



# **Physical activity audit of West Midlands Primary Care Trusts**

In partnership with

# Contents

## Section 1

- 3 **1.0 Executive Summary**
- 3 **1.1** Headline Findings
- 4 **1.2** Recommendations

## Section 2

- 5 **2.0 Introduction** - Physical Activity and Health
- 5 **2.1** Physical activity's contribution to national targets (PSAs)
- 6 **2.2** The Evidence - what physical activity interventions are effective?
- 6 **2.3** Developing physical activity in Primary Care
- 6 **2.4** The infrastructure for developing and delivering physical activity and sport in the West Midlands

## Section 3

- 8 **3.0 The Context of the Physical Activity Audit of PCTs**
- 9 **3.1** Aims and objectives

## Section 4

- 10 **4.0 Methodology**
- 10 **4.1** Timescales
- 10 **4.2** Development of the audit tool
- 10 **4.3** Pilot Study
- 10 **4.4** Data entry and analysis

## Section 5

- 11 **5.0 Response rate**
- 11 **5.1** LDP and website assessment
- 11 **5.2** PCT Survey

## Section 6

- 12 **6.0 Assessment of the PCT Local Delivery Plans**
- 13 **6.1** Topics within the LDPs

## Section 7

- 14 **7.0 PCT Survey Analysis**
- 14 **7.1** PCT Physical Activity leads
- 15 **7.2** Physical Activity Interventions
- 16 **7.3** Evaluations and target strategies
- 16 **7.4** Partnership working and networking
- 18 **7.5** Funding
- 18 **7.6** Training of Staff
- 20 **7.7** The NHS as a Corporate Citizen - A Healthy Workforce
- 21 **7.8** Increasing the profile of Physical Activity with Primary Care

## Section 8

- 23 **8.0 Discussion**
- 23 **8.1** Strategic Vision
- 24 **8.2** Resources
- 25 **8.3** Partnerships and Networks
- 25 **8.4** Evaluating Programmes
- 27 **8.5** Skills Development
- 28 **8.6** The NHS as an exemplar
- 29 **8.7** Strategic Support for the prioritisation of Physical Activity in Primary Care organisations

## Section 9

- 30 **9.0 Conclusions**
- 31 **9.1** Recommendations

## References

- 32 **Appendix 1** - The Regional Structures for Physical Activity and Sport
- 33 **Appendix 2** - The Audit Tool
- 34 **Appendix 3** - Designated Physical Activity Leads
- 37 **Appendix 4** - The Physical Activity Interventions that PCTs are hosting, delivering and commissioning

# 1.0 Executive Summary

The Chief Medical Officer's "Five a Week" report<sup>1</sup> and more recently the Choosing Health White Paper and its subsequent delivery plans have significantly increased the profile of physical activity as a public health intervention. The evidence base for physical activity's ability to contribute to the prevention and treatment of a number of chronic conditions has been established and continues to grow as does the number of localities in the West Midlands that have or are currently establishing physical activity programmes to tackle issues such as health inequalities, chronic disease and community regeneration.

At the moment, physical activity service provision is non mandatory for both health organisations and local authorities and there are currently no national indicators or performance measures for physical activity in its widest sense, although Public Service Agreement (PSA) targets do exist for Sport and School Sport. The Regional Plan for Sport<sup>2</sup> sets the target for a 1% increase in physical activity participation levels year on year in the West Midlands and Sport England West Midlands is working closely with the West Midlands Public Health Group and other partner organisations to make this outcome a reality.

The Mapping exercise of physical activity opportunities in the West Midlands<sup>3</sup> demonstrated the large amount of schemes running in the region, but also highlighted that the provision of opportunities was patchy with no single organisation taking responsibility for the provision or co-ordination of such schemes. It also found that the largest provider of physical activity programmes was local authorities rather than the health sector. This report details the contribution that the health sector is making to increasing physical activity levels in the

West Midlands and sets a baseline of what is happening prior to the merging of the Primary Care Trusts in October 2006.

It is envisaged that the audit report will be used by regional and local bodies (Sport England West Midlands, West Midlands Public Health Group, the Regional Obesity Task Group, the Regional Health Partnership, PCTs Local Authorities etc) to identify where additional support and resources are required and aid physical activity investment and resource planning in future years at a regional, sub regional and local level.

The audit was begun in March 2006 and comprised of an assessment of the Local Delivery Plans and published information for the regions PCTs and a self completion questionnaire that was sent to a pre identified physical activity lead or the Director of Public Health at each PCT with a cover letter from the Regional Director of Public Health.

## 1.1 Headline Findings

- The assessment of LDPs highlighted a lack of systematic, strategic vision for physical activity as a tool to promote and develop public health. Physical activity interventions were referenced in 7% of LDPs, with a further 20% of PCTs making non specific statements that may incorporate increasing activity levels, for example; increasing the number of healthy schools.
- Physical Activity was categorised as high priority in 41% of PCTs under the topic of tackling obesity
- 80% of PCTs in the region responded to the survey that formed the second part of the audit process.
- 67% of respondent PCTs have a named physical activity lead with 5 – 100% of their time spent on developing physical activity.
- 29% of PCTs had more than one

person developing physical activity within the organisation.

- Funding allocations for physical activity ranges from £0 - £320,000 and totals £1,002,522 across the region for 2006/07. This equates to 0.01% of the regions healthcare budget.
- 67% of funding allocated is spent directly in the development and delivery of interventions, a further 31% is spent on the staff resources to implement and develop programmes.
- PCTs with higher resource levels are more likely to be delivering a strategic programme comprising of a number of interventions.
- 9 PCTs provided details of their Choosing Health allocations, current figures suggest that increased spending on physical activity as a result of this funding ranges from £0 - £200,000 across these PCTs.
- 83% of PCTs cited the sport, leisure and fitness sector as a key partner.
- 87% of PCTs are involved in either a local or regional physical activity network.
- 50% of PCTs were cited as being engaged with the regions six County Sports/Physical Activity Partnerships
- 89% of PCTs reported evaluating and monitoring physical activity programmes – the definitions of success vary from scheme to scheme as do the objectives of the programmes and this means that it is not possible to compare and contrast interventions or areas at present.
- Nearly half (46%) of PCTs provide staff training regarding physical activity, this ranges from a two hour session to week long accredited courses.
- 79% of PCTs currently offer staff opportunities to participate in physical activity interventions, the most frequently cited interventions was health walks, which were offered by 14 PCTs.
- 67% of PCTs reported not currently

- having an employer travel plan in place that incorporates active travel.
- When asked what additional support was required to increase the priority of physical activity within PCTs 42% of respondents felt that support from central government was of key importance through the inclusion of physical activity within policy documents and the publishing of guidance on implementing policy and strategy regarding physical activity.
  - The issue of targets was also raised by 42% of respondents, with suggestions made that a National Physical Activity PSA Target be developed, that is linked to GMS contracts and star ratings.

## 1.2 Recommendations

- 1) Regional Partners to lobby for a national PSA target or performance indicator for physical activity.
- 2) PCTs to agree to develop physical activity action plans within local partnerships to encourage greater organisational sign up to physical activity from the Health Sector.
- 3) All strategic service leads should be supported in seeking opportunities to integrate Physical Activity within the wider public health remit.
- 4) All PCTs to actively engage with their County Sport/Physical Activity Partnership to enable the development of inclusive sub regional delivery plans for physical activity and sport.
- 5) PCTs should consult with County Sports/Physical Activity partnerships when reviewing and developing Local Delivery Plans (LDPs) to ensure that strategic visions for commissioning, delivering and the hosting of physical activity are incorporated into the Plans.
- 6) PCTs to refer to the Sport England 'Physical Activity and Sport Playing its Part in Choosing Health' Resource for Strategic Health Authorities and Primary Care Trusts<sup>4</sup> when reviewing and developing LDPs. (This resource can be downloaded from [www.sportengland.org/physical\\_activity\\_resource.pdf](http://www.sportengland.org/physical_activity_resource.pdf)).
- 7) All PCTs to have membership and representation within the Physical Activity Network for the West Midlands, contributing to the sharing of best practice and the development of physical activity across the region.
- 8) At a national or regional level a physical activity evaluation framework to standardise the collation of monitoring data should be developed to increase the evidence base for physical activity and enable benchmarking of interventions.
- 9) Ensure that PCTs recognise the cross-cutting nature of Physical Activity and the potential opportunities offered by taking a 'non-silo/thematic' approach to physical activity throughout their LDP
- 10) Enable the Strategic Health Authority, PCTs and partners to agree performance management criteria for commissioning and/or delivering physical activity through the development of recognised national targets.
- 11) The SHA should advocate the insertion of physical activity specific (targets/objectives) within LDPs and support the performance management of these physical activity objectives.
- 12) All PCTs to review 'in-house' workplace physical activity policy and be supported to recognise the benefits of having an active workforce.
- 13) All PCTs should be expected to have a named person responsible for the strategic development of physical activity. It will be necessary to ensure that investment and capacity is provided to guarantee that every PCT is in the position to have a Physical Activity Lead.
- 14) Develop a programme of training across the region to increase the capacity of front line health professionals to disseminate core physical activity messages to patients, for example utilising the BHF Physical Activity in Primary Care tool kit.<sup>5</sup>
- 15) Encourage all NHS organisations to develop employer travel plans inline with Regional Spatial Strategy targets and the Healthcare Commissions annual health check public health proposed developmental ladder.

## 2.0

# Introduction

## Physical Activity and Health

The Chief Medical Officers 'At Least Five a Week' report published in 2004/05<sup>1</sup> provided the scientific evidence-base on the impact of physical activity and its relationship to health. Following the publication of this report and the Choosing Health White Paper, the Choosing Health Physical Activity Delivery Plan<sup>6</sup> was developed which sets out a cross-government plan that recognises physical activity as a public health intervention. The most recent Department of Health publication, Your Health, Your Care, Your Say<sup>7</sup> supports continued improvement in opportunities and interventions that allow individuals to take responsibility for their own positive health choices. At the moment, physical activity service provision is non-mandatory for both health organisations and local authorities. As well as this, there are currently no national indicators or performance measures for physical activity in its widest sense, although PSA targets do exist for some specific elements of physical activity such as sport and school sport.

The new performance framework for NHS organisations<sup>8</sup> identifies the National priorities to inform localised targets. This framework covers the four broad areas detailed below:

- Health and well-being of the population
- Patient/user experience
- Access to services
- Long term conditions

This allows Primary Care Organisations (PCOs) to deliver locally defined and needs led services which improve health and social care outcomes within these four broad areas even if there is no mandatory national requirement for such activities.

Physical Activity interventions have been clearly shown to demonstrate wide ranging health benefits, both physical,

psychological and social in nature. Regular physical activity has been demonstrated to maintain and improve health and to prevent ill health, regardless of age, gender or ethnicity<sup>1, 9-16</sup>. Physical inactivity is responsible for an estimated 3% of all disease burden in developed countries<sup>17</sup>. The cost of physical inactivity in England, including both the direct costs of treatment for the major lifestyle-related diseases, and the indirect costs including sickness absence have been estimated at £8.2 billion a year<sup>1</sup>. Smoking costs around £3.8 billion per year.

### 2.1 Physical activity's contribution to national targets (PSAs)

With the increased focus on the use of developmental and core standards within health and social care, rather than targets and prescriptive measures, it is possible to develop a framework to support the delivery of National (often cross-departmental) Public Service Agreements (PSAs) to which sport and physical activity interventions can contribute.

A combination of the Department for Culture, Media and Sport (DCMS), the Department of Health (DH), the Office of the Deputy Prime Minister (ODPM) and the Department for Education and Skills (DfES) National PSA targets form the National overarching Governmental and strategic drive for increasing physical activity levels. However, the health PSA targets relating to physical activity are:

- Halting the year-on-year increase in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole.
- Improve the health of the population: By 2010 increase the life expectancy at birth in England to 78.6 years for men and 82.5 for women and improve health outcomes for people with long term conditions.

- Substantially reduce mortality rates by 2010: from heart disease and stroke-related diseases by at least 40% in people under 75, from cancer by at least 20% in people under 75.
- To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people at risk: All people (including children) with long-term conditions.
- Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30 % of the total being supported by social services at home or in residential care<sup>18:19</sup>.

Within the Choosing Health White Paper and its associated Physical Activity Delivery Plan<sup>6</sup>, reference is made to a series of ambitious targets to increase levels of participation in physical activity and sport:

"In his final report, Securing Good Health for the Whole Population<sup>20</sup>, Derek Wanless recommended delivery of the lower, 'medium term' Game Plan target by 2020, i.e. 50% of the participation, with short and medium term objectives fixed for 2007 and 2011. This would aim for a prevalence of physical activity in England that is similar to the levels found in Canada and Australia, and a **1% per annum trajectory**. Such a target would be both stretching and would require strategies to help individuals to build activity into their daily lives".

## 2.2 The Evidence - what physical activity interventions are effective?

The National Institute of Health and Clinical Excellence (NICE) has recently published guidance on four commonly used methods to increase physical activity and the most effective ways that professionals both within and outside the NHS in England can achieve this. The four interventions considered are brief interventions in primary care, pedometers, exercise referral schemes and organised walking and cycling groups or projects.<sup>21</sup>

The guidance document is published alongside implementation tools, including implementation guidance, an auditing system for NHS organisations to comply to the guidance and costing spreadsheets to identify the cost effectiveness of interventions. The NICE guidance and the implementation tools can be downloaded from the NICE website [www.nice.org.uk](http://www.nice.org.uk). NICE is currently developing a further set of guidance regarding physical activity focussing on the environment and physical activity that is due for publication in early 2007. The scope for developing this guidance is also available from the NICE website.

Further to this guidance NICE has recently published two briefing documents regarding the evidence base for the effectiveness of a variety of physical activity interventions;

- Transport Interventions promoting safe cycling and walking evidence briefing.<sup>22</sup>
- Promotion of physical activity among adults; Evidence into practice briefing.<sup>23</sup>

These documents can be downloaded from the NICE website.

## 2.3 Developing physical activity in Primary Care

In 2006 Sport England published a web based tool kit to aid the development of physical activity in primary care settings<sup>4</sup>. The resource is designed to help the health sector improve the planning, strategic placement, partnerships, resource commitments and performance management of physical activity. The resource has been developed through wide consultation with twenty eight Strategic Health Authorities, Teaching Primary Care Trusts and Primary Care Trust, key commissioners and local partnerships and builds on preliminary work by the British Heart Foundation National Centre for Physical Activity and Health, outlining where physical activity aids the delivery of health outcomes.

The resource has three main elements;

- Information for commissioners explaining the strategic fit of physical activity for specific target groups, incorporating priority activities, measuring progress and reaching health improvement targets.
- A service planning and monitoring table has been developed, setting out the relevant targets, priority areas and suggestions of physical activity interventions to meet the targets. These interventions are cross referenced to Health and Social Care core and developmental standards.
- A guide checklist for commissioners to use when planning potential physical activity interventions.

The resource can be downloaded from [www.sportengland.org/physical\\_activity\\_resource](http://www.sportengland.org/physical_activity_resource).

## 2.4 The infrastructure for developing and delivering physical activity and sport in the West Midlands

The delivery structures for developing and delivering physical activity, sport

and active recreation in the region are now established and developing action and delivery plans to meet the commitments set out in the Regional Plan for Sport<sup>2</sup> and the Choosing Health Physical Activity Delivery Plan<sup>6</sup>. These structures exist at a regional, sub regional and local level and incorporate the delivery system for sport. Appendix 1 provides a diagrammatical overview of these structures and how they interact with other regional organisations and partnerships.

### 2.4.1 The Physical Activity Network for the West Midlands – PAN-WM

The need for a Regional Physical Activity Network in the West Midlands was identified during the consultation process for the Regional Plan for Sport in late 2003, early 2004 and a mapping exercise of physical activity interventions in the West Midlands. Physical activity and sports programme deliverers and practitioners in the region identified a number of barriers to developing the physical activity agenda and felt that a regional network would enable the sharing of information across organisation boundaries; enabling the sharing of good practice, providing increased networking opportunities in the West Midlands to support the emerging physical activity agendas, and encouraging the development of local networks and partnerships.

As a result of this identified need the development of a Physical Activity Network for the West Midlands was written into the “Improving the Health and Well-being of People Through Sport” objectives detailed in the Regional Plan for Sport 2004 – 2008.

The Network was officially launched on the 7th of December 2005 and became a constituted body in July 2006 at its first Annual General Meeting. Since then the Network has gone from strength to strength providing support

to those working to increase physical activity participation levels across the region, to the hosting of events, the development of resources, the dissemination of information, and responding to consultations.

The Network has the vision to become “A Sustainable, Independent Network That Supports The Physical Activity Agenda For The West Midlands” and focuses its activity in four areas to aid the development of physical activity in the West Midlands:

- To be a consultative and influencing network for the development of regional physical activity planning.
- To hold regional events, relating to relevant topics that will have a regional and local impact.
- To provide opportunities for those working in the wider physical activity sector to network, share and access information and develop skills.
- To contribute to the evidence base of effective physical activity interventions through the collation of best practice examples.

The network hosts a number of sub groups including a research group and the health and activity legacy 2012 group for the region  
Further information on PAN-WM can be found at [www.wmpho.org.uk/paf](http://www.wmpho.org.uk/paf).

#### 2.4.2 The Delivery System for Sport

The Government expects local authorities and other public sector agencies and their partners to work together to ensure public services meet community needs. The Delivery System is Sport’s “delivery chain” and is shown in figure 1.

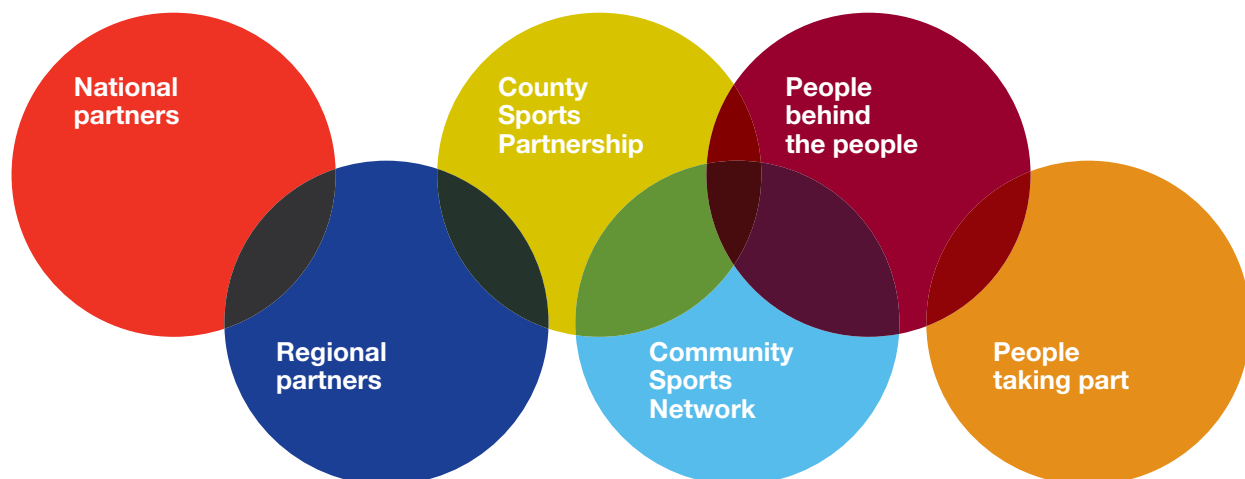
In addition to the aim of creating clear pathways for people talented in sport the main aim of the system is **to increase the number of people taking part in sport and recreation, especially among the hard to reach.**

The ambition of Sport England ([www.sportengland.org](http://www.sportengland.org)) is to lead and support the development of a holistic, coherent and quality assured Delivery System. The two key elements of the system at a local level are the County Sports Partnerships and the Community Sports Networks.

The entire current context of Sport and Active Recreation represents a huge challenge nationally and locally. The Delivery System is key to achieving Sport and Active Recreation goals by ensuring all bodies, agencies, organisations and partnerships leading sport are united beneath a shared vision and outcome. It clarifies the role that different agencies play in delivering sport and active recreation opportunities providing:

- An opportunity for agencies and organisations to work together towards agreed, shared goals
- An opportunity to reduce inefficiencies and create economies of scale
- The foundations to easily identify and fill gaps in local provision of sport and active recreation
- The opportunity for non-sporting agencies to gain the benefits from working with sporting agencies to achieve their own goals
- Effective measurement of performance and improvement over time
- The ability to quality assure and benchmark.

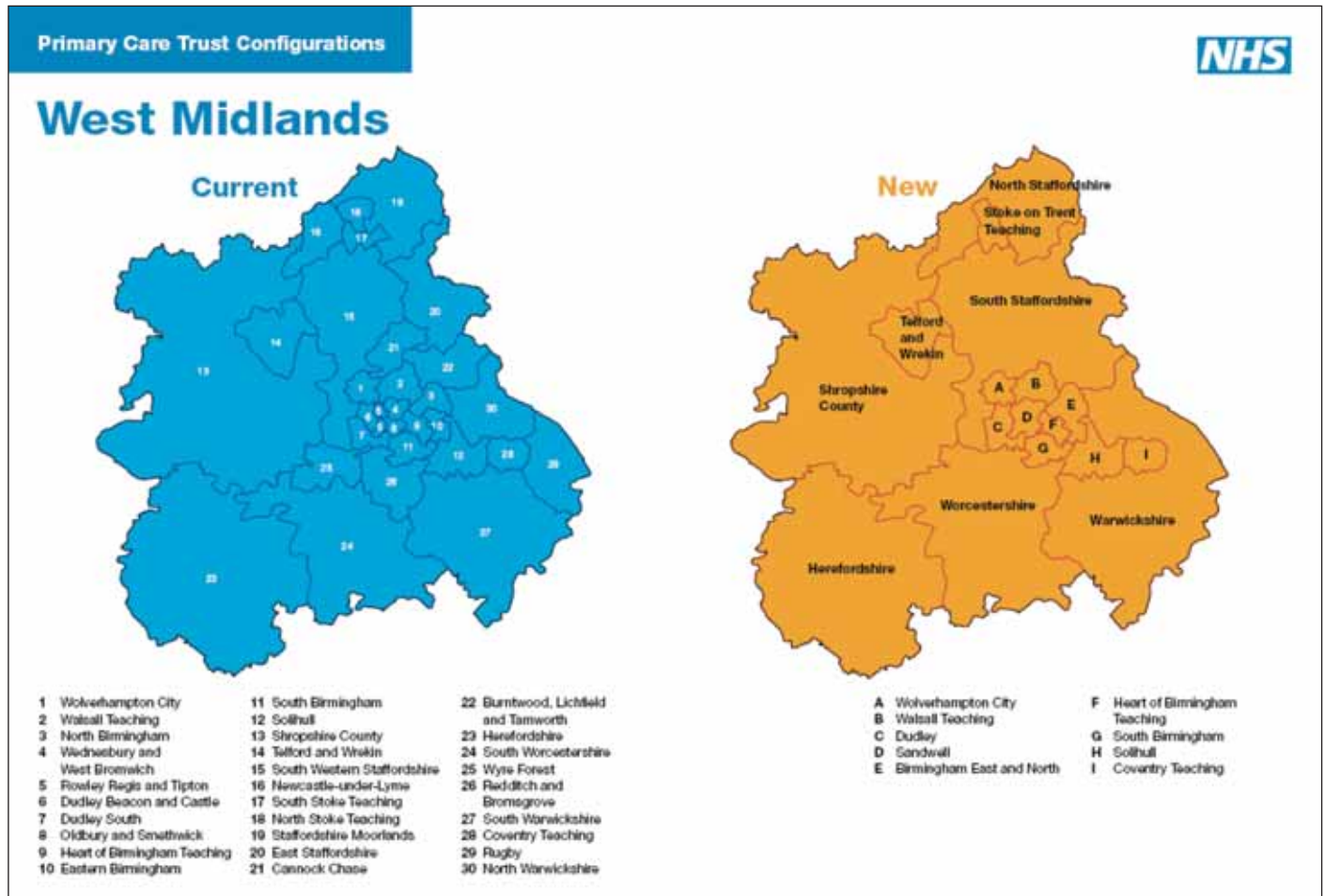
Figure 1. The Delivery System for Sport



### 3.0

# The Context of the Physical Activity Audit of PCTs

Figure 2: The old and new Primary Care Trust configurations for the West Midlands



The Chief Medical Officer’s “Five a Week” report<sup>1</sup> and more recently the Choosing Health White Paper and its subsequent delivery plans<sup>6</sup> have significantly increased the profile of physical activity as a public health intervention. The evidence base for physical activity’s ability to contribute to the prevention and treatment of a number of chronic conditions has been established and continues to grow as does the number of localities in the West Midlands that have or are currently establishing physical activity programmes to tackle issues such as health inequalities, chronic disease and

community regeneration. The Regional Plan for Sport<sup>2</sup> sets the target for a 1% increase in physical activity participation levels year on year in the West Midlands and Sport England West Midlands is working closely with the West Midlands Public Health Group and other partner organisations to make this outcome a reality.

It is envisaged that the audit report will be used by Regional and local bodies (Sport England West Midlands, West Midlands Public Health Group, Obesity Task Group, Regional Health Partnership, PCTs Local

Authorities etc) to identify where additional support and resources are required and aid physical activity investment and resource planning in future years at a regional, sub regional and local level.

The three main functions of a PCT are to;

- engage with its local population to improve health and well-being;
- commission a comprehensive and equitable range of high quality, responsive and efficient services, within allocated resources, across all service sectors; and

- 
- directly provide high quality responsive and efficient services where this gives best-value.

This includes assessing local needs and priorities, designing services, shaping the supply structure, managing the demand for services and providing community based services. The PCTs are performance managed by the Strategic Health Authorities whose function it is to provide strategic leadership and organisational and work force development.

The Healthcare landscape in the West Midlands changed in July 2006 with the regions three Strategic Health Authorities merging to become a single Strategic Health Authority. The PCT landscape in the West Midlands will be changing in October 2006 with a number of PCTs in the region set to merge, decreasing the numbers of PCTs from 30 to 17 Figure 2 provides the details of the old and new configurations for the PCTs in the region. It is important that in the current climate of financial concerns, staff resources and the merging of PCTs that public health interventions such as physical activity are improved upon and in no way reduced, as the Choosing Health agenda continues to be of high priority to NHS organisations.

This audit report provides a detailed picture of the current status of physical activity within each of the PCTs in the West Midlands and provides a baseline on which regional, sub regional and local partners can work with the newly configured PCTs to ensure that physical activity is embedded in the public health approaches that are being developed.

### **3.1 Aims and objectives**

The overall aim of the audit was to provide a baseline of the current activity and priority given to physical activity interventions within the Primary Care Trusts (PCTs) in the West Midlands Government Office Region.

The objectives of the audit are:

- To fully develop an audit tool to enable the collection of data concerning the planning, implementation and evaluation of physical activity interventions (including any whole system planning and partnership approach and priority given to such interventions).
- To undertake an audit of the published Local Delivery Plans (LDPs) through the PCTs in the West Midlands Government Office Region.
- To undertake an audit of the current planning, implementation and evaluation processes of physical activity interventions across the PCTs in the West Midlands Government Office Region.
- To assess the levels of partnership working, led by or including the NHS to improve physical activity levels across the population covered by the PCTs in the West Midlands Government Office Region.
- To complete a report detailing the findings of the audit process.

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## 4.0

# Methodology

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### 4.1 Timescales

The audit was undertaken in March 2006 prior to the new PCT configurations being announced.

### 4.2 Development of the audit tool

The audit developed had two main elements:

- An assessment of the Local Delivery Plan (LDP) and published information of the PCT was completed utilising the PCTS published documentation, including websites and LDPs and supporting documents.
- A self-completion questionnaire for PCT personnel to complete. This survey was sent to either a pre identified physical activity lead or Public Health Director at PCT. Each Survey was sent with a cover letter from the Regional Director of Public Health and a prepaid return envelope to aid response rates.

The audit tool can be seen in full at appendix 2.

### 4.3 Pilot study

An audit tool was developed and then piloted in two PCTs outside of the West Midlands. They were selected through a process of random number generation. The websites and LDPs were accessed prior to telephoning the PCTs to ask for permission to send the pilot audit tool. Both PCTs gave permission and completed and returned the tool within 7 days. Following the pilot no changes were made to questions asked in the survey, although some small changes were made to the presentation of the tool, this included a cover letter from the Regional Director of Public Health to support the audit and detailing the reasons for it.

### 4.4 Data entry and analysis

Each LDP and website was independently assessed by two members of the research team. Each researcher completed a written content analysis of the published information. For both the written responses to the LDP and website content analysis and the written responses to the PCT survey, quantitative information was entered onto one of two tables within an Access database. This reduced entry error. Qualitative data was entered onto a Word document and then uploaded into NVIVO (V5) a qualitative coding and analysis software package.

Quantitative data analysis was undertaken using SPSS v11 package for social statistics. This was used to generate frequencies and basic level statistical information. Qualitative information was coded using Burnards 13 stage thematic process.

## 5.0

# Response rate

### 5.1 LDP and website assessment

Of the 30 PCTs in the West Midlands only one LDP was not accessible during the audit process, meaning 29 PCTs were included in the assessment of LDPs. All 30 PCTs websites were accessed as part of the assessment of the strategic inclusion of physical activity within PCT plans.

### 5.2 PCT Survey

24 (80%) of the PCTs in the region responded to the survey. The responding PCTs are listed below in alphabetical order. It should be noted that a number of PCTs collaborate regarding physical activity and share resources, as such the Oldbury and Smethwick, Rowley Regis and Tipton, and Wednesbury and West Bromwich PCTs are all categorised within Sandwell's response, Dudley Beacon and Castle and Dudley South PCTs also share a response. The surveys were completed by either health improvement, health promotion or physical activity specialists within each PCT.

The PCTs who responded to the survey are seen below in alphabetical order;

- Cannock Chase
- Dudley Beacon and castle
- Dudley South
- East Staffordshire
- Heart of Birmingham
- Herefordshire
- Newcastle under Lyme
- North Warwickshire
- North Stoke
- Redditch and Bromsgrove
- Sandwell (incorporating Oldbury and Smethwick, Rowley Regis and Tipton and Wednesbury and Westbromwich)
- Shropshire County
- Solihull
- South Birmingham
- South Stoke
- South Warwickshire
- South Western Staffordshire
- South Worcestershire
- Staffordshire Moorlands
- Telford & Wrekin
- Wolverhampton City
- Wyre Forest

**Table 1: Response rates to the questionnaire per strategic health authority area.**

SHA	Number of PCTs responding	% of possible responses in SHA
West Midlands South	6	75%
Shropshire and Staffordshire SHA	9	90%
Birmingham & the Black Country SHA	9	75%
West Midlands GO region	24	80%

## 6.0

# Assessment of the PCT Local Delivery Plans (LPDs)

All PCTs are required to produce LPDs to determine how the local health systems will progress to achieve key targets set by the NHS. The LPDs set out how funding will be allocated to meet objectives and are developed in collaboration with local partners such as the Local Authority, Acute Health Trusts and Community Services. There is at present no mandatory requirement for PCTs to set objectives regarding increasing levels of physical activity, however as a strategic document and the main performance management framework for the PCT it is important that physical activity begins to be written in to the plans to ensure future prioritisation and funding.

Table 2 shows the main priority headings that PCTs would be expected to target through the LDP processes and highlights where physical activity has been cited explicitly as a method of meeting those priorities.

The assessment of the LPDs in the region highlighted that the predominant priority headings for PCTs are patient experience, cancer, older people, improving access to services, coronary heart disease, children, drug and substance misuse and reducing health inequalities with 70 – 96% of PCTs stating these as priorities. Public Service Agreement targets have been set for obesity by the Department of Health, it is noted that 30% of PCTs have this as a priority heading in the LPDs.

Table 3 highlights that out of the 11 priority areas within the LPDs, physical activity is infrequently cited in relation to the PCTs priority areas, only being mentioned under 5 areas. The most references for the use of physical activity interventions are associated with coronary heart disease, reducing health inequalities and obesity.

**Table 2: LDP Priority area with explicit reference to physical activity**

Priority Headings	No. of PCTs with this priority heading Stated in the LDP	Physical Activity Explicitly mentioned
Coronary Heart Disease	26	6
Diabetes	16	3
Obesity	9	4
Cancer	28	-
Older people	28	-
Workforce	16	-
Improving access	27	-
Reducing Health Inequalities	21	5
Children	26	3
Drugs and substance misuse	24	-
Patient Experience	29	-

**Table 3: Frequency of the inclusion of physical activity within LDP priority areas**

Priority area	No of LPDs explicitly mentioning Physical Activity
Coronary Heart Disease	6
Diabetes	3
Obesity	4
Reducing Health Inequalities	5
Children	3

The LPDs include proposed plans to progress towards meeting the standards laid out in the National Service Frameworks for Diabetes, Children, Older People, Coronary Heart Disease, Cancer and Mental Health.

Table 4 highlights that despite many PCTs referring explicitly to National Service Frameworks (NSF) within their LPDs, none referred to physical activity as a supporting or planned mechanism to achieve the outcomes of the NSFs.

There is a wealth of evidence that would suggest that several standards, across all National Service Frameworks could be partly achieved through the development of physical activity interventions. Further details of this evidence can be found in the Chief Medical Officers Five a Week report<sup>1</sup>.

Assessment of the objectives cited in the LPDs found that overall 21 references were made to the development of physical activity

interventions, increasing physical activity generally or programmes where an element of physical activity could be included (e.g. Healthy Schools). These 21 references were found across 8 of the 29 PCTs (28% of the reviewed PCTs) however only 2 PCTs (7% of those reviewed) referenced specific physical activity interventions or support. The rest of the references were non specific statements such as “improving healthy choices”, “supporting healthy lifestyles”, “action planning”, “improving Long Term Conditions” and “partnership work”.

The setting of targets and objectives regarding physical activity was also assessed and found that 21% (6) of PCTs specifically referenced targets relating to physical activity from one very specific reference of “decreasing from 400 the number of premature deaths due to physical inactivity” to more generic targets with an element of physical activity included, for example, “increasing the number of Healthy Schools in the locality”.

### 6.1 Topics within the LDPs

The Assessment of the 29 LDPs accessed was used to determine the priority of particular topics for the PCTs in the West Midlands, many of which relate to the Choosing Health agendas. Topics were rated as high priority if it was stated in the LDP text or tables, medium priority if mentioned in the LDP text and low priority if the topic was not mentioned at all. Figure 3 shows that the high priority topics across the PCTs are;

- Smoking (100% of PCTs)
- Developing the Workforce (100% of PCTs)
- Older People (96% of PCTs)
- Tackling Health Inequalities (93% of PCTs)
- Young People (93% of PCTs)
- Mental Health & Well Being (90% of PCTs)

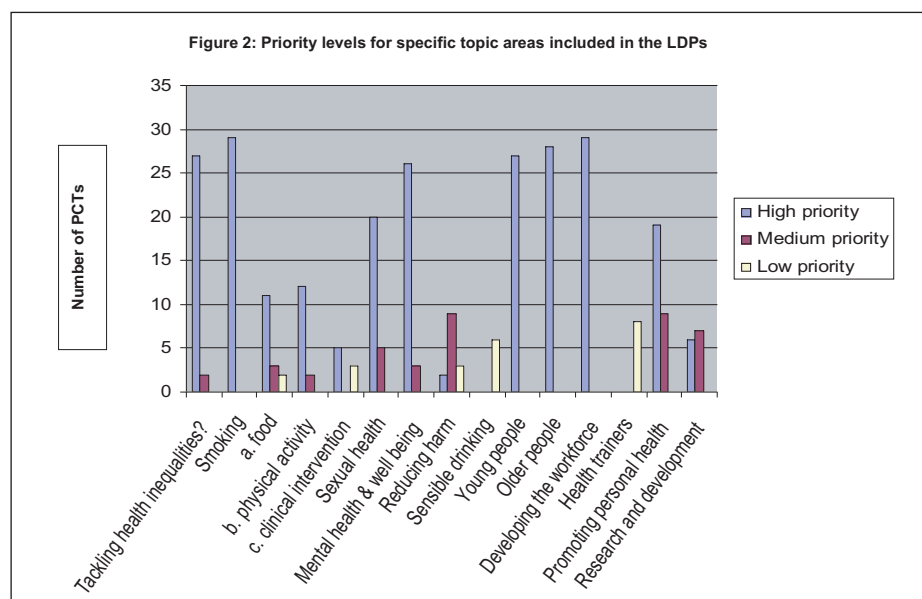
**Table 4: National service Framework references and explicit reference to physical activity**

NSF	Number of references	PA explicit reference
NSF: Diabetes	12	0
NSF: Children	18	0
NSF: Older people	13	0
NSF: Cancer	7	0
NSF: Mental health	19	0

Physical activity was categorised as a high priority for 41% of PCTs under the topic of tackling obesity, a further 7% of PCTs were categorised as having physical activity as a medium priority under the tackling obesity topic. These findings suggest that although a number of PCTs may not have Obesity as a priority heading (see table 2) within the LDP, obesity is being prioritised by approximately half of the PCTs within other priority headings for example, young people, diabetes, coronary heart disease and health inequalities.

Other priority topics not cited in figure 2 included 31% of PCTs prioritising diabetes, and small numbers of PCTs prioritising improving rates of breastfeeding (n=2), service sustainability (n=1), prison and ex offender health (n=1) and transport (n=1).

**Figure 3: Priority levels for specific topic areas included in the LDPs**



## 7.0

# PCT Survey Analysis

80% of the PCTs in the West Midlands responded to the mail out survey and an analysis of the responses has been completed. The surveys were completed where possible by the PCTs Lead on physical activity, where this role did not exist the survey was completed by the Director of Public Health or a member of the health promotion team.

### 7.1 PCT Physical Activity leads

Of the PCTs responding to the survey, two thirds (n=16, 67% of responders) had a named physical activity lead working within the PCT (Table 5).

The person who completed the survey on behalf of the PCT was asked to describe the amount of time in their role which is currently spent on developing/delivering physical activity interventions or support. Table 6 shows that the amount of time spent on developing physical activity ranged from 5% (n=7) to 100% (n=5) (mean 50%) (7).

It should be noted that where a PCT did not give an indication of the % of time that the physical activity lead or person answering the question spent on physical activity a percentage of 5% was attributed. Appendix 3 gives a list of the PCT physical activity leads identified in the survey.

Several of the PCTs have a number of staff available to develop and deliver physical activity interventions. Table 7 sets out the dedicated capacity that PCTs have put into place regarding physical activity. These staff may be funded by the PCT or by external grants and organisations, this is not clear at present.

**Table 5: Physical activity lead status within the PCT**

Response	Number of PCTs responding	Percentage of PCTs responding
No named physical activity lead	7	29%
Named physical activity lead	16	67%
No response to question	1	4%

**Table 6: % role spent on physical activity by the person completing the survey**

PCT Name	Physical Activity Named Lead Y/N	% of role spent on Physical Activity
Cannock Chase	N	5%
Dudley Beacon and castle	Y	75% - 80%
Dudley South	Y	75% - 80%
East Staffordshire	N	5%
Heart of Birmingham	Y	40%
Herefordshire	N	5%
Newcastle under Lyme	Y	100%
North Warwickshire	N	5%
North Stoke	Y	100%
Redditch and Bromsgrove	Y	20%
Sandwell (incorporating Oldbury and Smethwick, Rowley Regis and Tipton and Wednesbury and Westbromwich PCTs)	Y	100%
Shropshire County	N	5%
Solihull	Y	50% (part time post)
South Birmingham	Y	70%
South Stoke	Y	100%
South Warwickshire	N	5%
South Western Staffordshire	N	5%
South Worcestershire	Y	80%
Staffordshire Moorlands	Y	100%
Telford and Wrekin	Y	100%
Wolverhampton City	N	5%
Wyre Forest	Y	30%

## 7.2 Physical Activity Interventions

It is recognised that a PCT may host, deliver or commission physical activity interventions within its locality. The analysis found that of the PCTs responding to the survey, 71% of PCTs are hosting physical activity interventions, just under half of PCTs are commissioning physical activity interventions from partners and 42% of PCTs are delivering physical activity interventions.

Figure 4 further quantifies this support further identifying how many interventions are being hosted, delivered and commissioned by the PCTs. The number of activities hosted ranges from 0-3 (mean 1), delivered ranges from 0-3 (mean 1) and commissioned ranges from 0-6 (mean 1) per PCT. Several of the PCTs host and deliver a large number of projects under one programme, this has been included in the chart as one intervention programme for this analysis. 5 of the PCTs (21%) host, deliver and commission multiple interventions.

**Table 7: Dedicated Staff resources for physical activity within the PCTs**

PCT Name	Staff Resource for Physical Activity
Dudley Beacon and castle	1 lead plus 2 posts working across the 2 Dudley PCTs
Dudley South	1 lead plus 2 posts working across the 2 Dudley PCTs
Newcastle under Lyme	1 part time post working across 4 PCTs (lead)
North Stoke	1 part time post working across 4 PCTs (lead)
Sandwell (incorporating Oldbury and Smethwick, Rowley Regis and Tipton and Wednesbury and West Bromwich PCTs)	1 lead plus 4 posts working across the 3 PCTs
Solihull	1 lead post
South Birmingham	1 post working with schools
South Stoke	1 part time post working across 4 PCTs (lead)
South Worcestershire	1 post (currently vacant)
Staffordshire Moorlands	1 part time post working across 4 PCTs (lead)
Telford and Wrekin	1 lead plus 2 posts

**Table 8: The level of support given to physical activity interventions by PCTs**

Level of support	Number and Percentage of PCTs
PCTs Hosting Physical Activity Interventions	17 (71%)
PCTs Delivering Physical Activity Interventions	11 (46%)
PCTs Commissioning Physical Activity Interventions	10 (42%)

Example of analysis for Figure 4;

7 PCTs are hosting 3 interventions, 6 PCTs are delivering 3 interventions and 2 PCTs are commissioning 3 interventions.

The interventions being hosted by the PCTs include; exercise/GP referral schemes, the National Stepometer Programme, Sure Start activities, Walking schemes and programmes targeting older people and children.

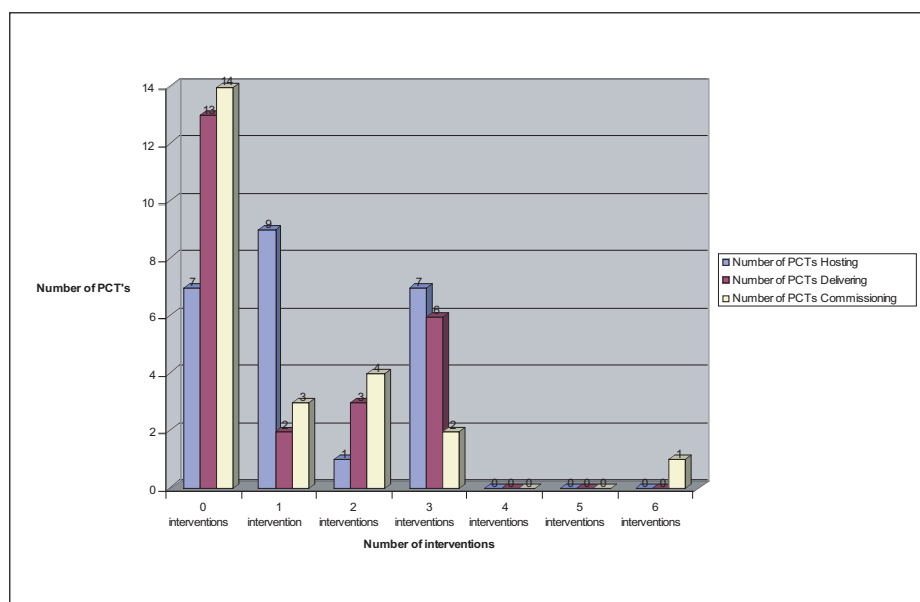
The interventions being delivered by PCTs include; the National Stepometer Programme, Walking schemes, Activity in schools, Falls prevention programmes, obesity programmes, large scale programmes to increase physical activity in target groups.

The interventions being commissioned by PCTs include; cycling schemes, free swimming, rowing activities in schools, exercise referral, arts type programmes to raise awareness, green gyms and green exercise. A comprehensive list of all of the interventions hosted, commissioned and delivered by each PCT can be found in appendix 4.

A number of the PCTs have initiated physical activity programmes to target specific group's in the community these include the following:

- Young offenders
- Rural isolated
- Over 60s/older people
- 5-13 year olds
- Low income families with young children
- Sedentary adults
- People aged 50+
- Under 4 year olds and their parents
- People with Long Term Conditions
- Black and ethnic Minority Clients
- Older people with a history of falling
- People with mental health conditions
- People at risk of CHD
- Practice populations with identified low- medium risk of ill health

**Figure 4: Number of PCTs hosting, delivering and commissioning number of interventions**



A number of these target groups are explicitly mentioned within the objectives of the Regional Plan for Sport.

### 7.3 Evaluations and target strategies

Evaluation strategies vary from organisation to organisation, and more specifically, from intervention to intervention, however, 89% of all of the interventions listed in the appendices have an evaluation strategy documented, whether quantitative or more qualitative. There is clearly not one framework or methodology being used that will allow for external comparison of one intervention with a similar one being run across PCT boundaries.

Definitions of success range from individual attendee details such as continued attendance and adherence to programmes, a year on year increase in use and attendance of a walk service and the number of GP's referring patients onto a programme. Objectives also include examples such as a

sustained increase in activity levels amongst the target groups and increased mobility in the client group. External evaluations are being undertaken on a number of interventions, this is particularly seen where external grant funding has been secured to deliver a programme. Several PCTs state that annual reports are available for the programmes that are being delivered and hosted within their locality.

### 7.4 Partnership working and networking

The health promotion, health improvement or physical activity specialists completing the survey were asked to identify the sectors that they work in partnership with and to estimate the regularity with which they are in contact with those identified partners.

Table 9 determines that the most commonly cited key partners were partners from sport/leisure/fitness

**Table 9: Partner contacts and key agencies**

Partner	Never meet	Occasional meet	Quarterly	Monthly meet	Weekly meet	Key Partner
Sport/Leisure/Fitness	0	1	4	6	11	20
Acute health	6	2	3	4	5	8
Community health	5	4	3	0	9	10
Voluntary groups	5	3	4	2	7	9
Private sector	5	6	4	4	1	6
School health	3	3	7	7	2	10
Education	1	2	5	6	8	12
Social Services	9	3	3	4	0	4
Transport	5	5	4	2	5	8
Environment	11	2	4	2	1	4
Council	4	1	4	4	8	7

agencies (n= 20, 83%), followed by education (n=12, 50%). The data suggests that many health improvement sections within the PCTs are not engaged with partners from environmental agencies with 11 respondents (46%) reporting never meeting with Environmental sector partners. 9 PCT respondents report never meeting with social services (38%). Over a third of respondents report never meeting with partners from acute health agencies (n=6, 25%), however there are a number of obvious areas where this could occur including cardiac rehabilitation, falls prevention, respiratory rehabilitation and the potential for health promotion within acute settings.

8 respondents (33%) listed transport as a key partner, there is much potential for this area of partnership working to expand with active travel, employer and school travel being obvious areas of interest as well as issues such as

access to healthy foods and health services. 38% of respondents cited voluntary groups as key partners, this is likely to increase in the future as the PCTs move towards a commissioning for health approach to service delivery.

Respondents reported meeting with their sport/leisure/fitness partners the most frequently, with 46% of PCTs reporting holding weekly meetings with this key partner.

The survey also requested details of the networks that the PCT were involved in, and looked to gauge the extent of the PCTs involvement in the networks.

Table 10 shows that the most frequently cited network for the PCTs to be involved in were physical activity networks with 3 PCTs (13%) not stating involvement in this type of network, therefore 87% of PCTs are involved in Physical Activity Networks in some capacity. A detailed analysis found that

6 PCTs Chair 10 physical activity networks in their locality, it should be noted that two of the network's chaired by PCTs were also initiated by the PCT, with a further 1 Network being initiated but no longer chaired by a PCT. A further 14 of the Physical Activity Networks in the region have the PCTs as members, this ranges from the Regional Physical Activity Network (PAN-WM) to local physical activity strategy and delivery groups.

Other key findings from the analysis are that;

- 12 (50%) PCTs were cited as members of the County Sports Partnerships in the region, a further 4 PCTs were involved in local Sports Networks such as PE strategy groups.
- 10 (42%) PCTs were cited as members of the Physical Activity Network for the West Midlands, (several of whom who were represented on the Networks steering group).

- 7 (29%) of the responding PCTs are involved in Transport Networks, all of which relate to cycling groups at either a regional or a local level. A third of PCTs are members of environment or planning groups

### 7.5 Funding

According to the completed surveys, approximate PCT funding allocations for physical activity interventions range from £0 - £320,090 for the 2006/07 financial year, 4 PCTs were unable to state the local commitment as this has yet to be defined. One PCT reported a large external grant to develop and deliver physical activity population interventions.

When the cited commitments from PCTs are added up, £1,002,552 (mean £41,773) is reportedly being spent on physical activity interventions in this financial year, with an additional £185,333 being allocated from external grants in one locality. This adds up to a spend of £1,187,885 on physical activity across the PCTs in the West Midlands.

Table 11 highlights where the financial allocations are being spent by the PCTs, 67% of the total funding from PCTs is spent on the development of interventions and programmes, with a further 31% spent on staff resources to implement and develop the interventions. It is assumed that the cost of evaluation and administration are included within the funding for development and interventions, as these were not detailed separately within many of the PCTs responses. 9 PCTs were able to give projected figures for implementing the Choosing Health recommendations. These range from £212,000 - £1,490,000 (mean £764,148.11). For most PCTs this is an opportunity to increase the funding allocated to physical activity interventions, further planned investment in physical activity ranges from £0 to £200,000 within the PCTs.

**Table 10: Number of networks chaired, initiated and member by respondent PCTs**

	Chair	Initiator	Member
Physical activity network	6	4	14
Sport Network	-	-	18
Transport	-	-	7
Healthy Schools	3	-	12
Environment/planning	-	2	8
Other	1	-	7

**Table 11: Range and mean cost allocation for physical activity from PCTs**

	Range	Mean	% of total spend across region
Staff	0-£128,000	£13,346.17	31%
Accommodation	0-£4,500	£187.50	0.20%
Admin	0-£17,000	£770.83	1.80%
Development and interventions	0-£200,00	£27,468.50	67%
Total Spend	£0 - £320,090	£41,733	100%

A number of PCTs are currently negotiating on the Choosing Health monies spending but one PCT where the allocation has not yet been announced has been prohibited from commissioning or delivering any innovation due to financial restraints.

The range of activities offered by the PCTs is in the most part dependent on the amount of funding available to develop interventions and the staff resources to develop such programmes. Table 12 highlights the type of interventions that the PCTs are involved in at the widest ends of the funding levels continuum (£3,000 and £320,000). The PCT at the higher end of the scale has a number of programmes running as part of a strategic activity programme, with dedicated staff time and resources available. The PCT at the lower end of

the spectrum does not have a dedicated physical activity person available to develop interventions and hosts and delivers smaller scale programmes

### 7.6 Training of Staff

11 PCTs (46%) offer some kind of training opportunities to staff regarding physical activity interventions, this training ranges from a two hour session to week long training courses some of which are accredited. The courses identified by the PCTs can be seen in table 13.

Table 13 shows that the walk for health initiative walk leader training is the most cited training offered to Primary Care staff, it also provided through several PCTs to community volunteers. Only 2 PCTs has reported providing generic training on physical activity to practice based staff. Twenty five (83%) PCTs in the region have signed up to the National Step-o-meter programme and as such it is envisaged that the amount of training regarding physical activity and walking in particular will rise significantly during 2006 – 2007.

**Table 12: Example of the Interventions developed at either end of the funding Scale**

Level of Funding	Interventions Hosted	Interventions Commissioned	Intervention Delivered
£3,000	<ul style="list-style-type: none"> <li>• Exercise Referral</li> <li>• Walking Scheme</li> </ul>	-	<ul style="list-style-type: none"> <li>• Route to Health</li> </ul>
£320,000	<ul style="list-style-type: none"> <li>• Strategic Activity Programme</li> <li>• Physical Activity Referral</li> <li>• Children's Physical Activity</li> </ul>	<ul style="list-style-type: none"> <li>• Gardening ideal for all</li> <li>• Green Gym</li> </ul>	<ul style="list-style-type: none"> <li>• Health Walks</li> <li>• Cycle Training</li> <li>• EXTEND</li> </ul>

**Table 13: The training currently offered to PCT staff regarding physical activity**

Type of Training offered	Length of training	Who is the training targeted at	Provided By	Accredited by	Number of PCTs offering the training
Walk Leader Training	1 day	Public Health Nurses, Volunteers, PCT staff, health professionals	The Countryside Agency	Walk for Health Initiative	5
CYQ/Gayton Group Exercise Referral Certificate	1 week	Fitness Instructors	YMCA	YMCA and SkillsActive	1
Step-o-meter training	-	Practice based staff	PCT	Walk for Health Initiative	2
Physical Activity Referrer training	30 minutes	Health Professionals	YMCA	-	1
Facilitating Change	1 day	Frontline Health Professionals	Health Promotion Directorate	-	1
Attendance at conferences etc	1 day	All staff	A number of providers	various	1
Physical Activity Training	2 hours	Practice based staff	Physical Activity Team	British Heart Foundation	2
Bike Week Training	1 week	All PCT staff	Cycling specialists	-	1
Obesity Training	2 days	Community healthcare staff working with children and families	Royal Dietetics Association Behavioural Psychologist	-	1

## 7.7 The NHS as a Corporate Citizen – A Healthy Workforce

### 7.7.1 Staff Opportunities to be active

19 of the respondent PCTs (79%) currently offer staff opportunities for participating in physical activity interventions. Table 14 provides details of the types of activities that are available for PCT staff in the region and the number of PCTs offering them.

The most popular activity opportunities offered by the PCTs for members of staff are walking schemes, with 14 PCTs (58%) offering this type of activity. 5 PCTs offer cycle to work incentives/schemes, 2 PCTs have cited implementing bike loan schemes, which may aid an increased number of people to cycle to work. Access to leisure passes to facilities are only cited as available by one PCT, which is surprising when a number of leisure facilities offer corporate membership schemes.

Methods of promoting these activity schemes and physical activity generally include email briefings, dedicated pages on PCT websites and intranet sites, team briefings, notice boards, articles in newsletters, local workshops, specific programmes and internal conferences.

### 7.7.2 Employer Travel Plans

The establishment of employer travel plans is one way in which an organisation can increase its staffs activity levels, through the implementation of active travel policies as part of the wider employer travel plan. The Regional Spatial Strategy<sup>24</sup> sets the target of 30% of the region's work force being covered by employer travel plans by 2010. The NHS as major employers in the region should be contributing towards this target, enabling them to meet some of their corporate citizen objectives. Figure 5 identifies the number of PCTs in the region that currently have an employer travel plan, that promotes active travel.

**Table 14: Activities offered to PCT staff**

Type of Activity	Number of PCTs offering staff opportunity
Access to Activity database	1
Activity Sessions including Pilates and circuits	6
Activity Assessment	1
Bike loan scheme	2
Cycle to work schemes	5
Cycle Training	2
Everyday Sport Campaign	3
Exercise Referral	5
Family activities	2
Gym Access	1
Jogging Group	1
Leisure Club	1
Leisure Passes to facilities (corporate memberships)	1
National Step-o-meter Programme	2
Outward bound team sessions	1
Race for Life training for team members	1
Sure Start activities	1
Swimming	1
Walking scheme	14
Walk and Talk meetings	4

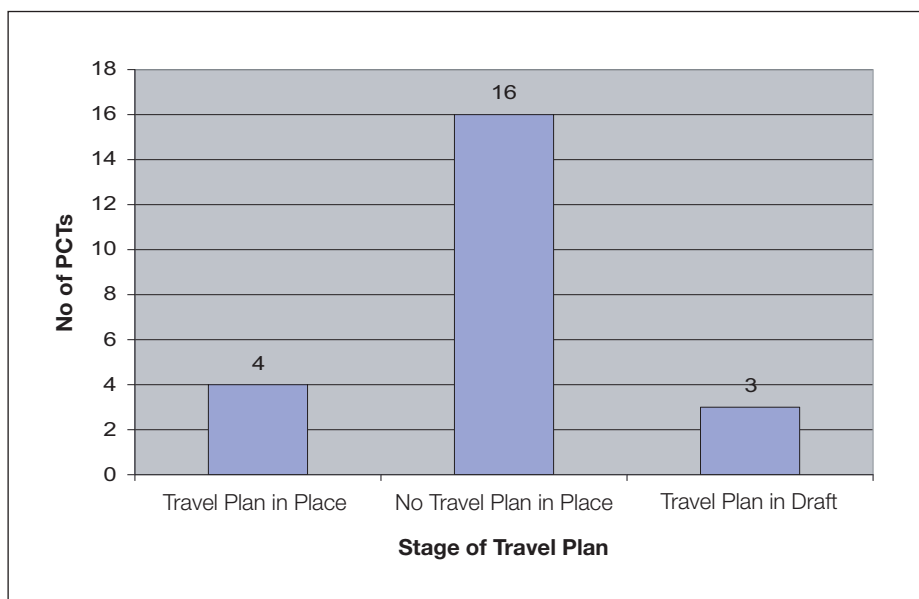
16 (67%) of PCTs responding do not currently have an employer travel plan in place for their staff that covers active travel. It should be noted that of the 16 PCTs reporting not having a travel plan in place, 4 of the PCTs have implemented a travel plan for the health promotion directorate but this does not cover the whole PCT. Only 17% of PCTs reported having a travel plan that covered active travel that was currently in place. There is huge potential for all PCTs to have Travel Plans in place that incorporate active travel programmes.

### 7.8 Increasing the profile of Physical Activity with Primary Care

Table 15 shows that almost half of PCTs stated, that an increase of or improved funding was required to enable them to increase the profile of physical activity within their PCT. This included the provision of ring fenced funding, more investment and the prioritising of funding. Linked to the funding issue is the investment in staff with 6 PCTs requiring improved or increased staff resources and time to develop and deliver physical activity interventions. Of these 6 PCTs, 3 did not have a Physical Activity lead. For the remaining 3 PCTs the time spent solely on the role of Physical Activity by the lead worker was 20% - 40%.

42% of respondents felt that support from central government was of key importance through the inclusion of physical activity within policy documents and the publishing of guidance on implementing policy and strategy regarding physical activity. The issue of targets was raised by 42% of respondents, with suggestions made that a National Physical Activity PSA Target be developed, that is linked to GMS contracts and star ratings.

**Figure 5: Travel plan status amongst respondent PCTs**



**Table 15: Content analysis of responses concerning the support needed to increase the priority of physical activity interventions within PCTs**

Theme	Number of PCTs mentioning
Support from Central Government through Policy and Guidance	10
Targets	10
Funding/Investment	11
Improved/More Staff resources	6
Strengthened partnership approaches	5
Improved Evidence base	3
Contractual frameworks	1
Senior management and organisations sign up	4
Agreed measurement/monitoring methods	4
Performance Management through SHA	2
Increased training opportunities	2

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Diagram 6 details the support that respondents suggested is needed to develop physical activity through the Primary Care Trusts and is categorised into National, Regional and local level support.

**Diagram 6: Support required at the different levels of Public Health Governance to develop Physical Activity through Primary Care Trusts**

**Department of Health and other Government Departments**

- National Physical Activity PSA target
- Target adopted into GMS Contract and Practice Based Commissioning and Star Rating audits
- Develop a stronger evidence base for effectiveness of specific interventions.
- Develop agreed monitoring and measurement criteria for targets
- Delivery of increased and adequate resources to PCTs to deliver physical activity agenda, it is suggested that this funding should be ring fenced.
- Duty for all PCTs to have a Physical Activity Action Plan in Place

**Strategic Health Authorities and Regional Public Health Groups**

- Develop a stronger evidence base for effectiveness of specific interventions.
- Performance Management of Physical Activity targets
- Duty for all PCTs to have a Physical Activity Action Plan in Place

**Primary Care Trusts**

- Organisational sign up to Physical Activity as a priority, through Chief Executive and Senior Management Teams.
- Adequate resources allocated to develop physical activity interventions
- Increased staff resources to develop physical activity
- Specific training on physical activity available for all PCT staff and frontline health professionals
- Stronger Partnership working, identifying joint priorities and increased joint commissioning for physical activity
- Development of Physical Activity Action Plan to determine practical actions
- Improved monitoring frameworks for physical activity to increase evidence base.

## 8.0

# Discussion

### 8.1 Strategic Vision

This audit has demonstrated the extent to which individual teams and workers within Primary Care Trusts in the West Midlands are currently working to implement positive public health activities through physical activity. The audit identified a range of physical activity interventions that PCTs are involved with implementing in their localities but raises questions regarding the strategic support for such interventions within primary care organisations. The assessment of the Local Delivery Plans (LDPs) highlighted the lack of a systematic, strategic vision for physical activity as a tool to promote and develop public health within the manifesto's of the Primary Care Trusts. The audit also demonstrated a seeming lack of strategic clarity relating to how physical activity interventions can be hosted, delivered or commissioned by PCTs to support strategic objectives and meet national standards and targets.

There is well documented evidence which suggests that physical activity interventions contribute to improved health and social outcomes for the population, and would enable the meeting of a diverse range of health targets, however most LDPs mentioned physical activity interventions fleetingly, if at all.

Most organisations cited Coronary Heart Disease (CHD) as a priority area, however only 25% (n=6) specifically mentioned physical activity interventions as a supportive mechanism to achieve the targets/objectives. Physical activity interventions have consistently been shown to reduce the risk of developing chronic diseases (Coronary Heart Disease, stroke, diabetes and cancers) by up to 50%<sup>9</sup>. It has been estimated that if the whole population were able to achieve the recommended levels of physical activity, stroke incidence could

be reduced by one quarter<sup>14</sup> and if those who are insufficiently active were to become moderately active, 10% of all deaths from CHD could be avoided<sup>15</sup>.

Evidence also exists which demonstrates that there is a convincing association between physical activity and the decreased risk of developing certain cancers<sup>1</sup>. This positive relationship is not picked up at all through the LDPs, despite 93% of PCTs having Cancer as a priority heading, physical activity is not detailed as an intervention towards meeting any objectives within this area of work.

The evidence for the use of physical activity interventions to prevent and treat diabetes is compelling, due to its ability to aid blood glucose control, 13% of organisations referred to physical activity interventions as a means of achieving the targets stated regarding diabetes prevention and management<sup>16</sup>.

For children, research evidence suggests that physical activity has a range of benefits during childhood, including healthy growth and development, avoidance of risk factors such as hypertension and high cholesterol, maintenance of energy balance, psychological and social well-being<sup>9</sup>, and yet only a small number (12%) of PCTs included physical activity as a means of achieving improvements in children's health under the priority area of Children within the LDP.

The recently published Obesity Care Pathway for the NHS recognises that Regular physical activity is important for weight control and reduces the risk of becoming obese by 50% compared to people with sedentary lifestyles<sup>1</sup>. A 10kg weight loss by an obese person is associated with numerous health benefits, for example, a 20% decrease in mortality. It also can reduce the risk of developing type 2 diabetes by up to

64%, independent of weight loss<sup>9</sup>. The results of the audit suggest that although a number of PCTs may not have obesity as a priority heading, it is being prioritised within other chapters such as young people, coronary heart disease and health inequalities, with physical activity categorised as a high priority for 41% of PCTs under the topic of tackling obesity. There is a need to build upon the focus of the National PSA target for obesity to increase the priority of physical activity as a prevention and treatment tool to enable this challenging target to be met long term.

Almost a quarter of objectives relating to reducing health inequalities (21%, n=5) referred to physical activity interventions within the priority headings of the LDP.

The British Heart Foundations National Centre for Physical Activity and Health have developed a number of briefing papers highlighting the evidence base for the meeting of National Service Framework (NSF) standards through increasing physical activity levels in the population generally and particularly for at risk groups. In particular two of the standards in the National Service Framework for Coronary Heart Disease specifically relate to increasing physical activity<sup>25</sup>;

Standard 1: All bodies will have agreed and be contributing to the delivery of a local programme of effective policies on increasing physical activity.

Standard 12: More than 50% of people discharged from hospital with a primary diagnosis of Acute Myocardial Infarction or with revascularisation, are regular exercisers at 1 year.

No PCTs referred to increasing physical activity as a mechanism to achieve any of the NSF outcomes within their LDP.

This suggests that further awareness raising is required at a strategic level of the use of physical activity as a strategic public health intervention to tackle a wide range of priorities. There is a clear need for planners and decision makers to understand the evidence base for physical activity, utilising tools such as *Sport England's Sport and Physical Activity playing its part in choosing health resource*<sup>4</sup>. The issue of cost effectiveness of interventions will also be of key importance, if resources are going to be forthcoming to physical activity development the case needs to be made for the inclusion of physical activity as an intervention over and above other interventions to tackle the prevention and treatment of chronic conditions i.e; medications etc. The issue of cost effectiveness must become a key research area for the physical activity sector.

## 8.2 Resources

Most respondent PCTs (67%) had a named physical activity lead, although the amount of time dedicated to physical activity varied widely from a minimum of 5% to 100% of a roles focus. A third of respondent PCTs reported employing a physical activity lead that had a 100% focus on physical activity with 7 PCTs (29%) reporting having more than one post devoted to the development of physical activity, this ranged from 2 – 4 persons within the organisations. Unsurprisingly, areas with at least one 100% focussed full time worker were able to deliver more than areas without one. This is reiterated further when cross referencing staff resource capacity with the range of interventions that are being commissioned, delivered and hosted by the PCTs shows that 5 of the 7 PCTs with more than one member of staff developing physical activity are delivering, hosting and commissioning multiple interventions in their locality. The two additional PCTs are delivering and

hosting large-scale interventions to meet specific strategic plans for increasing physical activity levels in the local population.

It has been estimated that physical inactivity costs England £8.2 billion<sup>1</sup> in health care and costs to the economy, this equates to a cost of £162.70 per person, based on the office of national statistics mid year population estimates for 2005, of 50.4 million people living in England<sup>26</sup>. The population of the West Midlands is 5.3 million people<sup>27</sup>, and equates to 10.5% of the total population of England. The financial implication of physical inactivity in the region could therefore be estimated to be 10.5% of the national cost, equating to £861,000,000 per annum in healthcare costs and losses to the economy through absence from work. These figures do not take into account the cost of rising obesity levels. Sport England's Active People Survey will enable levels of inactivity to be measured across England and monitor progress of the target to increase participation in sport and active recreation by 1% year on year. The results of the survey will be available from December 2006 at [http://www.sportengland.org/wm\\_active\\_people\\_headline\\_results\\_dec\\_06.pdf](http://www.sportengland.org/wm_active_people_headline_results_dec_06.pdf)

The funding allocations for physical activity interventions from the PCTs ranged from £0 - £320,000 and totalled £1,002,552 across the region for the 2006/07 financial year. The context of this should be set against the total PCT funding allocation for the same financial year of £6,757,456,000 across the West Midlands<sup>28</sup>. Physical activity commitments account for just 0.01% of the healthcare budget for the region. This equates to a spend of £0.19 per head of population on physical activity across the region by the Primary Care Trusts.

The audit found that 67% of the funding allocated to physical activity by the

primary care trusts was spent on the development and delivery of interventions, it is assumed that the costs of evaluation and administration are contained within these figures and suggests that the majority of the funding is going into the provision of services for the local community to access. A further 31% of funding is allocated to the staff resources needed to implement and develop these physical activity services. The audit found that the PCTs with the higher resource levels were more likely to be delivering a strategic programme of a number of interventions to target the local community than those PCTs with very limited resources.

With the publication of the Choosing Health White Paper came the promise of further funding to enable the implementation of the commitments in the delivery plans, this funding will be available in the PCTs 2006/07 and 2007/08 budgets as non-ring fenced monies. This funding includes what was referred to in the Choosing Health; Choosing Activity Delivery Plan as the "National Physical Activity Promotion Fund"<sup>6</sup>. As the funding is not ring fenced the PCTs can allocate the funding to meet local needs and priorities, and this process may mean that the increased funding does not lead to an increase in spending on physical activity as originally designed. The audit sought to establish where this additional money would increase current spending on physical activity. The audit found that 38% of the respondent PCTs were able to provide figures for the funding allocations for implementing the choosing health recommendations. The amounts of added investment for developing public health interventions from the Choosing Health allocations ranged from £212,000 - £1,490,000 in these PCTs. This additional funding has enabled a subsequent increased investment in physical activity ranging from £0 - £200,000 within the 9 PCTs providing details of the Choosing Health allocations. The use of the

choosing health allocations is still being negotiated in some organisations and as such there may be greater investments in physical activity than this report is able to suggest at present. There is a need to maximise the potential of the choosing health funding and build a strong case for PCTs to divert more of this funding to physical activity interventions. There is potential that this funding could be used by the PCTs to lever external funding sources to increase the investment in physical activity across the region.

For example, the new County Sports and Physical Activity Partnerships are now engaging a wide range of Local Authority, Education, Health, Commercial sector, etc. partners to combine funding to optimise returns on investment through the efficient delivery of Physically Activity related objectives. For the first time creating a consistent infrastructure for 'across the board' strategic planning and support at a local level.

When asked what support was needed to increase the profile of physical activity within the PCTs, those that reported not have a Physical Activity Lead reported a shortage of funding resulting in the lack of staff resource and subsequent lack of time for developing external funding applications, leading to further funding and development constraints. This problem may escalate, leading to a widening of the differences that this report has found between those PCTs investing in physical activity development and those that are not.

Without the staff resources the PCTs will clearly struggle to move forwards with the choosing health physical activity agendas. There is therefore a clear need to work with the PCTs that do not have a named physical activity lead and make the case for funding for such a post to enable internal and external funding to be levered to further the development of physical activity in

these localities and to influence the direction/detail within specific job descriptions to reflect a role around Physical Activity.

### 8.3 Partnerships and Networks

The need to and benefits of working in partnership with other sectors to achieve agreed aims and objectives has never been greater, particularly when taking into account the current funding climate and the development of local area agreements within the region. The "Delivery System for Sport" recommends the development of community sport and physical activity networks to drive forward the development of programmes and interventions at a local level. The Majority of PCTs (83%) rated the sport, leisure and fitness sector as a key partner, with just under half (46%) reporting meeting with representatives from these sectors on a weekly basis. It is heartening to see that 87% of PCTs reported involvement with a physical activity network, this ranged from being a member of the Physical Activity Network for the West Midlands to 6 of the PCTs chairing a local physical activity networks, although it should be noted that the effectiveness of these partnerships was not included as part of the audit.

42% of the PCTs reported having membership to the Physical Activity Network for the West Midlands. It is recommended that PAN-WM promotes itself as a support mechanism for PCTs regarding physical activity and that it should work to achieve a 100% sign up to from the PCTs in the region. 50% of PCTs were cited as being a partner in the County Sports Partnerships in the region. The County Sports Partnerships are the strategic lead for sport and physical activity at a sub regional level and as such it is recommended that Sport England and the West Midlands Public Health Group work with the County Sports Partnerships and PCTs to ensure that all PCTs are signed up as partners of the County Sports Partnership.

There is a need to raise the profile of transport and health partnerships with only a third of respondents citing the transport sector as key partners. There is much potential for this area of partnership working to develop for example;

- increasing participation in walking and cycling through initiatives such as school travel plans and its links to healthy schools and employer travel plans
- Access to health services
- Access to healthy foods

Many areas have undertaken health impact assessments of the local transport plans, enabling health approaches to be embedded with in local transport strategies. This is an approach which should be advocated across the region.

Many areas are developing increasing numbers of activities with wide and diverse partner agencies, and with wide and diverse target groups, this should continue to be promoted and endorsed

### 8.4 Evaluating Programmes

The evidence base for physical activity interventions that are effective in increasing physical activity levels is growing and it is important that local schemes continue to add to this by ensuring that programmes are evaluated and monitored at regular intervals.

Naidoo and Willis<sup>29</sup> outline that a rational planning process for programmes should be used to ensure that programmes are;

- based on evidence of local need
- have clearly defined aims and objectives
- consider evidence of effectiveness
- Have clearly defined outcome measures based on the specified aims and objectives

The ability to prove effectiveness and cost effectiveness of programmes is highly important from the point of view of maintaining or attracting continuation funding. The majority of interventions (89%) cited within this audit were found to have an evaluation strategy documented; this ranges from the collation of hard statistics and quantitative data to qualitative and anecdotal information.

The definitions of success vary from scheme to scheme as do the objectives of programmes, it is therefore difficult to compare and contrast schemes to establish whether one approach is more cost effective or successful than another even if the schemes appear to be similar from other perspectives. The development of a performance management framework, containing core indicators for the evaluation of physical activity interventions in the West Midlands would help to support and strengthen the evaluation work that is happening in the region and enable the comparison of interventions across PCT boundaries. This would enable a strengthening of the evidence base for effective physical activity interventions and enable best practice to be shared across the region through the regional physical activity network, PAN-WM, whilst enabling local areas to have the flexibility to ensure that their monitoring needs are met. The need for the development of a performance management framework for evaluating physical activity and sport interventions in the region was first identified in the 2004 Physical Activity Mapping in the West Midlands report published by the British Heart Foundations National Centre for Physical Activity<sup>3</sup> to enable the sharing of data across organisations. This remains a priority for the region.

	Internal Evaluation	External Evaluation
Objectivity & Credibility	Can be perceived as being less objective and credible due to perceived lack of evaluation expertise.	Usually perceived as being more objective and credible due to independence and fresh outlook on programme/strategy because of lower level of direct connection with the programme strategy. Providing time is taken to understand programme functioning.
Skills	Skilled and knowledgeable about functioning of the programmes and strategy but may lack evaluation skills.	Skilled and knowledgeable about evaluation strategies but potentially not the functioning of programmes /strategies.
Usefulness	Information produced may be more useful because of familiarity with the programme/strategy.  Potentially increased flexibility due to team role.  May be distracted by day to day tasks.	Information produced may be less useful because of a lack of familiarity with the programme/strategy.  May have competing priorities for time.  Not distracted by day to day tasks.
Communication	Increased accessibility and communication due to common language and understanding of programme.	May be difficult due to lack of knowledge of programme, community and limited accessibility due to competing priorities.
Success	May be more successful in getting support from those involved in implementing programme/strategy.	May be less successful in getting support from those involved in implementing programme/strategy.
Cost	Usually less expensive.	Usually more expensive.

The issue of internal versus external evaluation was also raised during the audit with the majority of intervention evaluations being completed internally. The audit found that external evaluation usually occurred when external funding had been sourced for a programme or when it was part of a wider programme such as Walk for Health, Active England or Well@Work. It is expected that programmes would be evaluated and monitored internally as a minimum to determine local effectiveness. Academic reviews of evaluation methods highlight a number of pro's and cons to both approaches, the table overleaf summarises these and is adapted from one utilised by SICA Training<sup>30</sup> using additional information from Dahler-Larsen & Foss-Hansen<sup>31</sup> and Huddleston et al<sup>32</sup>. Dahler-Larsen & Foss-Hansen<sup>31</sup> highlights that external evaluation does not in itself guarantee competence and that the type of evaluation utilised and the management procedures for the evaluation are of key importance and advocate an integrated approach to evaluation using a combination of both internal and external evaluation and monitoring enabling the evaluation skills of the workforce to be increased.

The recently published NICE guidance on four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community based exercise programmes for walking and cycling<sup>21</sup> makes a number of recommendations following a rapid review of the evidence of effectiveness and cost effectiveness for these interventions. The review highlighted gaps in the current evidence base for exercise referral, walking & cycling and pedometer schemes and recommended that these schemes only be endorsed if part of a properly designed and controlled research study to determine effectiveness. Discussions

regarding the implementation of this guidance are ongoing, particularly regarding the co-ordination of research. The designing of properly designed and controlled research studies will require input from academics and as such it is likely that there will be an increase in external and internal evaluation collaborations to determine effectiveness at a local, regional and national level to meet the gaps in the current research.

The measurement of the **1% year on year increase in physical activity** participation levels was not cited as an objective through the LDPs or within the individual programme evaluations. The need for developing a method of determining population based physical activity participation levels in adults for localities has been met through Sport England's Active People Survey<sup>33</sup> although the need to establish a method to collate data on childrens activity levels still remains a priority. The Active People Survey provides data on population activity levels at local authority and PCT boundary level, information on the survey can be found at [www.activepeoplesurvey.com](http://www.activepeoplesurvey.com).

### 8.5 Skills Development

The Choosing Health Physical Activity Delivery Plan<sup>6</sup> recognises the need for sufficiently skilled local capacity to deliver the need for increasing physical activity interventions and highlights the further investments that are being made to PCTs to strengthen their local health improvement workforce. The audit found that 46% of respondent PCTs were offering some kind of training opportunities to staff regarding physical activity interventions, although details of the numbers of staff trained were not quantified as part of this report. This means that over half of PCTs in the region are offering no training to staff on physical activity, the need for it, implications of not doing it and methods

of facilitating behaviour change in activity levels.

The most frequently cited training course offered to staff was the Walk for Health Initiatives (WHI) volunteer walk leader training and relates directly to enabling local walk for health schemes to operate with support from PCT personnel. A fifth of the respondent PCTs cited providing this training to public health nurses, health professionals and volunteers. The majority of the training courses cited by the PCTs provide specific skills to enable the delivery of specific programmes and interventions, i.e exercise referral schemes, bike week activities and the National Step-o-meter programme. 2 PCTs reported providing generic training on physical activity to its staff, utilising the British Heart Foundations National Centre for Physical Activity and Health Primary Care Toolkit<sup>5</sup>. A further PCT reported providing facilitating change courses to frontline health professionals to provide core skills in facilitating behaviour change in patients.

It has been recognised that primary care settings provide huge potential for increasing activity levels with 70% of people in the UK visiting their GP per year<sup>34</sup>. The recently published NICE guidance<sup>21</sup> recommends that PCTs should implement brief intervention packages in primary care, having found compelling evidence for the effectiveness and cost effectiveness of this approach in increasing physical activity levels long term. The implementation of this guidance would require a substantial increase in the training offered to health professionals across the region, to ensure that core messages could be put across to patients in an appropriate way and that frontline health professionals were able to motivate patients to become more active and adopt healthier behaviours,

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The British Heart Foundations National Centre for Physical Activity and Health Primary Care Tool Kit<sup>6</sup> is currently being reviewed in light of the recent guidance and will incorporate brief intervention training to enable PCTs to meet the latest guidance. It is recommended that a programme of cascade training of this tool kit take place across the region to enable PCTs to utilise the tool kit for in house training, and increase the capacity of front line health professionals to disseminate core physical activity messages to patients.

### 8.6 The NHS as an exemplar

The evidence for developing a physically active workforce is compelling with the evidence suggesting that physically active employees take 27% less days of sick leave than those who are inactive, this equates to over 2 days improved attendance and savings of £135 per employee per year<sup>35</sup> and improve performance by 4 – 15%<sup>36</sup>. On site physical activity programmes have been proven to reduce staff turnover by 8 – 13% and reduce injuries at work by up to 25%<sup>35</sup>. Physically active employees have reported better concentration and mental alertness, reduced stress and improved memory, greater energy levels, improved rapport with colleagues and improved morale<sup>37</sup>.

The Choosing Health Physical Activity Delivery Plan<sup>6</sup> discusses the potential for the NHS to be exemplar organisation, recognising that staff should be supported to lead more active lives through supportive workplace practices and policies. It is estimated that individuals spend up to 60% of their waking hours at work<sup>38</sup> and as a major employer within the region the NHS has the potential to influence a huge number of West Midlands residents health and well being.

79% of the respondent PCTs currently report offering staff opportunities to

participate in physical activity programmes, although it is not clear if this is part of a wider workplace health policy or whether these are activities initiated by staff groups.

The most frequently cited activity opportunity was joining a walking scheme, with 58% of respondent PCTs offering this option to staff, with led walks available at lunch times and after work. A quarter of PCTs cited providing exercise sessions such as pilates, circuits and yoga sessions for staff, it is not clear whether this is funded, subsidised or just organised by the organisations. A fifth of PCTs reported providing cycle to work opportunities, ranging from bike loan schemes and tax free cycle schemes to adult cycle training and family cycle ride opportunities.

A fifth of PCTs also provide exercise referral services to staff, although it is not clear if this is a separate referral pathway through occupational health services or via the employees GP surgery.

The number of activities offered across the PCTs ranges from 0 – 5 or more different activities for staff to partake in and suggests that there is much work to be done in raising the profile of the benefits of work place health initiatives. The learning from the Telford and Wrekin PCTs Well@Work pilot will provide key evidence of how the NHS can improve physical activity levels within its own workforce.

The Regional Spatial Strategy<sup>24</sup> sets the target for 30% of the regions workforce to be covered by an employer travel plan by 2010, working towards targets to decrease car use, congestion and pollution. The development of employer travel plans provides huge potential for increasing active travel opportunities for commuting and provide one way of potentially influencing the activity levels

of staff. As a major employer the NHS should be contributing to the target on employer travel plans and as a result this audit identified the numbers of PCTs that currently had an employer travel plan that promoted active travel. It was found that less than one fifth of organisations, (n:4, 17%) currently have an employer travel plan in place that promotes active travel plan for staff. A further 13% of these are in the process of drafting plans. This means that 67% of primary care organisations do not have an organisation wide travel plan in place, although it should be noted that four of these organisations had developed plans for the health promotion department. The Healthcare Commission's "Developing the annual health check 2006/2007" consultation document<sup>39</sup> recognises the potential for greater sign up to travel plans within the health sector in its proposed developmental ladder for public health. The document suggests that auditing the use of transport as a result of its business and developing and implementing travel plans, without incorporating incentives, structures and wider work place health policies would contribute to a rating of weak for PCTs. This suggests that developing and implementing a travel plan is seen as the minimum a PCT should be doing to improve the health of its staff and local community. Bearing this in mind there is a need to harness the massive potential to increase the health sectors sign up to employer travel plans and it is imperative that PCTs are encouraged to work with their Local Authority Transport and TravelWise officers to develop employer travel plans.

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### **8.7 Strategic Support for the prioritisation of Physical Activity in Primary Care organisations**

There is a strong indication from the PCTs that to enable the prioritisation of physical activity at a local level, further support is needed at a national, regional and local level.

The PCTs prioritised the need for further support from central government to develop the policy, guidance, appropriate targets and subsequent investment to enable physical activity to be embedded in working practices and the LDP processes.

The key challenge for those PCTs that do not have a role focussing on physical activity appears to be the need to improve or increase the staff resources available for driving forward the physical activity agenda within the organisation. It is recognised that without the dedicated resources and specialist knowledge these roles bring, it is difficult to prioritise physical activity above other public health interventions and difficult for PCTs to develop partnerships and attract external funding to develop interventions.

42% of the respondent PCTs raised the issue of developing dedicated targets for physical activity, suggestions included the development of a PSA target for physical activity, linked to an increase in activity levels and a decrease in sedentary behaviour. It was felt that this target should be linked into GMS contracts and performance management framework for PCTs and be included in star rating criterias. It was felt that this would help lever funding and resources and ensure that physical activity has a higher strategic profile within primary care. The requests for clearly defined targets were predominantly raised by PCTs that have a dedicated physical activity lead/specialist in post (8 out of the 10 PCTs citing targets as a key priority for support).

The support requested also recognised the need for standardised monitoring and performance management and indicated that guidance stipulating a duty for all PCTs and partners to develop physical activity action plans would be key to driving forward the prioritisation of physical activity with in primary care leading to greater organisational sign up long term.

## 9.0

# Conclusions

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This audit of Physical Activity within West Midlands Primary Care Trusts presents clear evidence on the extent of work being carried out by the health sector, directly and indirectly.

By considering the LDPs and collating all responses, it is felt that a baseline has been developed from which future work can be balanced.

The evidence supporting physical activity as a mechanism for delivering health gain in physical, mental and social terms across a wide array of health 'theme' areas (e.g. obesity, CHD, Mental Health, etc.), from public health to rehabilitation, is unequivocal.

The extent to which Physical Activity (including 'Sport') is being utilised by PCTs in pursuit of their objectives is seen to be very mixed, with a few PCTs fully engaged whilst others have a very minimal level of engagement.

Whilst it is noted that the constraints of the audit mean that not every detail has been isolated across the region and for each specific PCT, it is felt that an objective overview has been achieved.

Particularly clear is the indication of an overall lack of strategic vision, drive, commitment and clarity. There is also a general failure to recognise the potential role for physical activity, relating to how interventions can be delivered, hosted and commissioned to support the achievement of PCT and partner strategic objectives.

This is, in part, understandable given the current financial climate and lack of specific directives to make physical activity per se a 'must-do'. However, given the potential for delivering to a number of 'must do' objectives through physical activity, this must be seen as an opportunity that is not being addressed. Particularly so, in light

of the 'Game Plan' (2002) strategy objective to increase Physical Activity by 1% per annum year on year.

Delivering a community based physical activity programme may significantly contribute to obesity, mental health and stronger safer communities agendas, rather than be seen as a stand alone 'mechanism'. Shared delivery modes may provide obvious economic benefits whilst delivering more efficiently than when working in isolation.

There has also been an historical issue around the consistent measurement of physical activity that has now been resolved with the introduction of the 'Active People' survey that has established a sound baseline against which progress can be monitored.

Many PCTs are not recognising the extensive opportunities to deliver varied health agendas via physical activity mechanisms and the unequivocal support for the health benefit of being active, through their LDPs. The Physical Activity and Sport infrastructure in the West Midlands is now well defined and in position to strategically support planned local delivery with partners at all levels. This delivery may support the setting and achievement of LAA targets.

This research has found that many organisations are delivering interventions to diverse populations to improve public health outcomes, in line with current national policy and guidance.

However, the strategic vision of organisations appears to be lacking, with a dearth of acknowledgements in the strategic vision for primary care organisations of the role of physical activity interventions in key priority areas such as chronic disease prevention and management, reducing health inequalities and stop smoking services.

Education of strategic visionaries is needed, to ensure that organisations can capitalise and continue to resource physical activity interventions against a competitive and often financially restrained background.

Improving and supporting organisations so each has at least one full time physical activity, in line with current stop smoking services will help to improve public health and focusing of resources. Measurement of efficacy of interventions is another key area for organisations to prioritise and is an area which needs strategic support to develop and deliver mechanisms for continuous improvement and targeting of resources.

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## 9.1 Recommendations

- 1) Regional Partners to lobby for a national PSA target or performance indicator for physical activity.
- 2) PCTs to agree to develop physical activity action plans within local partnerships to encourage greater organisational sign up to physical activity from the Health Sector.
- 3) All strategic service leads should be supported in seeking opportunities to integrate Physical Activity within the wider public health remit.
- 4) All PCTs to actively engage with their County Sport/Physical Activity Partnership to enable the development of inclusive sub regional delivery plans for physical activity and sport.
- 5) PCTs should consult with County Sports/Physical Activity partnerships when reviewing and developing Local Delivery Plans (LDPs) to ensure that strategic visions for commissioning, delivering and the hosting of physical activity are incorporated into the Plans.
- 6) PCTs to refer to the Sport England 'Physical Activity and Sport Playing its Part in Choosing Health' Resource for Strategic Health Authorities and Primary Care Trusts when reviewing and developing LDPs. (This resource can be downloaded from [www.sportengland.org/physical\\_activity\\_resource.pdf](http://www.sportengland.org/physical_activity_resource.pdf)).
- 7) All PCTs to have membership and representation within the Physical Activity Network for the West Midlands, contributing to the sharing of best practice and the development of physical activity across the region.
- 8) At a national or regional level a physical activity evaluation framework to standardise the collation of monitoring data should be developed to increase the evidence base for physical activity and enable benchmarking of interventions.
- 9) Ensure that PCTs recognise the cross-cutting nature of Physical Activity and the potential opportunities offered by taking a 'non-silo/thematic' approach to physical activity through out their LDP.
- 10) Enable the Strategic Health Authority, PCTs and partners to agree performance management criteria for commissioning and/or delivering physical activity through the development of recognised national targets.
- 11) The SHA should advocate the insertion of physical activity specific (targets/objectives) within LDPs and support the performance management of these physical activity objectives.
- 12) All PCTs to review 'in-house' workplace physical activity policy and be supported to recognise the benefits of having an active workforce.
- 13) All PCTs should be expected to have a named person responsible for the strategic development of physical activity. It will be necessary to ensure that investment and capacity is provided to guarantee that every PCT is in the position to have a Physical Activity Lead.
- 14) Develop a programme of training across the region to increase the capacity of front line health professionals to disseminate core physical activity messages to patients, for example utilising the BHF Physical Activity in Primary Care tool kit.
- 15) Encourage all NHS organisations to develop employer travel plans inline with Regional Spatial Strategy targets and the Healthcare Commissions annual health check public health proposed developmental ladder.

This report provides a base upon which the West Midlands can build an integrated approach to strategically developing physical activity through primary care and clearly details the support and guidance that is required from partners at all levels to embed physical activity within local planning and raise the profile of physical activity within primary care and health organisations.

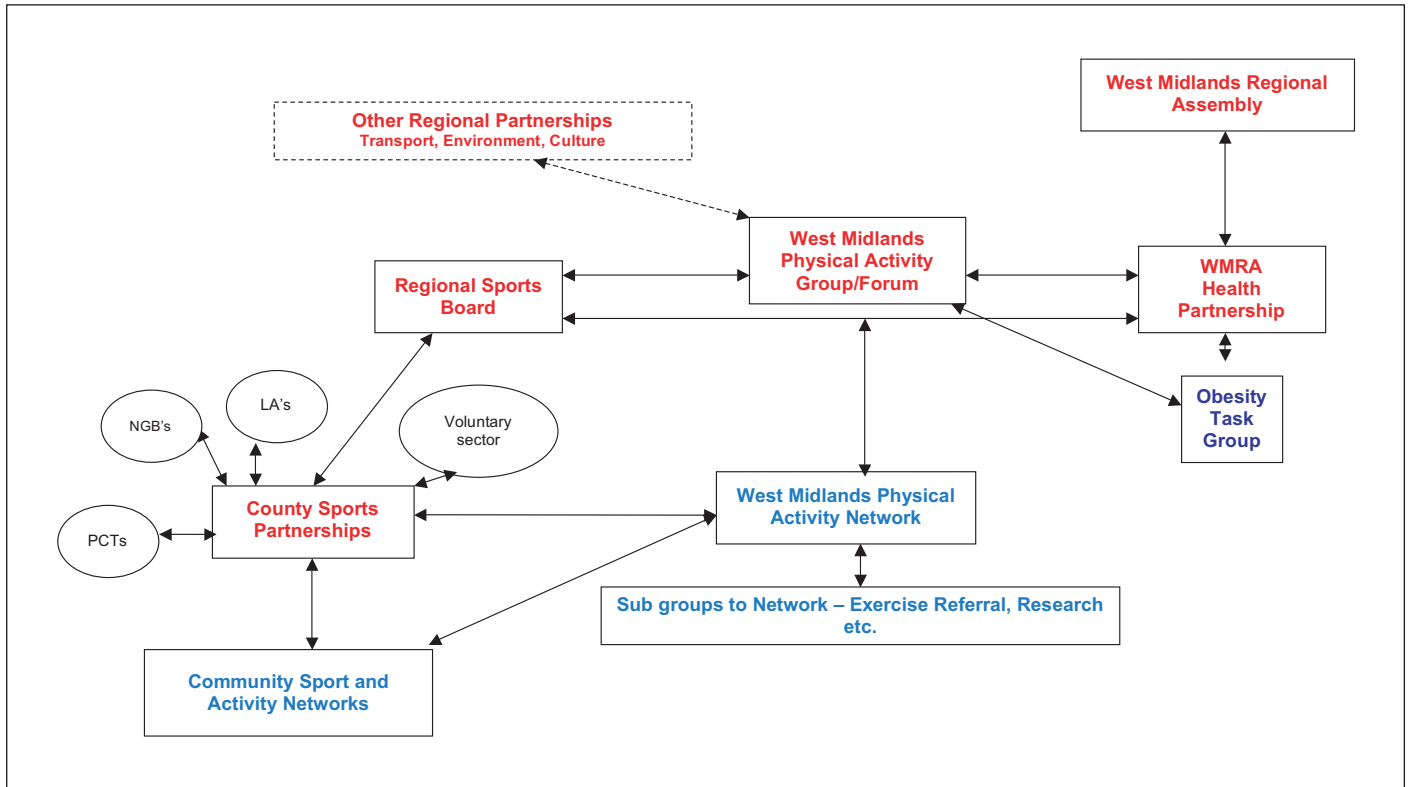
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# Appendix 1

## The Regional Structures for Physical Activity and Sport

Appendix 1: The Regional Structures for Physical Activity and Sport



# Appendix 2

## The Audit Tool

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### Appendix 2: The Audit Tool – Sport England and West Midlands project

Name of PCT?

Name of person completing questionnaire?

Job title of person completing questionnaire?

Is there a defined Physical Activity Lead in your organisation?

If yes, approximately what percentage of the role focuses purely on physical Activity?

### Does your PCT host or deliver any physical activity interventions or projects?

#### Host

Name of intervention/ project	What targets does this have?	How is it being evaluated?	Time and frequency of the evaluation	Definition of success	Key target group

#### Deliver

Name of intervention/ project	What targets does this have?	How is it being evaluated?	Time and frequency of the evaluation	Definition of success	Key target group

#### Commissioned

Name of intervention/ project	What targets does this have?	How is it being evaluated?	Time and frequency of the evaluation	Definition of success	Key target group	SLA/CA/LAA attached?

**Do you have contact with the following partners?**

Partner	Never	Occasional/ Ad hoc	Quarterly	Monthly	Weekly	Is this a key partner?	Name and Role and organisation of key contact
Sport/Leisure/ Fitness							
Acute health							
Community health							
Voluntary groups (please name)							
Private sector (please name)							
School health							
Education							
Social services							
Transport							
Environment							
Council							
Other (please state)							

**Do you participate in any networks relating to Physical Activity?**

Topic	Network name	Extent of involvement: Chair, Initiator, member
Physical activity		
Sport		
Transport		
Healthy schools		
Environment/planning		
Other (please state)		

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What is the approximate funding allocation for physical activity interventions from the PCT?

**How much of this is to be spent on the following areas?**

Item	Cost	Funding allocated	In kind contribution	Cash contribution
Staff				
Accommodation				
Administrative costs				
Development/interventions				
Sustainability				
Evaluation				
Other (please state)				

What is the PCT allocation for implementing Choosing Health?

Will this affect the budget for physical activity interventions, if so, how?

**Do PCT staff currently have training relating to physical activity/promoting an active lifestyle?**

Staff type	Length of training	Level of training	Who is the provider?	How is it evaluated?	Accredited? By Who?

Are there opportunities for staff to participate in physical activity interventions?

Please provide a summary of the interventions/opportunities available below:

Do you have a travel to work plan in place that includes promoting active travel?

How do you promote active travel and physical activity opportunities to staff?

What do you think the PCT needs to increase the profile of physical activity?

What support do you think is needed (and who would you like the support from) to enable this to happen?

**Thank you for completing this questionnaire**

# Appendix 3

## Designated Physical Activity Leads

**Appendix 3: Which PCTs have a designated Physical Lead and which do not have one in place**

PCT Name with named lead	Lead Name	PCT without named lead	Name of Person completing form
<b>North Stoke</b>	Carl Bennett	<b>Wolverhampton</b>	Katie Watson
<b>Newcastle under Lyme</b>	Carl Bennett	<b>North Warwickshire</b>	Dr M.C. Stern
<b>Staffordshire Moorlands</b>	Carl Bennett	<b>Herefordshire</b>	Francis Howie
<b>South Stoke</b>	Carl Bennett	<b>Cannock Chase</b>	Laura Davies
<b>Sandwell</b>	Helen Brock/Cathy Ferriday	<b>South Warwickshire</b>	Deb Saunders
<b>Dudley Beacon and Castle</b>	Dean Hill	<b>East Staffordshire</b>	Mark Powell
<b>Dudley South</b>	Dean Hill	<b>Shropshire County</b>	Miranda Ashwell/Kate McGeary completed form, however physical activity is shared amongst the health improvement team
<b>Solihull PCT</b>	Angela Gabb	<b>Heart of Birmingham</b>	Lead not named (Kevin Haywood Completed tool)
<b>Telford and Wrekin</b>	Louise Mills	<b>South Birmingham</b>	Lead not Named (Dr C J Spencer Jones completed tool)
-	-	<b>South Worcestershire</b>	Post Vacent (Lola Abudu completed tool)
-	-	<b>Wyre Forest</b>	Lead not named (Christina Attwood completed tool)

# Appendix 4

## The Physical Activity Interventions that PCTs are hosting, delivering and commissioning

### Physical activity interventions hosted by PCTs

Name of PCT	Intervention Hosted	Targets	Evaluated	Definition of Success	Key Target Groups
<b>Redditch and Bromsgrove</b>	Introduce to Exercise-pilot Programme for Exercise Referral Joint Project with Local Authority Sports / Exercise Specialists. (Still at planning stage)	1. Reduce risk and limit disease progression. 2. Increased levels of PA and sustained lifestyle changes. 3. Develop sustainable referral system.	Baseline assessments, lifestyle questionnaire, weekly reviews, End report and Case Study. Evaluations will be carried out throughout the programme and a case study at 4 weeks following completion	Support from GP's and other Health professionals. Numbers of referrals and evidence of sustainable behaviour change.	Stable Chronic Medical Conditions and Inactive patients
<b>South Warwickshire</b>	GP Referral Scheme	Reduce CHD and Strokes	Through quantitative data run over 12 week cycles.	Reduction in the number of cases of CHD and Strokes	Stroke and CHD patients
<b>Wolverhampton City</b>	Sure Start Projects: a range of projects developed under Sure Start by PCT hosted staff including mother and child swimming, tumble tots, aerobics for mums	To increase physical activity amongst families on low incomes with young children	Numbers attending, feedback etc. The evaluation will be on-going throughout the duration of the intervention	Sustained increased activity amongst targets group	Families on low incomes with young children
<b>East Staffordshire</b>	Exercise on Referral	-	Patient follow up every 12 weeks	Patient under takes regular exercise	Sedentary adults
	ESPCT road shows	SRB	Through a number of ongoing measures	Various	Deprived Communities
	ESPCT healthy lifestyle clinics	SRB	Patient Questionnaire at the end of each course	Increase in Physical Activity levels	Deprived Communities
<b>Sandwell</b>	Active Sandwell	-	No's change in activity levels measured on a Quarterly bases	-	50+
	Physical Activity Referral	-	Change in activity levels and health improvement measured on a Quarterly bases	-	-

## Physical activity interventions hosted by PCTs

Name of PCT	Intervention Hosted	Targets	Evaluated	Definition of Success	Key Target Groups
<b>Sandwell</b>	Children's Physical Activity	–	Quantitative data collection on a quarterly bases	–	5 – 13 years olds
<b>Cannock Chase</b>	Exercise referral	Low and Medium risk populations	Other than data collection none at the moment	Increase in number of referrals and successful completion of the scheme	Low and Medium risk as referred to in the NQAF
	Walking Scheme	–	Through the public health nurse, measured half yearly	Increased request for walk leaflets and uptake in guided walks	Sedentary population and those wanting to increase their uptake.
<b>Shropshire County</b>	Structured opportunity for sharing good practice and ensuring quality standards organising 3 volunteer walk leader days.	–	–	–	Sedentary adults
	Shropshire exercise Network for Older People	Compile database of local provision of exercise appropriate for older people i.e. chair – based. Structured opportunity for sharing good practice and ensuring quality standards.	–	–	Older people
	Shropshire and Telford & Wrekin Activity Referral Scheme (GP Exercise on Referral Scheme)	Deliver a GP Exercise Referral Scheme	–	–	Adults with Specific health conditions
<b>North Stoke</b>	Go5 Programme (Strategic Host)	Increase the percentage of inactive people becoming and remaining active	Self Evaluated/ Reported of 10 week programme	Completion of 10 week programme	Those at risk of or with signs/ symptoms of CHD
<b>Newcastle under Lyme</b>	Go5 Programme (Strategic Host)	Increase the percentage of inactive people becoming and remaining active	Self Evaluated/ Reported of 10 week programme	Completion of 10 week programme	Those at risk of or with signs/ symptoms of CHD

## Physical activity interventions hosted by PCTs

Name of PCT	Intervention Hosted	Targets	Evaluated	Definition of Success	Key Target Groups
<b>Staffordshire Moorlands</b>	Go5 Programme (Strategic Host)	Increase the percentage of inactive people becoming and remaining active	Self Evaluated/ Reported of 10 week programme	Completion of 10 week programme	Those at risk of or with signs/ symptoms of CHD
<b>South Stoke</b>	Go5 Programme (Strategic Host)	Increase the percentage of inactive people becoming and remaining active	Self Evaluated/ Reported of 10 week programme	Completion of 10 week programme	Those at risk of or with signs/ symptoms of CHD
<b>Dudley Beacon and Castle</b>	Leap over 60 (older people activity plan)	Increased participation in Physical Activity	Registers and Satisfaction Survey. Surveys etc on frequent bases	Regular Attendance	Over 60's
	Walkzone (website)	Increase in walking	Web based, evaluated ad-hoc	Increased in walks, steps and miles walked	Whole population
	Steps to Health (Park based activity programme)	Increases in structured activity within parks – increases in population participation – changes to park	Questionnaires and Reports. Through an ongoing process	Numbers of events, numbers of coaching courses, numbers of training courses.	Whole population.
<b>Dudley South</b>	Leap over 60 (older people activity plan)	Increased participation in Physical Activity	Registers and Satisfaction Survey. Surveys etc on frequent bases	Regular Attendance	Over 60's
	Walkzone (website)	Increase in walking	Web based, evaluated ad-hoc	Increased in walks, steps and miles walked	Whole population
	Steps to Health (Park based activity programme)	Increases in structured activity within parks – increases in population participation – changes to park	Questionnaires and Reports. Through an ongoing process	Numbers of events, numbers of coaching courses, numbers of training courses.	Whole population.
<b>Solihull</b>	Solihull Physical Activity Strategy(In partnership with Leisure Services SMBC)	1. To work towards the delivery of 75% of children spending at least 2 hours per week on PE and Physical Activity by 2006.	Currently developing monitoring plan to be implemented on a 6 monthly review steering group	Milestones achieved and progress against targets	Population of Solihull with particular reference to priority groups: 1. Older People (50+) 2. Children and young people (0-25 with special reference to women)

### Physical activity interventions hosted by PCTs

Name of PCT	Intervention Hosted	Targets	Evaluated	Definition of Success	Key Target Groups
<b>Solihull</b>	-	2. To work towards the delivery of 75% of children spending at least 1 hour per day on physical activity. 3. To work towards the Governments target of 70% of the adult population moderately physically active five days a week by 2020	-	-	3. People with Disability (Including those with mental health problems) 4. Black + Ethnic Minority Groups
<b>Heart of Birmingham</b>	None at present, however have just signed up to the National-Step-O-Meter programme so that our frontline healthcare professionals can provide support materials to patients to encourage them to increase levels of Physical Activity	-	-	-	-

## Physical activity interventions commissioned by PCTs

Name of PCT	Intervention Commissioned	Targets	Evaluated	Definition of Success	Key Target Groups
<b>Wolverhampton City</b>	Cycling For Health	-	Road Safety are evaluation nos. attending, feedback from participants and progress made.	-	Children and families not accessing cycle ways
	Communities for Health Family Fundays	To increase opportunities for children and families to learn about healthy eating and physical activity	Each neighbourhood project completes a standardised evaluation	Work has targeted children and families with little opportunity to access healthy food and physical activity	Children and families with little access to healthy food and opportunities for physical activity
	Free swimming for kids	-	Wolverhampton School of Swimming are collating information on nos, weight loss, feedback from children and parents, nos. successfully learnt to swim.	-	Children from low income families
<b>Heart of Birmingham</b>	Villa Vitality	Access HoB tPCT schoolchildren	Monitoring returns quarterly	Schoolchildren access scheme	Schoolchildren
	Rowing Machines in Schools	Ensure each school receives x 3 rowing machines and machines are used by pupils	Monitoring returns quarterly	All HoB Schools receive machines and machines are used by children to improve physical fitness	Schoolchildren
	Exercise On Prescription	-	Monitoring returns – formal evaluation of scheme to be undertaken quarterly	HoB GPs refer patients into scheme and patients successfully complete programme and show a % weight loss.	CHD/Diabetes patients
	Stair Climbing	Increase awareness of the benefits of stair climbing within HoB employees	Formal evaluation by B'ham University still to be confirmed	Increase in number of people using stairs instead of lifts/escalators	Workforce within tPCT area

## Physical activity interventions commissioned by PCTs

Name of PCT	Intervention Commissioned	Targets	Evaluated	Definition of Success	Key Target Groups
<b>Heart of Birmingham</b>	Grants For Health	Provide funding for local community/ voluntary groups to implement projects to increase levels of physical activity	Monthly monitoring returns/Bi annual meetings	Full and audited expenditure of available funding by local groups.	HoB tPCT population
	Suleman'er Kotha	Write and produce a play to target South Asian community and encourage greater levels of physical activity	Attendance at play Bi annual	–	South Asian Community
	Laurel Road Active Schools Project	Deliver series of fun-based activities Climbing, Basketball, Assault Course to HoB schools (yr5)	Children and Teachers are completing evaluations and an end of project report	–	HoBt PCT school children
<b>South Worcestershire</b>	Extend Classes	–	Questionnaire Annually	Increased Mobility	Older People
	South Worcester Walking Network	Walk Leaders – 50, 800 walkers involved over 3years, development of walks directory.	Annual Questionnaire	Increased Mobility	Older People
	Rehab Extend	–	Annual Questionnaire	Increased Mobility	Older People
<b>Herefordshire</b>	Wider Wood Project	Health benefits of woodland	External evaluation by all users	Improved healthy lifestyle	Young offenders, rural isolated.
	Lift Referral	Encourage attendance at Gym.	Not currently evaluated	Attendance	GP decision – those who would benefit.
<b>Sandwell</b>	Gardening – IDEAL for All	–	Number/Breakdown on a Quarterly bases	–	50+ / disabled
	Green Gym	–	Number/Breakdown on a Quarterly bases	–	–
<b>Dudley Beacon and Castle</b>	Leap over 60 (older people activity plan)	Increased participation in Physical Activity	Registers and Satisfaction Survey. Surveys etc on frequent bases	Regular Attendance	Over 60's

### Physical activity interventions commissioned by PCTs

Name of PCT	Intervention Commissioned	Targets	Evaluated	Definition of Success	Key Target Groups
<b>Dudley South</b>	Leap over 60 (older people activity plan)	Increased participation in Physical Activity	Registers and Satisfaction Survey. Surveys etc on frequent bases	Regular Attendance	Over 60's
<b>Solihull</b>	Increase the health of patients referred to the GP referral scheme by increasing their adherence rates to a cumulative minimum of 378 over the 3 years ending 31 March 2007	a) No. being referred. b) No. (responding to survey) who are still participating in a level of physical activity greater than the baseline level, 6 months after their initial assessment. c) No. who demonstrated positive changes to health having completed 12wk programme in at least 1 of the following physiological measures: Body Mass Index, Blood Pressure and Peak Flow. All to be measured quarterly	-	Hitting the targets set.	CHD Patients

## Physical activity interventions delivered by PCTs

Name of PCT	Intervention Delivered	Targets	Evaluated	Definition of Success	Key Target Groups
<b>Redditch and Bromsgrove</b>	National Step-o-meter Programme (in planning)	1. Recruitment of front line NHS staff 2. Motivate inactive patients	1. Local Staff to monitor own patients for increased activity and impact on health 2. National evaluation These are evaluated throughout the step-o-meter loan period and an end of pilot (national evaluation)	NHS staff involvement and evidence of patient benefit and sustained change	1. Inactive patients
	Walking for Health Project (In partnership with Leisure Services SMBC)	To encourage local people with a particular emphasis on those who are disadvantaged and/or sedentary, to participate in walking as a health related activity through the development of a network of walking groups across the Borough and the development of supporting initiatives.	Number of walking groups established, Number of people trained as walk leaders, Number of walks, Number of participants, Frequency of attendance, Amount of press/media coverage, Qualitative feedback from participants, volunteers and associated partners <ul style="list-style-type: none"> <li>• Uptake of walking as a health-related activity</li> <li>• Population groups involved</li> <li>• Number of agencies/services involved</li> </ul>	–	Disadvantaged or Sedentary
	Local Walking for Health Initiative (Joint Initiative) (Volunteer led, LA and Strategic Partnership support). Current resource issues for further development/ sustainability	General health and well-being	Data collection, numbers participating, Feedback from volunteer leaders and participants	–	General public, people of all ages
<b>South Birmingham</b>	Physical Activity in Schools	All Schools to have a plan	Annual Report	Participation	School aged children
	Heart, sole and spokes	Kilometers walked	Annual Report	Increased Activity	PLD

## Physical activity interventions delivered by PCTs

Name of PCT	Intervention Delivered	Targets	Evaluated	Definition of Success	Key Target Groups
<b>Wolverhampton City</b>	Walking Health	To increase the level of walking amongst those who do not meet recommended levels of activity.	Annually Evaluated: Regular evaluation by Health walks coordinator: Nos. of walks, nos. of participants, nos. of walk leaders. Methods of evaluation vary appropriate to groups.	Nos. of participants, increased and sustained walking behaviour	Sedentary, low income, over 50s, those with risk factors for CHD/Diabetes, Asian population, overweight population, those with depressions and anxiety
	Falls Prevention	To reduce falls in elderly who have previously fallen or are at risk of falling. Programme includes exercise	On-going evaluation: No. of referrals, survey of participants, changes in prevalence of falls and hospitalisation	Prevent injury, hospitalisation and complications resulting from falls in the elderly. Improve confidence and maintain independence in the elderly	Elderly who have previously fallen or at increased risk of falling.
<b>East Staffordshire</b>	Children's obesity programme	-	Programme evaluation by children, parents. To be evaluated after each programme	Long term increase in Physical Activity	Overweight and Obese Children
<b>Sandwell</b>	Health Walks	-	Quarterly analysis of numbers and participation breakdown.	-	50+
	Cycle Training	-	Quarterly analysis of numbers and participation breakdown.	-	Adults and Children
	EXTEND	-	Quarterly analysis of numbers and participation breakdown.	-	Older People
<b>Cannock Chase</b>	Route to Health	-	As part of a wider project evaluation of a three year series of projects by an external evaluator which has been ongoing over the three year period since the project started as they engaged the external evaluator from the start.	Growing interest year on year, previously an under utilised walk that has now seen over 50,000 visits.	Families, easy flat to be pushchair and wheel chair friendly, local schools and community groups are all involved in the art prices and are encouraged to bring their families and friends to see their work displayed around the walk.

## Physical activity interventions delivered by PCTs

Name of PCT	Intervention Delivered	Targets	Evaluated	Definition of Success	Key Target Groups
<b>Dudley Beacon and Castle</b>	Active Dudley under 4's Activity Walks	Nursery Age Children and Families increases in Physical Activity	Local KPI's in conjunction with Sport England Framework, on a Quarterly bases	Increased Physical Activity uptake of Equipment	Under 4's and parent
	Primary Care Package (Pedometer/Training exercise on referral)	Physical Activity Increase	Ongoing differing Methods for intervention	Increases in Physical Activity	Practice Population (patients)
	Walking Programme -Training -Walkzone -LED Walks - Parks Walking, routes and walking uses	Increases in Walking	Continuous monitoring of Attendance Figures, Web feedback	Numbers Walking, numbers trained, website data	Whole population
<b>Dudley South</b>	Active Dudley under 4's Activity Walks	Nursery Age Children and Families increases in Physical Activity	Local KPI's in conjunction with Sport England Framework, on a Quarterly bases	Increased Physical Activity uptake of Equipment	Under 4's and parent
	Primary Care Package (Pedometer/Training exercise on referral)	Physical Activity Increase Increases in Walking	Ongoing differing Methods for intervention	Increases in Physical Activity	Practice Population (patients)
	Walking Programme -Training -Walkzone -LED Walks - Parks Walking, routes and walking uses	-	Continuous monitoring of Attendance Figures, Web feedback	Numbers Walking, numbers trained, website data	Whole population
<b>Telford and Wrekin</b>	Let's Get Physical Programme (LGP)  N.B LGP is a 3 year funded programme and is one of 200 Active England Projects (Sport England/ Big Lottery Fund)	Targets for <b>Number of participants:</b>  Breakdown by Women Men Over 45's Under 16's Priority areas	Evaluations are on a quarterly bases:  Support is being received nationally from Sport England, Hall Aitkin and Bearhunt as part of the Active England Project	Targets/outcomes achieved	Women and girls BME Priority Neighbourhoods Disabled Young people at risk (looked after children)  Health and leisure professionals

## Physical activity interventions delivered by PCTs

Name of PCT	Intervention Delivered	Targets	Evaluated	Definition of Success	Key Target Groups
<b>Telford and Wrekin</b>	16 projects within LGP <ul style="list-style-type: none"> <li>• Urban Girlz</li> <li>• Community Aerobics</li> <li>• Annual Fun run event</li> <li>• Street Sports</li> <li>• Woodside Activity Programme</li> <li>• Adults learning disabilities</li> <li>• Children learning and physical disabilities</li> <li>• Looked after children's project</li> <li>• GP Referral scheme</li> <li>• Childhood obesity research project</li> <li>• Training for community volunteers and coaches</li> <li>• Marketing and public information</li> <li>• Training for health and leisure professionals</li> <li>• Referrals from Help 2 Quit smoking cessation programme</li> <li>• School based programmes</li> <li>• Walking Programme</li> </ul>	BME New to sport Disability Young people at risk Health Referrals  Throughput – frequency of participation	Value Map Software (web based tool) is being used to monitor the effectiveness of the programme.  Evaluation techniques include participatory appraisal, focus groups, questionnaires	-	-
	Well @ Work  1 of 9 pilots for workplace health	Targets for the number of staff engaged as part of the intervention	Evaluated quarterly:  Nationally through the research team at Loughborough University	Targets/outcomes achieved	PCT Workforce



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Awarding funds from  
 **The National Lottery**<sup>®</sup>

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**Stock code number** No SE stock number

**Date of publication** November 2006

**Produced by** ELC Consultancy Ltd for Sport England in the West Midlands

In partnership with