAA Health and Well-being Board  
(all informal)                                                                                                                                                                                                                                                                                               |
| 6           | • Executive Board  
• Stakeholder Group  
• Sport England  
• County Council Performance Board  
• Department of Health                                                                                                                                                                                                                                                                                     |

This formal reporting mechanism is important as it implies a clear governance structure and accountability framework for the partnerships, enabling the escalation of programme risks that may require senior level input to resolve.
Targets

All of the 9 Partnerships identify a number of Physical Activity targets which they are working towards; frequency of responses is indicated in Figure 12 below.

**Figure 12:**

![Physical Activity Targets of the Physical Activity/Sports Partnerships](image)

The Local Area Agreement was identified as one of the three most important targets that 8 of the 9 partnerships are working towards. The Active People Survey was also identified as a target that 8 of the 9 partnerships are working towards and 7 of the partnerships identified it as one of the most important targets. Six partnerships identified ‘National Indicators’ as a target with 5 of them citing this as one of the three most important targets. However, the Active People Survey is not a target but a way of measuring physical activity across a community. The Active People survey is the mechanism to show progress against the Local Area Agreement and National Indicator 8, which are managed through the Local Authorities. Given this it is not surprising that all three ‘targets’ have been listed.

Other targets include the ‘Legacy Action Plan’ target, cited in the Department of Health’s Physical Activity Strategy ‘Be Active, Be Healthy’, and a target for 5 of the partnerships and ‘most important’ for four of these.

Local targets are also listed by 2 partnerships and cited as ‘most important’, whilst ‘vital signs’ was listed by 1 partnership as a target and this also came under the ‘most important’ banner. However, as previously discussed, whilst vital signs has been referenced, there is no specific vital signs target for physical activity, the targets are broader and led by the PCT.
Strategies and documents

All 9 of the partnerships have a physical activity strategy, out of these 1 is currently undergoing consultation (although in addition to the CSP strategy there is a Countywide physical activity strategy in place until 2011) and 1 is referred to as a business plan rather than a strategy.

Budgets

Six of the partnerships stated that they had a budget aligned to their local strategy and three stated that they have a budget, not specifically aligned to the strategy, but for funding of specific projects across the partnership.

When asked to state their budgets and time-scales, a combination of survey results and follow up discussion led to 5 out of the 6 Partnerships specifying budget amounts and time-scales, in varying levels of detail, as shown in Table IV below:

Table IV: Partnership budgets for physical activity

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Budget (£ 000)</th>
<th>Time-scale for funding</th>
<th>Additional Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1,000</td>
<td>09/10 &amp; 10/11</td>
<td>No additional budget allocated to the strategy - existing budgets secured via partnership working: £1,000,000 to extend and enhance existing physical activity provision towards NI8 and £160k for Exercise Referral</td>
</tr>
<tr>
<td></td>
<td>160</td>
<td>10/11</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>74 (Core)</td>
<td>Annually 2010-2013</td>
<td>Project funding from external sources. The new CSP strategy to be launched, core funding will be allocated to the priority areas, which may change the current core funding allocation.</td>
</tr>
<tr>
<td></td>
<td>208 (Project)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>305</td>
<td>3 years (unclear start and finish)</td>
<td>This covers one project. Additional budget may be committed to other projects but this was not specified.</td>
</tr>
<tr>
<td>7</td>
<td>2,340</td>
<td>2 years for specific projects</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>763</td>
<td>Confirmed until March 2011</td>
<td>This is all the funding allocated to the CSP. Other funding will be secured locally through LAs, CSN’s and NGB’s. PCTs also fund a number of projects eg exercise referral scheme.</td>
</tr>
</tbody>
</table>

| Total       | 4,850          |                        |                     |
| Mean        | 970            |                        |                     |
| Median      | 763            |                        |                     |

There is a wide variation in the budgets aligned to the partnerships, although the median budget is £763,000. However, the figures stated above, are in some cases, estimates and, in some cases, the figures only represent investment in a specific project as total budgets are unknown. These figures may therefore not be a true representation of actual investment, but they are based on the information submitted for the purpose of this audit.
The three partnerships that do not have a budget aligned directly to the strategy do have individual organisational budgets for specific projects.

Based on the available information, of the total budget identified 4 Partnerships spent between 75-100% on Physical Activity, however, 1 of these Partnerships also estimating spend on ‘sport’ and ‘other’ at 0-24% each and 1 stated that 75-100% is allocated out of specific budgets for specific projects rather than this amount allocated to the entire partnership budget.

Two other Partnerships also identified total % exceeding 100 across all categories of ‘Sport’, ‘Physical Activity’, ‘2012’ and ‘Other’, although the largest % was on Sport.

One Partnership estimated an equal split between spend on Physical Activity and Sport. This may be because individual projects are funded so the total budget allocated to that project will be spent on its intended purpose, but that does not represent the full total budget for that Partnership.

Budgets across the Partnerships come from a variety of sources as indicated in Figure 13 below:

**Figure 13**

![Sources of Partnership Budgets](image)

‘Other’ included:
- Department of Health
- Local University
- County Council
- Regional Development Agency
- English Federation of Disability Sport

Primary Care Trusts are the most frequent providers of funding into the Partnerships. As a commissioning agency, with a primarily strategic function, this is not surprising. However, whether this investment will remain will be dependent on confirmed allocations.
Partnership input on Physical Activity into local policies or strategies

All 9 Physical Activity Partnerships provide physical activity input into broader policies and strategies, as listed below:

- Leisure and Recreation (7 Partnerships)
- Parks, Forests and Green Spaces Policy/Strategy (3 Partnerships)
- PCT Local Operating Plans (5 Partnerships)
- Walking Strategy (5 Partnerships)
- Cycling Strategy (4 Partnerships)
- Local Development Framework (planning) (2 Partnerships)
- Healthy Schools Policy (1 Partnership)
- Extended Schools Policy (1 Partnership)

Input provided into ‘other’ strategies was as follows:
- Physical Activity Strategy
- Play Strategy
- Community Sports Networks Plans
- Healthy Weight Strategy
- Other local Physical Activity Plans

Commissioning or Delivery of physical activity services

All 9 Partnerships provide or commission physical activity services as shown in Figure 14 below:

Figure 14

The most popular interventions which are currently delivered/commissioned by 6 of the Partnerships are: Exercise Referral; Sport Outreach and Obesity Programmes. The least popular interventions currently being commissioned/delivered are Health Trainers
promotion of physical activity and other referral to primary care. However, this is not surprising as traditionally these are services commissioned through the PCT.

In terms of interventions which are planned to take place, Active Travel promotion is the most popular possibly due to the publication of the Active Travel Strategy.

In addition, 1 partnership said that whilst they were not formally running activities listed, members of the partnership were as it fit with the strategic plan’. 1 partnership also stated that they do link with exercise referral, but don’t formally deliver or commission and 1 said that they, ‘work through Sports development and work with other partners who are involved with many of the projects listed, but don’t formally provide or commission these’.

**Target groups**

All 9 Partnerships identified at least one key target group, as defined in their strategy, these were as follows:

- Adults (8 Partnerships)
- Children and Young People (8 Partnerships)
- Older Adults (5 Partnerships)
- People who are overweight/obese (4 Partnerships)
- Black and Minority Ethnic Groups (4 Partnerships)
- People from lower socio-economic (4 Partnerships)
- People with Disabilities (3 Partnerships)

In addition, 1 Partnership which just identified ‘Adults’ said that ‘...all of the subgroups are relevant but Adults are a key focus when it comes to Physical Activity’. and 1 added that ‘In terms of physical activity (ie not sport), our main focus is on adults of all ages and with sport, children & young people’.

All of the Partnerships stated that the target groups and priorities defined within the strategy are based on evidence.

Following on from this, one Partnership said that this targeting happened ‘sometimes, but [it was] not possible in all cases’. Another partnership stated that, ‘funding is predominantly for working with adults and work is prioritised based on low participation rates identified through the Active People Survey’.

In terms of programmes, eight out of nine partnerships who responded, identified that their programmes are based on evidence and seven of the partnerships use evidence used to determine target groups and priorities and programmes, as listed in Figure 15:
Figure 15

Evidence used to inform target groups and priorities and programmes identified in the Partnership Strategies

With the exception of the NICE children and young people guidance, evidence is used generally to inform priority groups more than it is for programme development although that could in part be due to the nature of the evidence and how that is presented. One of the eight partnerships stated that there are no specific physical activity programmes mentioned in the strategy’ and, as such, they were unable to list the evidence that informed programme development.

Evaluation

The 8 Physical Activity Partnerships who responded use a range of methods to evaluate progress made through the strategy as follows:

- 8 out of 8 Partnerships who responded use ‘monitoring’ e.g. numbers taking part
- 3 out of the 8 Partnerships who responded use ‘commissioned (independent) evaluation’

No Partnerships use ‘in-house evaluation’.

Responsibility for monitoring progress was varied across the Partnerships, but can be clustered as follows:

- All Partners but Sport Partnership taking leading role.
- CSPAP and PCT joint lead
- Accountable LAA Officers.
- Sports Partnership Core team, reporting to Key funding bodies.
- Individual monitoring by organisations delivering projects
Evidence

In the absence of available evidence, out of the 7 Partnerships who responded, 3 said they would ‘commission a study to provide the evidence’; with 2 Partnerships stating they would pilot a programme to ‘determine its success’ or to ‘prove/disprove theory’. Three said they would ‘commission the intervention anyway’; with 1 Partnership providing an example of a programme they commissioned based on ‘anecdotal evidence’.

In addition, 2 of the 3 Partnerships who did not directly respond to the question, did provide responses through ‘Additional Comments’:

- ‘in this time of limited resources we would not be commissioning work where it is not backed up by evidence’
- ‘the NHS Commission the CSPAP to deliver based on evidence’
- ‘The main projects we ‘commission’ are as a result of Sport England funding, which is allocated to certain projects, some which have an evidence base and some which don’t. If we were commissioning interventions using funding that had less specific guidelines on what the money can be spent on then we would always look to commission interventions which have an evidence base or look to provide evidence if sufficient funding was available’.

Out of the 7 Partnerships that responded, none of them have used the Standard Evaluation Framework, published by the National Obesity Observatory.

Policy Issues that drive the commissioning of physical activity across the Partnership

All 9 Partnerships responded, 8 through the survey and 1 through follow up with all of these citing ‘Health (obesity, cardiovascular disease, mental health, falls prevention)’ as a key policy issue for their partnership. Eight of the Partnerships identified ‘Physical inactivity/sedentary behaviour’; 2 Partnerships cited ‘London 2012’ and 1 cited ‘Improving social cohesion/social capital’

‘Other’ policy issues listed were:
- ‘Sport for Sports sake’ in relation to the delivery of Sport England and Youth Sport Trust initiatives.
- An increase in the 2 hour offer and 5 hour offer through schools
- Club development
- Volunteering

Influencing Factors to raise the profile and investment in physical activity.

Across the 5 Partnerships who responded, the following factors were identified:

- Ring fenced funding designated towards both treatment and prevention
- Better knowledge of the impacts and importance of Physical Activity within NHS Strategic management circles particularly director and CEO’s
• PCT to have dedicated ring fenced resource for the prevention agenda.
• Inclusion of NI8 as a key indicator
• More evidence on the effectiveness of Physical Activity initiatives, e.g., the effectiveness of cycling on health.
• Continued relationship with the NHS
• More evidence on specific physical activity interventions that result in long term behaviour change to help make the case for investment, especially with current financial pressures
• More support from DH nationally to put pressure on PCTs to focus more on physical activity as a tool to help a range of conditions, not just obesity.

‘Other issues’ raised by 3 Partnerships were as follows:

• Evidence based approaches and research and evaluation are important to inform future decision making and resource allocation.
• Payments in all areas are made for project delivery and do not take into account nor adequately fund the research and development work that has to take place prior to funding agreement.
• Funding for projects is usually short term affecting the sustainability of opportunities... to make an impact we need to industrialise our efforts to shift the curve in sedentary behaviour. Rather than piece meal funding need additional/dedicated resource.
6. Progress towards physical activity indicators

This section of the report considers data on agreed indicators for physical activity, and describes the progress in each PCT against these indicators.

The only reliable data available at a regional level for analysis come from Sport England’s Active People Survey. The Health Survey for England provides occasional data on physical activity using a well-validated questionnaire, but the survey does not focus on physical activity frequently enough to measure trends in activity, and the sample size is not large enough to allow analysis at PCT or local authority level.

Local data may be being collected by individual PCTs to monitor progress towards NHS Health Check programmes or Let’s Get Moving (as highlighted in earlier sections of this report) but these data are currently sporadic and inconsistent across the region. In the future these data are likely to become mandatory as part of the NHS health checks.

The advantages of the Active People survey data are that the sample size is large enough to allow analysis at local authority/Primary Care Trust level; the survey covers all the main forms of sport and active recreation; and the data are made available as they are used to monitor progress towards national indicators. The main disadvantage of the survey is that it uses a 30 minute cut-off for most activities, so that activities carried out for less than 30 minutes are not counted. This is likely to under-represent activities such as walking and cycling.

For detailed planning and targeting, local authorities can also take advantage of the profiling work that has been done by Sport England using the Active People Survey\(^4\). Data are available for 19 market segments with distinct sporting behaviours and attitudes. This includes information on specific sports people take part in as well as why people do sport, whether they want to do sport and the barriers to doing more sport. Maps are also available for PCTs showing the data for their local areas\(^5\) [www.promotingactivity.com](http://www.promotingactivity.com)

**National Indicators**

National Indicator 8 is the only national indicator that currently relates directly to sport/physical activity and is defined as:

“the percentage of the adult population (age 16 years and over) in a local area who participate in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks (equivalent to 30 minutes on 3 or more days a week).”

It is also the only indicator for which analysed data are made available by Sport England (as the Legacy Action Plan target includes additional forms of physical activity to those included in NI8). For this reason we focused our analysis on progress towards the NI8 targets.


\(^5\) [www.promotingactivity.com](http://www.promotingactivity.com)
The NI8 target is considered to be the most important target in the region by 8 out of 9 partnerships interviewed. The partnership that does not currently have the NI8 as a target within their LAA which they are performance managed against, they do however have this as a separate local target and are involved in ongoing discussions to place this within the LAA. In addition, all six of the 9 PCT’s who state they are working towards a physical activity targets, refer to their contribution towards NI8.

Methods

National Indicator 8 data at local authority level were downloaded from the Sport England website\(^6\) \(^7\).

Averages of LA data were used to estimate PCT data, as all boundaries except Derbyshire were coterminous. (Only part of High Peak LA is within Derbyshire County PCT.)

Target data for 2008-2011 are based on a yearly increase of 1.33% using APS 2005/06 data as the baseline. These target data are consistent with the National Indicator 8 target data published by the Data Interchange Hub\(^8\).

Results

Charts showing progress towards the NI8 target are shown below for PCTS\(^9\).

In summary:

<table>
<thead>
<tr>
<th>Likelihood of meeting targets</th>
<th>PCT name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very likely</td>
<td>Bassetlaw, Derbyshire County, Lincolnshire</td>
</tr>
<tr>
<td>Possible</td>
<td>Leicester City</td>
</tr>
<tr>
<td>Unlikely</td>
<td>Derby City, Leicestershire County and Rutland, Northamptonshire, Nottingham City, Nottinghamshire</td>
</tr>
</tbody>
</table>


\(^8\)https://www.hub.info4local.gov.uk/DIHWEB/About.aspx

\(^9\) Charts for local authorities are available on request.
Bassetlaw PCT is above its target level for 2008/9 and appears to be on track to exceed or meet its NI8 target.

Derby City PCT is now slightly below its target level for 2008/9. If the trend continues it appears to be unlikely that the PCT will meet the NI8 target.
Derbyshire County PCT appears to be on track to meet its NI8 target.

Leicestershire County and Rutland PCT is now slightly below its target level for 2008/9. If the trend continues it appears to be unlikely that the PCT will meet the NI8 target.
Leicester City PCT is now slightly below its target level for 2008/9. If the recent upward trend continues it may meet the NI8 target.

Lincolnshire PCT is slightly above its target level for 2008/9 and appears to be on track to exceed or meet its NI8 target.
Northamptonshire PCT is now slightly below its target level for 2008/9. If the recent trend continues it appears to be unlikely that the PCT will meet the NI8 target.

Nottingham City PCT is now below its target level for 2008/9, having seen a sharp downward trend since 2007/8. If this trend continues it appears to be unlikely that the PCT will meet the NI8 target.
Nottinghamshire County PCT is now below its target level for 2008/9, having seen a sharp downward trend since 2007/8. If this trend continues it appears to be unlikely that the PCT will meet the NI8 target.
7. Conclusions

The overriding conclusion from this audit is that the promotion of physical activity as an independent lifestyle behaviour does not, on the whole, seem to have a high priority within delivery agencies in the region, especially within Primary Care Trusts. It has a relatively low status in strategic documents, and is allocated a relatively low level of financial and human resources compared to other lifestyle behaviours. There are no full-time physical activity leads in PCTs, as postholders only spend on average one day a week on the topic. These physical activity leads have few if any staff, and control small budgets.

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 such as obesity, cardiovascular disease and cancer. Physical inactivity is estimated to cost £17 per person across the region, but PCTs are investing only just over £1 per head in promotion of physical activity.

LOPs are the ‘delivery’ plans of the PCTs broader strategic plans, which often span across a number of years. The prioritisation of physical activity within the strategic plans is therefore 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, where this exists from local and national evaluation, in a bid to maintain, increase or re-invest in this area.

PCTs do, however, appear to be engaging with strategic partners on a wide range of issues linked to physical activity, including leisure, recreation, education and transport. Key to this are the county/city sport and physical activity partnerships, which provide a focus for action. Within these partnerships, levels of staffing and budgets are higher than in PCTs.

There appears to be a degree of synergy between the information collated through the strategic reviews and the survey information in relation to the development and delivery of plans at a strategic level. Leisure services and the sports partnerships have a clear delivery role compared to the predominant commissioning role now seen across Public Health.

With the increased commissioning function held by Health Improvement/ Public Health and increasingly restricted budgets, it is not uncommon for Health Improvement and Public Health specialists to cover a range of topic areas. It appears that this is not an issue where there is a strong physical activity partnership across the local area and a clear delivery mechanism for physical activity programmes across other partner agencies. However, the strength of partnerships across the region is varied. Given the commissioning focus of PCTs and the current economic climate, the need for collaboration on physical activity is even greater, to ensure that programmes can be delivered, monitored and evaluated. It is a vital area of work for PCTs and their knowledge of the local population and inequalities are invaluable to ensure 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, especially with the publicity and support surrounding ‘London 2012’.
However, it has to be said that London 2012 does not appear to be a driver for action: none of the strategic documents mentioned the Olympics, and in discussion few physical activity leads referred to the Legacy Action Plan.

The picture of targets and indicators for physical activity appears to be quite confusing and does not seem to be driving action across the region. There is an inconsistent approach taken to indicators such as NI8, and a need for more firm and consistent indicators. It appears that between 3 and 4 of the 9 PCTs in the region will hit their NI8 target by 2012.

It is encouraging however, that the vast majority of PCTs in the region are intending to implement the Let’s Get Moving care pathway. This should be seen to be a major priority, as it is specifically mentioned in the NHS Operating Plan for 2010-11. As this 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.

The approach to evaluation appears to be quite inconsistent across the region, with a great deal of in-house evaluation and little use of clear guidance such as the Standard Evaluation Framework from the National Obesity Observatory.
8. **Recommendations**

1. PCTs in the Region should be urged to give a far greater priority to the promotion of physical activity as an independent lifestyle behaviour within their commissioning plans and establish formal commissioning arrangements across physical activity partnerships.

2. 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.

3. Efforts should be made to ‘make the case’ for physical activity to the PCT executive team, supported by the Region, to ensure that the broader role of physical activity in achieving the PCT’s long term strategic priorities in relation to both prevention and treatment, is acknowledged.

4. Partnership strategies on physical activity should be in place across each PCT, with clear links between the plans of City and County Physical Activity partnerships.

5. Implementing *Let’s Get Moving* 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.

6. Physical activity leads within PCTs should increase their focus on working to influence other policy areas, by emphasising the multi-faceted role of physical activity in achieving multiple agendas and embed it within service provision. Examples include: NHS health checks; use of the General Practice physical activity questionnaire within primary care; weight management services; other lifestyle issues such as smoking cessation.

7. Physical activity leads in PCTs should review their focus away from achieving NI8, and instead advocate for a new Tier 1 or 2 Vital Sign for physical activity against which the PCT should be managed.

8. The evaluation component of programme should be prioritised to ensure evidence of impact and outcomes can be demonstrated. The Standard Evaluation Framework for weight management interventions should also be applied to physical activity interventions across the region.

9. National evidence in the form of NICE guidance and Cochrane reviews should be used to inform the development of the physical activity programmes, especially in light if the financial constraints.
References


Appendix I: Introductory E-mail to PCTs

Dear All

The East Midlands Directorate of Public Health has recently commissioned Cavill and Associates (Nick Cavill and Debra Richardson) to conduct an audit of physical activity within the region.

The overall long term aims for this piece of work is to:

• To inform commissioning on physical activity
• To ‘make the case’ for increased investment in physical activity.
• To help targeting of physical activity interventions
• To help us understand the level and type of services that need to be commissioned to meet key national and regional targets.

The objectives of this work is to:

• To develop a methodology for a needs assessment, which can be applied to PCT and Local Authorities populations, which will identify the size and population groups who might benefit from a physical activity interventions.
• To develop an audit tool to assess the investment, partnership buy-in, strategic planning, levels of service provision, levels of evidence based practice/evaluated practice, workforce capacity and capability, for physical activity by PCTs and their partners.
• Using this tool undertake an audit with PCTs and their partners to establish a baseline profile for each local partnership, to include reviews of strategic documents (e.g. Local Operating Frameworks, WCC Documentation, N I8 Action Plans, 2012 Legacy Action Plans) and interviews with local leads and a sample of service providers.
• For each local partnership compare current provision against need and make recommendations for future investment and delivery, including work force plans, and where new national initiatives should take place.
• Produce a template for a Business Case that PCTs and their partners can use to advocate for future investment needs.
• To work alongside the Regional Physical activity manager in a gap analysis study of all East Midlands PCTs in their capacity in rolling out Let’s Get Moving, the physical activity care pathway.

The first stage of the audit process will be for the contractors to conduct an online survey with all key physical activity personnel within the region from PCT leads, CSP leads through to some key Local Authority contacts. I would appreciate when this is sent through, that you are able to find some time to complete it. Following on from this, one to one interviews will be conducted with your selves to discuss more in-depth the provision of physical activity within your respective PCT. Alongside this I will be accompanying Debra and conducting an interview regarding Let’s Get Moving.

In order to get the latter process moving, I would appreciate if you could provide me with your availability late February for the interview, I would anticipate we would need approx 2 1/2 hours in total for both sets of interviews.

If you have any queries regarding the above please do not hesitate to contact me.

Kind regards

Sarah

Sarah Quilty
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Directorate of Public Health and Social Care East Midlands
GOEM
The Belgrave Centre
Stanley Place
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Nottingham
NG1 5GG
Tel: 0115 971 2777

www.promotingactivitytoolkit.com
Appendix II: Invitation E-mail to PCTs

Dear East Midlands PCT physical activity leads,

Sarah Quilty emailed you on January 6th alerting you to the physical activity audit which she is conducting across the East Midlands Region. The survey is being conducted on behalf of the East Midlands regional public health group by Cavill Associates and the South East Public Health Observatory (SEPHO), the lead public health observatory for physical activity.

The study aims to:
• Inform commissioning on physical activity
• ‘Make the case’ for increased investment in physical activity
• Help targeting of physical activity interventions
• Help understand the level and type of services that need to be commissioned to meet key national and regional targets.

We would be grateful if you would complete a short survey to tell us about the commissioning of physical activity services in your PCT. The survey should take around 20 minutes. To complete the questionnaire you will need information about projects, staffing and budgets for physical activity in your PCT.

To proceed with the survey please click on the link below
http://www.surveymonkey.com/s/KF79STZ

We would be grateful for your responses by Friday 5th February 2010.

Sarah Quilty has been in touch to arrange a date for a follow-up interview. This will allow us to discuss issues of interest in more depth.

If you have any queries regarding the completion of the survey please contact Cathy Mulhall at SEPHO (cathy.mulhall@sepho.nhs.uk). If you would like to discuss any other aspect of the research please contact me: nick@cavill.net

Many thanks for your help with this, especially at this busy time.

Best Wishes

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SEPHO is delivered by Solutions for Public Health
Appendix III: Invitation E-mail to County/City Sport and Physical Activity Partnerships

Dear East Midlands County Sport and Physical Activity Partnership / Local Authority Physical Activity leads,

As you may already be aware, Sarah Quilty, Regional Physical Activity Manager, is conducting a physical activity audit across the East Midlands Region. The survey is being conducted on behalf of the East Midlands regional public health group by Cavill Associates and the South East Public Health Observatory (SEPHO), the lead public health observatory for physical activity.

The study aims to:
• Inform commissioning on physical activity
• ‘Make the case’ for increased investment in physical activity
• Help targeting of physical activity interventions
• Help understand the level and type of services that need to be commissioned to meet key national and regional targets.

We would be grateful if you would complete a short survey to tell us about the commissioning of physical activity services in your County Sport and Physical Activity Partnership or Local Authority. The survey should take around 20 minutes. To complete the questionnaire you will need information about projects, staffing and budgets for physical activity in your partnership.

To proceed with the survey please click on the link below
http://www.surveymonkey.com/s/7DFHK77

We would be grateful for your responses by Thursday 25th February 2010.

If you have any queries regarding the completion of the survey please contact Cathy Mulhall at SEPHO (cathy.mulhall@sph.nhs.uk). If you would like to discuss any other aspect of the research please contact me: nick@cavill.net

Many thanks for your help with this, especially at this busy time.

Best Wishes,

Nick Cavill
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SK7 1BA

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Cathy.Mulhall@sph.nhs.uk | www.sepho.nhs.uk

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Appendix IV: Interview Process

Standardised Introduction

As you are aware, Sarah Quilty, through the EMPHG, is conducting a PA audit across the EM region. This audit is conducted by Cavill Associates, who I am representing today and SEPHO, the lead PHO for physical activity. The audit includes PCT’s, CSPAP and where relevant other local PA partnerships.

The purpose of the interview is to follow up on some of your responses to the survey (thank you for completing this) and to ask you some additional questions regarding your PCT’s strategic plans. The questions are split into 7 broad areas plus add questions: role, plans and policies, commissioning, budget, targets, evaluation and evidence.

I will be taking notes, but to ensure I capture all your responses accurately I would like to record the interview – is that ok?

To start please can you confirm your name, job title and the name of your PCT.

Discussion Guide

Role
- Time spent on PA operationally/strategically and other areas of work and line management responsibilities.
- Other people across the PCT who work on PA

Plans/Policies
- PA strategy - Targeting - How is this informed
- Contribution to other strategies in relation to PA
- Key partners on PA, strategically and operationally
- PCT representation on any PA network or partnership across the PCT boundary and importance of these
- LOP has been produced and includes PA, is this for this year and next year?

Commissioning
- Commissioning process for PA across the PCT
- Joint commissioning arrangements for PA – LA and others
- Stability of current commissioning process - proposed changes
- What would help increase the commissioning of PA services

Budget
- PA budget for 09/10 – dedicated budget line or broader; committed v planned; programmes
- Matched funding
- Budget for 10/11 – confirmed allocation? key issues and potential implications

Targets
- Targets working towards in relation to PA - Accountability
- Role of commissioned programmes in reaching targets
- Data used to inform targeting of work and programmes
- Awareness of the numbers of people that have to be ‘converted’ to activity to reach key targets?
- PA target? Sedentary Behaviour target?

Evaluation
- Main methods and rationale for choice
- % budget allocated
- LT behaviour change
- Use of the SEF
- Evaluation support?

Evidence
- How has ‘evidence’ influenced the design/choice/prioritising of the programmes in place
- No evidence - what inform the decision to commission – funding
- Access to evidence in relation to PA
• Evidence gaps

Other
• Additional support regional/national level?
• Next years LOP and WCC plans - access
Appendix V: Online Questionnaires
Thank you for agreeing to complete this questionnaire. This research aims to establish what action is being taken by Primary Care Trusts (PCTs) in the East Midlands to promote physical activity. It is being conducted by the South East Public Health Observatory and Cavill Associates, on behalf of Department of Health.

The survey is designed to be completed by the physical activity lead in each PCT. Please only complete this questionnaire if you have been asked on behalf of your PCT to do so. The survey should take around 20-30 minutes to complete.

The information you supply will be included in a report about the commissioning of physical activity services in the East Midlands, 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.

If you would like to preview a printable version of the questionnaire please click here

* 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 and delivery of physical activity services)

* 2. Please select your PCT
   - Bassetlaw
   - Derby City
   - Derbyshire County
   - Leicester City
   - Leicestershire County and Rutland
   - Lincolnshire
   - Northamptonshire
   - Nottingham City
   - Nottinghamshire County
3. Please select your job title
- Consultant in Public Health
- Director of Public Health
- Director of Health Improvement / Health Promotion
- Health Improvement / Health Promotion Manager
- Health Improvement/ Health Promotion Specialist
- Public Health Specialist
- Other (please specify)

2. Page 2

4. As the physical activity lead, how many days of your time are allocated to physical activity?
- 1 day
- over 1 but less than 2 days
- over 2, but less than 3 days
- over 3, but less than 4 days
- over 4, but less than or equal to 5 days

5. Is your work on physical activity at a strategic or operational level?
- Strategic
- Operational
- Both

6. 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

7. What physical activity targets is your PCT working towards?

- National Indicator 8
- Legacy Action Plan target - 2 million more active
- Local targets
- Local Area Agreement targets
- National Indicator 55
- National Indicator 56
- Any others
- Other - please specify
8. Does your PCT have a budget for physical activity in the current financial year, 2009/2010?
   - No
   - Yes

   If yes, Please state how much this budget was for 2007/08 and 2008/09

9. Has your PCT allocated a budget for physical activity in the next financial year, 2010/2011?
   - No
   - Yes

   If yes, please state how much this budget will be

10. Of the total budget identified in the previous question, what percentage is spent on -
    - Staff Costs (including overheads) (%)
    - Interventions or projects (%)
    - Evaluation (%)

11. Has your PCT secured any non-NHS funding for physical activity for next financial year, 2010/2011?
   - No
   - Yes

   If yes - please state the source/amount/period of time for non-NHS funding received for physical activity
### 4. Policies and Partnerships

#### 12. Has your PCT

a) produced any of the following plans or documents?

b) produced any of the following plans or documents which refer to physical activity?

<table>
<thead>
<tr>
<th>Plan / Strategy / Plan</th>
<th>a) produced any of the following plans or documents?</th>
<th>b) produced any of the following plans or documents which refer to physical activity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 Plans</td>
<td></td>
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<tr>
<td>Adult Obesity Strategy/Plan</td>
<td></td>
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<tr>
<td>Cardiovascular Disease Prevention Strategy/Plan</td>
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<tr>
<td>Childhood Obesity Strategy/Plan</td>
<td></td>
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<tr>
<td>Diabetes Prevention Strategy/Plan</td>
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<tr>
<td>Falls Prevention Strategy/Plan</td>
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<tr>
<td>Local Operating Plan</td>
<td></td>
<td></td>
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<tr>
<td>Mental Health Strategy/Plan</td>
<td></td>
<td></td>
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<tr>
<td>National Indicator 8 Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Activity Strategy/Plan</td>
<td></td>
<td></td>
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<tr>
<td>Workplace Health Strategy/Plan</td>
<td></td>
<td></td>
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<tr>
<td>World Class Commissioning Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other - please specify

- [ ]

#### 13. 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

- [ ]
14. Has your PCT helped to develop the physical activity component of the following local policies or local strategies? If yes, please select

- Cycling Strategy
- Extended Schools
- Healthy Schools
- Leisure and Recreation
- Local Development Framework (planning)
- Parks, Forests and Green spaces
- School Travel
- Walking Strategy
- Other - please specify

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

- Active travel promotion
- Cycling promotion
- Exercise referral schemes
- Health trainer’s promotion of physical activity
- Obesity programmes/interventions
- Other referral from primary care (including to counselling services)
- Sport outreach
- Walking the way to health/led walks
- Other - please specify
16. Who are your key partner agencies for the delivery of the physical activity project(s) above?

- Local Authorities
- Voluntary sector
- Private sector
- County Sports & Physical Activity Partnerships

17. Who are the target groups for the physical activity interventions that your PCT commissions/delivers? Please identify the top 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
- Other - please specify

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

- Monitoring (e.g. numbers of people taking part in the project)
- In-house evaluation (conducted by the PCT)
- Commissioned (independent) evaluation
- Not evaluated
- Other - please specify
19. Have you used the Standard Evaluation Framework published by the National Obesity Observatory?

- Yes
- No
20. Do your PCT’s physical activity programmes monitor long-term behaviour change?

☐ Yes
☐ No

21. What do you see as the main policy issue that drives the commissioning of physical activity within your PCT?

☐ 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

22. 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
☐ Market segmentation data (for example use of the activity tool kit)
☐ Individual research studies and evaluations
☐ Other - please specify
23. 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

24. 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

25. What would help your PCT increase the commissioning of physical activity services?
26. Is your PCT currently using the ‘Let’s Get Moving’ physical activity care pathway?
   - Yes
   - No

27. If your PCT is not currently using the ‘Let’s Get Moving’ physical activity care pathway, does it intend to?
   - Yes
   - No

28. Are there any other issues in relation to the commissioning or provision of physical activity that you would like to raise?
Thank you for agreeing to complete this questionnaire. This research aims to establish what action is being taken in the East Midlands to promote physical activity. It is being conducted by the South East Public Health Observatory and Cavill Associates, on behalf of the Department of Health.

In this phase of the research, we are interested in the work of Physical Activity Partnerships, which includes those working at a county level and those covering a Local Authority geographical area. In this phase of research we are interested in work of key physical activity professionals working at the county level or those covering a local authority level.

The information you supply will be included in a report about the commissioning of physical activity services in the East Midlands. Individual respondents will not be identified. To complete the questionnaire you will need information about your County/Local Area in relation to the strategic physical activity priorities; partner agencies who support your work on physical activity; and the overall investment in physical activity. The survey should take around 20 minutes to complete.

We would be grateful for your responses by Thursday 25th February 2010.

Thank you.

**1. Are you the physical activity lead for the County Sport and Physical Activity Partnership (CSPAP) or Local Authority?**

- Yes
- No (If no, please ensure this questionnaire is now completed by the person who is the CSPAP lead or Local authority physical activity lead)

**2. Please select your CSPAP/Local Area**

- Derby City
- Derbyshire County Sport and Physical Activity Partnership
- Leicester City
- Leicestershire County and Rutland Sport and Physical Activity Partnership
- Lincolnshire County Sport and Physical Activity Partnership
- Northamptonshire County Sport and Physical Activity Partnership
- Nottingham City
- Nottinghamshire County Sport and Physical Activity Partnership
3. As the CSPAP/physical activity lead, how many days of your time are allocated to working on physical activity each week?

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

4. What percentage of this time is working a) operationally and b) strategically?

<table>
<thead>
<tr>
<th>Operationally</th>
<th>Strategically</th>
</tr>
</thead>
</table>

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

- No
- Yes

   If yes, please state the number of whole-time equivalents and their job titles

6. How many days per week in total are allocated to working on physical activity by the all members of the partnership board?

<table>
<thead>
<tr>
<th>Total number of days per week</th>
<th>Number of members on the partnership board</th>
</tr>
</thead>
</table>

7. What percentage of this time is working a) operationally and b) strategically?

<table>
<thead>
<tr>
<th>Operationally</th>
<th>Strategically</th>
</tr>
</thead>
</table>

   If yes, please state the number of whole-time equivalents and their job titles


8. Across the entire partnership how many people work on physical activity and what are their job titles?

<table>
<thead>
<tr>
<th>Number of people (Whole Time Equivalent)</th>
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</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Job titles</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

9. Which physical activity targets is your partnership or Local Authority working towards?

- Active People Survey targets
- Legacy Action Plan target - 2 million more active
- Local Area Agreement targets
- Local targets
- National Indicators
- Vital signs
- Other - please specify / or additional comments

10. Which are the three most important targets for your partnership?

- Active People Survey targets
- Legacy Action Plan target - 2 million more active
- Local Area Agreement targets
- Local targets
- National Indicators
- Vital signs
- Other - please specify / additional comments
11. Which organisations are current members of the partnership?

- Primary Care Trusts
- Practice Based Commissioning Groups
- National Governing Bodies
- Local Authorities
- Voluntary/3rd sector
- Private/Commercial
- Other (please specify)

12. Are there any organisations that have withdrawn from the partnership?

13. What was their main reason(s) for withdrawing from the partnership?

- Unrealistic recommendations or targets in the strategy
- Lack of funding
- Lack of staff resources
- Priorities/target groups no longer aligned
- Other (please specify) / additional comments

14. Who does the partnership report to?


5.

15. Does your partnership have a strategy?
   - Yes
   - No
   - Additional comments

16. Do you have a budget for physical activity aligned to your local strategy?
   - Yes
   - No
   If yes, please state how much this budget is and the time-scale for funding

17. Is this budget protected/ring fenced?
   - No
   - Yes
   Additional comments

18. Of the total budget identified in the previous question, what percentage is spent on -
<table>
<thead>
<tr>
<th></th>
<th>0-24%</th>
<th>25-49%</th>
<th>50-74%</th>
<th>75-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Activity</td>
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</tr>
<tr>
<td>Sport</td>
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<tr>
<td>2012</td>
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</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

19. Please indicate where this funding has come from and how much it is?
   Local Authorities
   Primary Care Trusts
   Sport England
   Voluntary Agencies
   Other
   Additional comments
20. Has your Partnership helped to develop the physical activity component of the following local policies or local strategies? If yes, please select.

- PCT Local Operating Plans
- Local Development Framework (planning)
- Healthy Schools
- Extended Schools
- School Travel
- Parks, Forests and Green spaces
- Leisure and Recreation
- Cycling Strategy
- Walking Strategy
- Other - please specify

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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Current</th>
<th>Planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise referral schemes</td>
<td></td>
<td></td>
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<td>Other referral from primary care (including to counselling services)</td>
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<td></td>
</tr>
<tr>
<td>Obesity programmes/interventions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other - please specify / additional comments
22. What do you see as the main policy issues that drive the commissioning of physical activity within your Partnership?

- Health (obesity, cardiovascular disease, mental health, falls prevention)
- Improving social cohesion/social capital
- Physical inactivity/sedentary behaviour
- London 2012
- Other - please specify

23. Who are the key target groups for your Partnership, as defined in the strategy? Please identify the top three.

- Children and Young People
- Adults
- Older Adults
- People with Disabilities
- Black and Minority Ethnic Groups
- People who are overweight/obese
- People from lower socio-economic groups

Other (please specify)
24. Are the target groups and priorities defined within the strategy based on evidence?
   - Yes
   - No

Additional comments

25. If yes, what evidence was used? Please select.
   - Public Health Data
   - Market Segmentation (e.g. Sport England, Change4Life)
   - 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
   - Market segmentation data (for example use of the activity tool kit)
   - Other reviews (state)
   - Individual research studies and evaluations

26. Are the programmes defined within the strategy based on evidence?
   - Yes
   - No

Additional comments
27. If yes, what evidence was used? Please select.

- Public Health Data
- Market Segmentation (e.g. Sport England, Change4Life)
- 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
- Market segmentation data (for example use of the activity tool kit)
- Other reviews (state)
- Individual research studies and evaluations
28. 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

Additional comments

29. How do you evaluate progress made through the strategy?

- Monitoring (e.g. numbers of people taking part in the project)
- In-house evaluation (conducted by the PCT)
- Commissioned (independent) evaluation
- Not evaluated

Additional comments
30. Who is responsible for monitoring this progress?

31. Have you used the Standard Evaluation Framework published by the National Obesity Observatory?
   - Yes
   - No
   - Don't know

32. What would help to raise the profile and investment in physical activity in your partnership?

33. Are there any other issues that you would like to raise?