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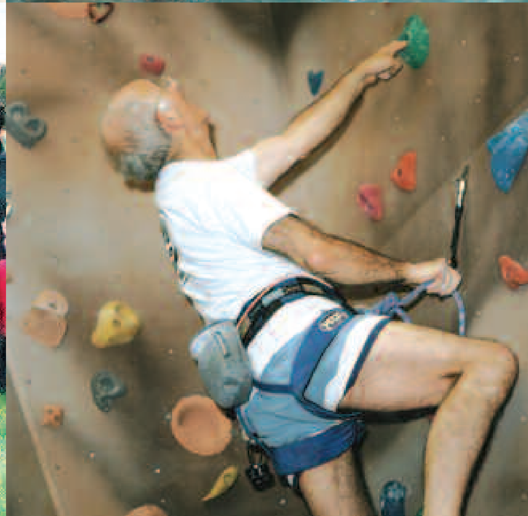

Physical Activity & Sport playing its part in delivering Choosing Health

A Resource for Strategic Health Authorities and Primary Care Trusts

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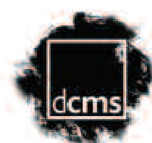

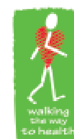

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The Resource

Purpose

The purpose of this resource is to help the health sector improve the planning, strategic placement, partnerships, resource commitments and performance management of physical activity. The aim is that commissioners and service providers such as Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) or Practice Based Commissioners (PBC) will use the resource as an aid to, supporting partnerships, setting local targets and monitoring of physical activity levels. It will also be of interest to local authorities who are working with partners to deliver physical activity particularly through Local Area Agreements, including County Sport Partnerships and Community Sport Networks who are working as part of the Delivery System for Sport to increase participation.

The resource has been developed through wide consultation with the twenty-eight Strategic Health Authorities, Teaching Primary Care Trusts, Primary Care Trusts and other key commissioners and service delivery colleagues and stakeholders, as well as through evidence gathering and assimilation. This has informed the shape and contents of the resource, drawing on the needs and ideas of those consulted.

It also builds on preliminary work by the British Heart Foundation National Centre for Physical Activity and Health (2004), which outlines where physical activity can help to deliver the Department of Health (2004) National Standards, Local Action; Health and Social Care Standards and Planning Framework for 2005/06 to 2007/8.

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How to use the resource

There are three main elements of the resource.

Firstly, information for commissioners and providers is presented by key target groups' i.e. **children, adults, older people and people with long term medical conditions,** which are related to key Public Service Agreement (PSA) targets and possible local targets. The following questions are addressed for each target group:

1. How can physical activity interventions help commissioners and deliverers of services achieve the Choosing Health delivery recommendation of 1% increase per annum in physical activity and how can it help them to reach the over arching health improvement targets?[1; 2]
2. What are the priority activities that can help deliver the targets for each group? This has drawn on consultation responses from stakeholders, commissioners, deliverers and users.
3. How can progress against the specific targets relating to this group be measured?

Secondly, the resource is presented in a tabular format, to assist with service planning and monitoring. The table sets out the relevant targets within each priority area and suggests a series of physical activity interventions that could be used to help meet these

targets. These interventions are cross referenced to core and developmental standards as set out in the Health and Social Care Standards and Planning Framework[3]. A user at a strategic or commissioning level can identify the outcomes, which can be monitored, and a service provider, such as a Primary Care Trust (or alternative service provider) can identify the data, which should be collected to provide quantifiable process and outcome evaluations. To be taken straight to the service planning and monitoring table, click here.

Thirdly, a summary checklist is available at the end of the resource to act as a guide for commissioners to help with planning potential physical activity interventions. To be taken straight to the summary checklist for commissioners click here.

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Definition

Unless otherwise stated, 'Taking part in Sport and/or physical activity' is defined as:

'All forms of physical activities which, through casual or organised participation, aim at expressing or improving physical fitness and mental well-being, forming social relationships or obtaining results in competition at all levels[4]. It is noted that this may seem to exclude non exercise activity such as walking to work or school, or DIY and gardening, however, for the purposes of inclusivity, these terms are included within this definition.'

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Context

Introduction

The Chief Medical Officers 'At Least Five a Week' report in 2004[5] 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 Plan1 was developed which sets out a cross-government plan that seeks to promote physical activity for all, in accordance with the evidence and recommendations set out in the CMOs report.

Discussions between Sport England and health partners, at a commissioning (Strategic Health Authority) level, have shown that there is a need to develop resources to support commissioners, such as Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs), to use physical activity to deliver the relevant targets.

At the moment, physical activity service provision is non mandatory for both health organisations and local authorities. One of the aims of this resource is to support organisations to prioritise physical activity interventions within the holistic health and wellbeing agenda, despite the non mandatory status of such interventions.

The purpose of this resource is to improve the planning, strategic placement, partnerships, resource commitments and performance management of physical activity. In terms of resource allocation a key driver for the work is the opportunity to inform PCTs Choosing Health funding allocations for action on diet, obesity and physical activity, which amounts to £13m in 2007/8[2].

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Context

The NHS Performance Management Framework

The performance framework for NHS organisations[3] identifies the National priorities to inform localised planning. This framework covers the four broad areas detailed below:

1. **Health and well- being of the population**
2. **Patient/user experience**
3. **Access to services**
4. **Long term conditions**

There has also been a shift in focus from a target driven health and social care sector to one in which standards are a driver for continuous improvement in quality. This approach allows greater scope for addressing local priorities and provides incentives to support the system.

The UK Department of Health has defined 'standards' in health care as 'a means of describing the level of quality that health care organisations are expected to meet or aspire to'. The performance of organisations can then be assessed against this level of quality[6]. This definition singles out 'standards' from other quality and performance management definitions and descriptors commonly used in the NHS including targets, benchmarks and criteria. All of these differ, sometimes subtly, from the definition of a standard, which is measurable and quantifiable.

Pragmatically there are two categories of standard presented here:

1. **Core standards:** bring together and rationalise existing requirements for the health service, setting out the minimum level of service patients and users have a right to expect.
2. **Developmental or aspirational standards:** signal the direction of travel and provide a framework for the NHS bodies to plan the delivery of services that continue to improve in-line with increasing patient expectations.

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The Evidence - how physical activity contributes to health

Considerable evidence is available which demonstrates the positive impact that physical activity has in the prevention, treatment and management of health conditions.

Prevention of health conditions:

Adults who are physically active have a 20-30% reduced risk of premature mortality (i.e. prior to the age of 75)[5]. Adults who expend approximately 1000 calories per week through physical activity have a reduced risk of all-cause mortality, with risk reductions in the order of 20-30%[7]. (To expend 1000 calories in a week, an average sized adult would need to walk for around 45 minutes per day at a speed of 2 miles per hour) There is evidence that regular walking reduces the risk of mortality 8and can increase life expectancy by 4-5 years[8].

Physical activity has been shown to reduce the risk of developing chronic diseases (Coronary Heart Disease, stroke, diabetes and cancers) by up to 50%[5], thereby reducing the burden upon local health and social care economies as well as improving the individuals quality of life. 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[10] and if those who are sub-optimally active were to become moderately active, 10% of all deaths from CHD could be avoided[11]. Evidence also exists which demonstrates that there is a convincing association between physical activity and the development of breast cancer[12]: Two-thirds of studies have observed a reduction in breast cancer risk among women who are most active in their occupational and /or leisure time[9].

Although there is only weak to moderate evidence that participation in physical activity tracks through from childhood to adulthood, 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[5]. Physical activity also plays an indirect role in preventing the development of risk factors for cardiovascular disease[5].

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Context

Treatment & management of health conditions:

Physical activity plays a role in the treatment and management of a range of chronic or recurrent diseases, such as cardiovascular disease, obesity, diabetes, asthma, chronic obstructive pulmonary disease and osteoporosis[5]. It also plays a role in reducing the severity of some diseases and consequently, the need for hospitalisation[13]. One cohort study reported that walking more than 4 hours or more per week was associated with a reduced risk of hospitalisation over a 2-year follow-up period in adults (aged 65 and over) with cardiovascular disease[13].

Diseases of the heart and circulatory system are the main cause of death in the UK: More than 1 in 3 people die from Cardio Vascular Disease[14]. Regular physical activity or improved cardio-respiratory fitness decreases the risk of cardiovascular disease mortality in general and CHD mortality in particular[15].

Regular physical activity is important for weight control and reduces the risk of becoming obese by 50% compared to people with sedentary lifestyles[16]. A 10kg weight loss by an obese person is associated with numerous health benefits[17], 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[5].

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The Evidence - what physical activity interventions are effective?

The National Institute of Health and Clinical Excellence (NICE) is currently preparing guidance on 4 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.

Final guidance is due to be released by the end of March 2006. Details can be obtained from the NICE website www.nice.org.uk. NICE is planning to produce further guidance on wider physical activity interventions during 2007.

For the purposes of this resource the interventions suggested for particular priority groups are based on SHA/PCT consultation, anecdotal research and drawing on the existing evidence base, much of which does not meet the NICE criteria for inclusion within their current guidance.

Sources of case studies

The following sites are good sources of physical activity case studies and evidence;

- > Walking the Way to Health case studies at: http://www.whi.org.uk/
- > British Heart Foundation National Centre for Physical Activity and Health Physical Activity Case Study Zone at: http://www.bhfactive.org.uk/case_studies/index.htm
- > Sport England's funded projects at: http://www.sportengland.org/index/get_funding/funding_case_studies.htm
- > Physical activity and community renewal/development at: http://www.sportdevelopment.org.uk/html/sportrenew.html
- > Healthy schools case studies (all subjects including physical activity) can be found at: http://e.doh.gov.uk/healthyschools/casey/main/default.asp
- > Health projects in neighbourhood renewal areas at: http://www.renewal.net/Nav.asp?Category=:health

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, and support the achievement of the overarching population level recommendation identified in papers such as Choosing Health[22]. However, at the moment, physical activity service provision is non-mandatory for both health organisations and local authorities.

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

The relevant PSA targets are set out below:

Public Service Agreements Targets:

Physical activity contributes to a number of specific departmental PSAs as well as a number of shared PSAs. These are set out below;

Health

> 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 (DH/DFES/DCMS).

> 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 most at risk: All people (including children) with long-term conditions.

> Improve the quality of life and independence of vulnerable 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.

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Culture, Media and Sport [18;20]

By 2008, increase the take up of sporting opportunities by adults and young people aged 16 and above from priority groups by increasing the number who participate in active sports, at least 12 times per year by 3%, and increasing the number who engage in at least 30 minutes of moderate-intensity-level sport, at least three time per week by 3%.

Education [18; 21]

Enhance the take up of sporting opportunities by 5 to 16 year olds so that the percentage of school children in England who spend a minimum of 2 hours each week on high quality PE and School sport within and beyond the curriculum increased from 25% in 2002 to 75% by 2006 and 85% by 2008 in England (DFES/DCMS)

Choosing Health recommendation [22]

Within Choosing Health and its associated Physical Activity Action Plan[1], 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[23], 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".[22]

With the increased focus on the use of developmental and core standards, it is possible to work towards developing a framework for physical activity interventions to support the achievement of the overarching population level recommendation identified in papers such as Choosing Health[22]. The Choosing Health Physical Activity Delivery Plan[1] reflects the responses to Choosing Health[22] and the associated consultation which expressed overall agreement with a target for a **year on year incremental increase, by 1% per annum, in physical activity levels of the whole population.**

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Context

This 1% increase in physical activity (year-on-year) has been adopted through the National Framework for Sport[24] and the Regional Plans for Sport that many of the Regional Public Health teams are contributing towards. This target could influence local targets, for example through Local Area Agreements (LAAs).

This resource will help support performance managers and commissioners in assessing and extrapolating data provided through service delivery, to provide trajectories or other visioning mechanisms to assess the likelihood of achieving year-on-year incremental changes in population levels of physical activity.

To be taken straight to the summary checklist for commissioners click here

The importance of physical activity to local priorities and partnerships [26-28]

Physical activity is increasingly being used as a tool to contribute towards locally agreed / shared priorities and targets at the local level through Local Area Agreements (LAAs), Local Public Service Agreements (LPSAs) and Comprehensive Performance Assessments (CPAs). Improving health and reducing health inequalities are priority issues for a wide range of partners at the local level. Physical activity has an important role to play in addressing health issues as part of a partnership approach most notably through Local Strategic Partnerships.

A wide range of potential partners can be involved in the delivery of physical activity at the local level including:

- Volunteers (school governors, health walk leaders, Women's Institute members, playgroup leaders)
- Charitable and not for profit organisations (Salvation Army, British Legion, Mencap, scouting/guiding organisations)
- Education sector (sure starts, nurseries, schools, colleges, higher education)
- Local Authorities (eg leisure, parks, community development, youth teams, planning departments)
- Healthy living centres
- Employers (Chamber of commerce, large employers)
- Local sports clubs (professional and voluntary)
- Independent and commercial sector organisations (health clubs, slimming groups, etc).

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Local Area Agreements

Local Area Agreements were introduced in 2004 and are a new way of working to build a more simplified, yet flexible and responsive relationship between central government and a local authority on the priority outcomes that need to be achieved at a local level. The Agreements provide a valuable opportunity to engage local authorities and other local partners in the health agenda and to bring public health to the forefront of the local community plan. Most are structured around three key themes; children and young people, safer and stronger communities and healthier communities and older people.

Local authorities and their partners, including PCTs have negotiated clear targets and outcomes with central government, but have the freedom to decide locally how to achieve them. In many of the first[21] pilot agreements, physical activity has been recognised as a key contributor to health within the 'healthier communities and older people` and 'children and young peoples` themes. Local Area Agreements; Sport playing its part 2005[26-29] reviews the first[21] pilots to learn where and how sport contributed to meeting shared local priorities and provides advice on how to build sport and physical activity into future agreements.

The revised approach to the Local Government's Performance Management Framework through Comprehensive Performance Assessment (CPA) will provide further opportunities for sport and physical activity to contribute. The delivery of the shared priorities by local authorities will form part of the corporate assessment block and the cultural block has been strengthened with a strong role for sport and physical activity.

To be taken straight to the summary checklist for commissioners click here.

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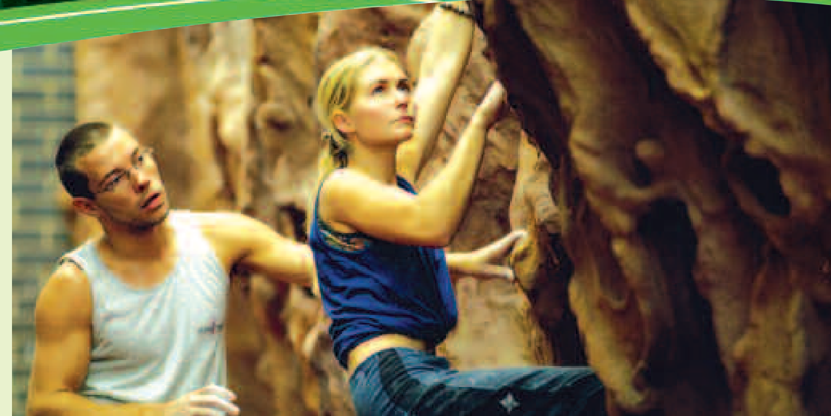
Local Physical Activity Indicators and measures

The Department of Health has recommended that the proposed indicator used to measure physical activity levels in Local Area Agreements is:

The proportion of adults taking part in moderate intensity sport and recreational physical activity for at least 30 minutes on at least 3 days a week.

It is being stressed that this indicator should be used explicitly in the context of the CMO`s recommendation that people undertake at least 30 minutes of moderate intensity physical activity on at least 5 days a week. This indicator excludes walking and cycling for travel (as well as gardening, DIY, housework and occupational activity) and so it is being suggested that the indicator be supplemented by a local indicator related to active travel.

For a copy of the local physical activity indicators and measures briefing note click here.



Local Area Agreement Stretch Targets

Many Local Authorities are considering setting 'stretch' targets for levels of participation in sport and active recreation.

The national Public Service Agreement target for levels of participation has been set at 3% increase over 3 years for priority groups. This level of increase has generally been accepted as the population 'baseline' level of increase against which local authorities will need to achieve a 'stretch'. The achievement of 1% a year is a challenging target and any increases that are significantly greater than this are indeed 'a stretch'.

Based on analysis from the Active People survey the recommended stretch for levels of participation in sport and active recreation is 4% over three years (an average of 0.33% 'stretch' per year, on top of the 1% increase.

For a copy of the LAA stretch targets for participation in sport and active recreation briefing note click here.

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The Contribution of Sport to Healthier Communities

Government has set a target to increase the take up of sporting opportunities by adults and young people aged 16 and above from priority groups by increasing the number who participate in active sports, at least 12 times per year by 3% and increasing the number who engage in at least 30 minutes of moderate intensity level sport at least three **time per week by 3% by 2008**.

Based on the recommended level of physical activity for general health (30 minutes of physical activity at least five times per week)*, sport aims to contribute towards delivering three of these five sessions.

The recently developed Active People Survey (www.activepeoplesurvey.com) will establish how many people participate in sport and active recreation in England. Every local authority in England (354 in total) will be able to obtain representative statistics on participation in sport and active recreation for their local community.

*Recommended physical activity levels for adults[5]: at least 30 minutes of at least moderate intensity physical activity, on five or more days per week.

The survey will not, however, measure wider physical activity levels such as job related activity, incidental activity and household activity i.e. cleaning, gardening, DIY.

Supportive quotes

During the consultation phase, several of the Strategic Health Authorities described the importance of physical activity to health improvement and the need to engage with a wide range of partners.

"We see physical activity as part of the wider strategy of health improvement, and along side diet and nutrition to contribute to halting and hopefully reversing the rising trend in obesity. Thus as part of the SHA role in performance managing the Local Delivery Plan we can challenge and influence PCTs to deliver physical activity. The development of LAAs is likely to make this more explicit." (SHA 6)

"Physical activity is a very important agenda: it needs to be developed at different levels: school children, general population and target groups…(We) welcome more focus on lifestyle approach but these needs to be within the local socioeconomic context: needs to be a joined up target such as coterminous Local Area Agreement." (SHA 4)

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Context

"The PCTs and we have engaged in the development of Local Transport Plans. We are working on Health Promoting Healthcare with acute and specialist trusts as part of their plans to meet the Healthcare Commission Public Health Standards in the self-assessment tool. We work with colleagues in Government Office to ensure that physical activity (along with other public health targets) is being addressed by Local Strategic Partnerships and in the pilot Local Area Agreement sites".

"This SHA performance manages physical activity interventions through quarterly accountability reviews on public health performance and uses wider health and social care targets derived from National service Frameworks, DCMS, DH and DfES guidance and frameworks, such as prevention of falls in older people, over 65, National Healthy Schools Standards and halting the year on year increase in obesity". (SHA 3).

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Target group: Children

Context

By 2020 the predicted prevalence of childhood obesity will be in excess of 50%[30]. The most important consequence of obesity for children and young people is the potential high incidence of obesity carrying over into adulthood and its subsequent contribution to long-term medical conditions, such as cardiovascular disease and type 2 diabetes[17].

This section of the resource looks at some of the relevant national and local targets and recommendations relating to health outcomes for children, as well as an overview of the available evidence concerning the impact of physical activity interventions. Finally, this section considers the information gathered via the national SHA and PCT consultation as well as anecdotal and research evidence to suggest three pragmatic priority activities to increase the chance of achieving the targets.

Priority area: Health and well being of the population

Potential relevant national and local targets and recommendations:

Physical activity can contribute to a range of national and local targets that are focused on children.

DH/DFES/DCMS PSA Target

> 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 (DH/DFES/DCMS).

DCMS/DFES PSA Target

> To increase the proportion of school children in England who spend a minimum of two hours each week (within or outside of school time) on high quality PE and sport from 25% in 2002, to 75% by 2006 and 85 per cent in 2008.

> By 2010 aim for all pupils to have the opportunity to do up to two hours of sport in school hours and two to three hours of sport outside of school hours.

Target group: Children

DCMS/DFES PESSCL target (Physical Education, School Sport and Club Links):

> By September 2005, we will have increased by a third (to 75%) the number of maintained schools (secondary, primary and special) in school sports partnership and will achieve 100% coverage from September 2006. By 2006, we also aim to have at least 400 sports specialist schools and academies with a sports focus.

Choosing Health delivery actions:

> Aim for an increased prevalence of physical activity amongst the whole population in England, with an increasing year on year 1% per annum trajectory.

Healthy Schools Standard:

> Half of all schools will be Healthy Schools by 2006 with all schools working towards Healthy School status by 2009.

School Travel Plan:

> Building on existing progress, by 2010 all schools will have active school travel plans.

How can physical activity interventions help achieve the targets?

There is growing public health concern over the effects that sedentary lifestyles are having on the health of young people, particularly in relation to overweight and obesity.

According to the CMO report[5], regular physical activity helps control weight and can reduce the risk of becoming obese. It also brings important reductions in risk of mortality and morbidity for those who are already overweight.

Physical activity has a range of benefits during childhood, including healthy growth and development, maintenance of energy balance and psychological well being[5]. It also has a direct link in preventing the development of cardiovascular disease risk factors (e.g. obesity, raised blood pressure, adverse lipid profiles), through preventing excess weight gain during childhood, or promoting weight loss in overweight children[5].

The Chief Medical Officer[5] recommends 'children and young people (aged 5-18 yrs) should achieve at total of at least 60 minutes of at least moderate intensity physical activity each day. At least twice a week this should include activities to improve bone health, muscle strength and flexibility. This can be gained in one session, or though several shorter bouts of activity of 10 minutes or more.'

Trajectories

In areas without a current baseline of physical activity uptake, an assumption of the average can be made to extrapolate the numbers of participants needed to achieve an increase in physical activity levels.

At present 70% of boys and 61% of girls aged 2-15[36] are achieving the recommended amount of activity per week: in any 100,000 population, approximately 20% will be aged 2-15, equalling 20,000 children and young people.

Therefore an area with a 100,000 general population, 13,100 pupils would already be meeting the target. To achieve a 1% increase in the number of young people being active, a further 200 children would need to meet the activity recommendations each year from the baseline figure.

Based on the SHA and PCT consultation, anecdotal and research evidence what are the three pragmatic priority activities to increase the chance of achieving the targets?

In order to achieve the targets set staff need to be competent at engaging with and delivering services for children and young people. This outcome may be achieved through having attended training with a focus on population and individual lifestyle change to assess plan and deliver successful services with and for children and young people[32-34].

1. Work with partners in education, local authority and alongside families/governors to increase the number of children walking and cycling to school: including increasing the use of pedometers as a motivational tool to assess baseline activity status and to allow for measurement of effect.
2. Work with partners (school health, acute services, sports development and leisure services, etc) to offer increased physical activity interventions to all children and their families.
3. Identify and promote the use of any local green spaces and parks for activity. Encourage the use of safe playing areas to allow children and young people to have more opportunities to participate in physical activity and sports in their locality.

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How can progress against these targets be measured?

A service monitoring system will need to be developed and implemented, using the tables and guidance towards the back of this resource. The table includes suggestions on what to measure and the type of data to collect. Any system developed will need to provide a way of monitoring the demographics of individuals participating in physical activity and the outcome (i.e. increased physical activity, self esteem, maintained/increased/decreased level of physical activity following a physical activity programme). Comparisons can then be made from this system against any national or local targets set.

The system needs to include, or use as a baseline, Local Authority or other Comprehensive Performance Assessment (CPA) or assessment tools or mechanisms, so that partners can share information that is meaningful and useful to all partner agencies.

It is important that the evidence and data used to track efficacy (broadly tracked participation, for example) should be of the same quality and longevity as other evaluations of interventions such as stop smoking services.

Click here for the service planning and monitoring table for this group.

Any system should also encourage cross-regional information sharing, enabling regions to highlight strengths and weaknesses of individual approaches or methodologies. Data collected should be similar and usable by partners such as National Healthy Schools Standard (NHSS), Local Education Authorities (LEAs), Community Sports Networks and Local Area Agreement teams (LAAs). Monitoring systems therefore should be developed within a partnership framework, CPA or a Single Assessment Process (SAP).

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Example 1 - supporting schools data collection

All pupils in school X are given pedometers for one week. Each day they are asked to reset their pedometers at 3pm and record the number of steps taken on a paper table. At the end of the week, all pupils are supported with transferring the data from paper to a class based computer record. The class records are recorded on an excel spreadsheet for the whole school. This system is then repeated following the introduction of a walking bus and safer routes to school system. Changes can then be plotted for different classes, age groups and genders.

Class 1

Gender	Boys	Girls
Total steps day 1		
Total steps day 2		
Total steps day 3		

Case study

The Choosing Health White Paper set out the commitment to "pilot the use of pedometers in schools - both as a tool to support a wide range of curriculum topics and to increase awareness amongst pupils of the need to be active". This is being implemented through a joint DH-DfES-Youth Sport Trust

(YST) programme "Schools on the Move", which includes resource materials for schools, teachers and young people to help integrate pedometers into the life of the school. Pedometer pilots were introduced in 50 schools in October 2005 and the progress will be evaluated over 2 school terms, however the impact is already being experienced by pupils. According to David Lodge at Garibaldi College, Nottingham 'Pedometer fever has swept the school! Everyone, including the staff have gone crazy for it so far'.

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Target group: Adults

Context

Adults who are physically active have a 20-30% reduced risk of premature mortality (i.e. prior to the age of 75)[5]. Adults who expend approximately 1,000 calories per week through physical activity have a reduced risk of all-cause mortality, with risk reductions in the order of 20-30%[7]. (To expend 1,000 calories in a week, an average sized adult would need to walk for around 45 minutes per day at a speed of 2 miles per hour). There is evidence that regular walking reduces the risk of mortality[8] and can increase life expectancy by 4-5 years[8].

This section of the resource looks at some of the relevant national and local targets and recommendations relating to health outcomes for the adult population, as well as an overview of the available evidence concerning the impact of physical activity interventions. Finally, this section considers the information gathered via the national SHA and PCT consultation as well as anecdotal and research evidence to suggest three pragmatic priority activities to increase the chance of achieving the targets.

Priority Area: The health and well being of the population[3]

Potential relevant local and national targets and recommendations

Physical activity can contribute to a wide range of national and local targets that are focused on adults.

DH PSA Targets:

- Improve the health of the population: by 2010 increase life expectancy at birth in England to 78.6 years for men and 82.5 for women and improve the 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.

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Target group: Adults

DCMS PSA Target:

> By 2008, increase the take-up of sporting opportunities by adults and young people aged 16 and above from priority groups by increasing the number who participate in active sports, at least 12 times per year by 3%, and increasing the number of participants who engage in at least 30 minutes of moderate-intensity-level sport, at least three times per week by 3%.

Choosing Health delivery action:

> Aim for an increased prevalence of physical activity amongst the whole population in England, with an increasing year on year 1% per annum trajectory.

How can physical activity interventions help achieve the targets?

Adults who are physically active have a reduced risk of premature mortality (i.e. prior to the age of 75) of between 20-30%. They also have up to a 50% decreased risk of developing chronic diseases such as CHD, stroke, diabetes and cancer. Physical activity plays a role in the treatment and management of a range of chronic or recurrent diseases, such as cardiovascular disease, obesity, diabetes, asthma, chronic obstructive pulmonary disease and osteoporosis.[5]

Therefore, offering adults the opportunity and information to allow them to choose to participate in effective physical activity interventions is likely to contribute towards preventing the development of chronic diseases, improving the health and well being of people with existing long-term conditions, and reducing mortality rates.

The most recent Health Survey for England[35] found that 37% of men and 24% of women aged 16-to-24 years were physically active for 30 minutes or more at least five days a week.

Besides a clear disparity in participation by gender, there are large inequalities in physical activity participation levels, which are lowest amongst low income and BEM communities[5]. To increase activity levels amongst these population groups it is important that communities are involved in the planning and delivery of services to ensure the services meet local needs[1,2].

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Target group: Adults

Trajectories

For areas without a baseline, using the current available statistics on population activity[1] in an average area with a general population of 100,000, approximately 20% will be school aged children and young people[8], therefore 80% of the population are adults, (80,000 people in this example). 29% of the population, approximately 23,200 people are currently meeting the health generating physical activity requirement. This would leave a population of approximately 56,800 who do not currently meet the health generating physical activity requirements, which would need services or support to increase their activity levels.

To achieve a 1% per annum increase in physical activity, a commissioning or monitoring organisation should aim for service delivery partners to achieve 800 more adults than baseline undertaking 30 minutes of physical activity on five or more days in a week per year. The 800 extra adults per year (1% trajectory increase per annum) should include a societal reflective stratification of results, for example, in a locality with 10% of clients being BEM, and 25% being from socio economic groups C2 or below, a minimum of 80 clients per year (10%) should be BEM (Black or Ethnic Minority) and a minimum of 200 clients per year (25%) from social classes C2 or below.

Total population	100,000
children	20,000
all adults	80,000
all adults meeting current recommendations	23,200
number not achieving current recommendations	56,800

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Target group: Adults

Based on the SHA and PCT consultation, anecdotal and research evidence what are the three pragmatic priority activities to increase the chance of achieving the targets?

In order to achieve the targets set staff need to be competent in engaging with and delivering services for adults. This outcome may be achieved through having attended training with a focus on population and individual lifestyle change to assess plan and deliver successful services with and for adults[32-34]. Achieving this also necessitates a wider understanding of the causes of higher rates of obesity in some groups in particular areas, which may relate to environmental and societal issues (lack of appropriate spaces, fear of crime etc).

1. Offering (and further developing) free health walks schemes providing opportunities for at least 4 hours per week.
2. Working with partners in local authorities and local employers to increase activity opportunities at work.
3. Offering and monitoring pedometers and cycling schemes, including travel plans for workplaces and localities.

How can progress against this target be measured?

A service monitoring system will need to be developed and implemented, using the tables and guidance towards the back of this resource. The table includes suggestions on what to measure and the type of data to collect. This system will provide a way of monitoring the demographics of individuals participating in physical activity and the outcome (i.e. increased physical activity, and a change in physical activity levels).

Comparisons can then be made against any national targets set. This system should also encourage cross-regional information sharing, enabling regions to highlight strengths and weaknesses of individual methodologies or interventions. Wherever possible systems should be aiming to collect similar data with other health services and also within and as part of wider partnership work such as Local Area Agreements (LAAs) or Community Sports Networks. The local authority CPA, common assessment framework or other assessment tools should be utilised wherever possible.

It is important that the evidence and data used to track efficacy (broadly tracked participation, for example) should be of the same quality and longevity as other evaluations of interventions such as stop smoking services.

Click here for the service planning and monitoring table for this group.

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Target group: Older people

Context

Physical activity is an important strategy for increased self care and decreased use of health and social care services amongst the older population. It plays a role in the treatment and management of a range of chronic or recurrent diseases, such as cardiovascular disease, obesity, diabetes, asthma, chronic obstructive pulmonary disease and osteoporosis[5]. It also plays a role in reducing the severity of some diseases and consequently, the need for hospitalisation[13]. One cohort study reported that walking more than 4 hours or more per week was associated with a reduced risk of hospitalisation over a 2-year follow-up period in adults (aged 65 and over) with cardiovascular disease[13].

This section of the resource looks at some of the relevant national and local targets and recommendations relating to health outcomes for the older adult population, as well as an overview of the available evidence concerning the impact of physical activity interventions. Finally, this section considers the information gathered via the national SHA and PCT consultation as well as the anecdotal and research evidence to suggest three pragmatic priority activities to increase the chance of achieving the targets.

Priority area: Patient /user experience

Potential relevant national and local targets and recommendations:

Physical activity can contribute to a wide range of national and local targets that are focused on older people

DH PSA Target:

> 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.

DCMS PSA Target:

> By 2008, increase the take-up of sporting opportunities by adults and young people aged 16 and above from priority groups by increasing the number who participate in active sports, at least 12 times per year by 3%, and increasing the number who engage in at least 30 minutes of moderate-intensity-level sport, at least three times per week by 3%.

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EXIT

Target group: Older people

NSF Older People Target[36]:

> Increasing the proportion of older people being supported to live in their own homes.

Relevant Choosing Health delivery action:

> Aim for an increased prevalence of physical activity in England, with a 1% per annum trajectory increase.

How can physical activity interventions help achieve the targets and recommendations?

Regular lifestyle activity is particularly important for older people for the maintenance of mobility and independent living[5]. The CMO report states that the health benefits of physical activity are even more pronounced in older adults and are particularly important because of the diseases involved[5]. Most notably, osteoporosis, circulatory diseases and depression, affect an older person's ability to maintain an independent lifestyle[5]. Physical activity, particularly strength, balance and coordination training, has also been found to be 'highly' effective in reducing the incidence of falls[5].

Approximately 30% of the population are aged over 50 years, 4.4% of the population are aged between 65-69, 4% are 70-74 and 8% are over 75 (The most recent census shows us that 16% of the population are aged 65+31).

Approximately 16% of the population aged 65-9 and 6% of those aged 75 and over[35;37,41] currently meet the current physical activity recommendation for general health benefits described in Choosing Health[22].

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Target group: Older people

Trajectories

In areas without baseline information, an average assumption may be made. For an average population of 100,000 people, 16% are over 65. Of these, according to the most recent Health Survey for England 22% currently meet the recommendations for health enhancing physical activity[37].

Total population	100,000
over 65	16,000
over 65 and achieving recommendations	3,520
over 65 not achieving recommendations	12,480

A 1% annual trajectory increase therefore, for this group is equivalent to approximately 160 more adults aged over 65 per year for a general population of 100,000.

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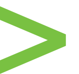
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Based on the SHA and PCT consultation, anecdotal and research evidence what are the three pragmatic priority activities to increase the chance of achieving the targets?

In order to achieve the targets set staff need to be competent in engaging with and delivering services for older adults. This outcome may be achieved through having attended training with a focus on population and individual lifestyle change to assess plan and deliver successful services with and for older adults[32-34].

1. Extend physical activity schemes for the elderly, available in their own homes or in a very local community setting, through engaging support workers with home visiting teams of health and social care workers, as well as local community groups such as those provided through the Salvation Army, British Legion or other agencies.
2. Increase and promote the use of pedometers as a motivational tool.
3. Develop and promote partnerships with other services through systems such as the Single Assessment Process (SAP).

How can progress against these targets be measured?

A service monitoring system will need to be developed and implemented, using the tables and guidance towards the back of this resource. The table includes suggestions on what to measure and the type of data to collect. This system will provide a way of monitoring the demographics of individuals participating in physical activity and the outcome (i.e. increased physical activity, and a change in physical activity levels).

This monitoring system should also encourage cross-regional information sharing, enabling regions to highlight strengths and weaknesses in individual methodologies or interventions. Data collected should be similar and usable by partners such as, elderly care teams, case managers, health and social care teams focusing on reducing falls, charities such as Care of the Elderly teams, Help the Aged, Community Sports Networks and Local Area Agreement teams (LAAs). Monitoring systems should therefore be developed within a partnership framework, which may include primary care activity indices, CPA, SAP and others.

It is important that the evidence and data used to track efficacy (broadly tracked participation, for example) should be of the same quality and longevity as other evaluations of interventions such as stop smoking services.

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Target group: People with long-term medical conditions

Context

Physical activity plays a role in the treatment and management of a range of chronic or recurrent diseases, such as cardiovascular disease, obesity, diabetes, asthma, chronic obstructive pulmonary disease and osteoporosis[5]. It also plays a role in reducing the severity of some diseases and consequently, the need for hospitalisation[13]. One cohort study reported that walking more than 4 hours or more per week was associated with a reduced risk of hospitalisation over a 2-year follow-up period in adults (aged 65 and over) with cardiovascular disease[13].

This section of the resource looks at some of the relevant national and local targets and recommendations relating to health outcomes for the population who have a long-term medical condition (LTC), as well as an overview of the available evidence concerning the impact of physical activity interventions. Finally, this section considers the information gathered via the national SHA and PCT consultation as well as the anecdotal and research evidence to suggest three pragmatic priority activities to increase the chance of achieving the targets.

Priority area: To improve health outcomes for people with long term conditions and to improve the health and well-being of the population[6]

Potential relevant national and local targets and recommendations:

Physical activity can contribute to a wide range of national and local targets that are focused on people with long term medical conditions.

DH PSA Targets:

- Improving health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk.
- 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.

DCMS PSA Target:

- By 2008, increase the take-up of sporting opportunities by adults and young people aged 16 and above from priority groups by increasing the number who participate in active sports, at least 12 times per year by 3%, and increasing the number who engage in at least 30 minutes of moderate-intensity-level sport, at least three times per week by 3%.

Relevant Choosing Health delivery action:

- Aim for an increased prevalence of physical activity in England, and a 1% per annum increasing trajectory.

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How can physical activity interventions help achieve the targets?

The increased incidence of chronic diseases and conditions presents a huge challenge. Chronic diseases are those that can only be controlled and not, at present, cured. They include diabetes, asthma, arthritis, heart failure, chronic obstructive pulmonary disease, dementia and a range of disabling neurological conditions. Living with a chronic disease has a significant impact on a person's quality of life and on their family. The incidence of such diseases increases with age. Many older people are living with more than one chronic condition and this means that they face particular challenges, both medical and social.

The proportion of people with a long-term illness or disability, which restricts their daily activities increases with age. Among women in Great Britain, the proportion of those aged 85 and over that reported such a disability in 2001 (74 per cent) was almost triple that for women aged 50 to 64 (26 per cent). The increase with age among men is not quite so strong - 27 per cent of 50 to 64 year olds compared with 67 per cent of those aged 85 and over in 2001[31]. 44% of the population in England consider themselves to have a long-term condition, and 25% have a limiting long-term condition[37].

Evidence from the CMO report has demonstrated that physical activity has a positive impact upon the treatment and management of a range of chronic or recurrent diseases, such as cardiovascular disease, obesity, diabetes, asthma, chronic obstructive pulmonary disease and osteoporosis[5].

Diseases of the heart and circulatory system are the main cause of death in the UK: More than 1 in 3 people die from CVD[14]. Regular physical activity or improved cardio-respiratory fitness decreases the risk of cardiovascular disease mortality in general and CHD mortality in particular[15] and physically active individuals are 1.9 times less likely to have a heart attack than inactive individuals[15].

The care of people with chronic conditions also consumes a large proportion of health and social care resources. People with chronic conditions are significantly more likely to see their GP (accounting for 60-80% of GP consultations), to be admitted as inpatients, and to use more inpatient days than those without such conditions[38; 39].

Improving health outcomes for people with long-term conditions through increased physical activity will therefore play a role in reducing the demand on the NHS and social care services.

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Trajectories

In areas without baseline information, an area of 100,000 people will have approximately 44,000 with a long-term condition, and of this group approximately 25,000 with a limiting long-term condition. Assuming that people with long term conditions have an average similar to the standard adult rates of the population achieving health enhancing rates of physical activity, just over 12,760 currently meet the recommendations. It is likely that this is in fact an overestimation, and baseline statistics are needed. In the most recent Health Survey for England, self reported bad health was negatively correlated with physical activity: in men, 16% of those who considered themselves in bad health, and only 3% of women in this group met the recommendations for physical activity. However, as is noted in the survey results, it is not clear whether low physical activity levels lead to poor health or whether poor health decreases the ability to be physically active.

Total population	100,000
Population with LTC	44,000
Population with any LTC achieving PA recommendations	12,760
Population with limiting LTC	25,000
Population with Limiting LTC achieving PA recommendations	8,410

A 1% annual trajectory increase therefore, for this group is equivalent to, in the best case scenario shown above, approximately 440 more people with a long term condition (as noted in either the GP registers or self reported through census data) taking up physical activity interventions each year per 100,000 of general population.

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Target group: People with long-term medical conditions

Based on the SHA and PCT consultation, anecdotal and research evidence what are the three pragmatic priority activities to increase the chance of achieving the targets?

In order to achieve the targets set staff need to be competent in engaging with and delivering services for people with long term conditions. This outcome may be achieved through having attended training with a focus on population and individual lifestyle change to assess plan and deliver successful services with and for people with long term medical conditions[32-34].

1. Where appropriate, offering exercise referral opportunities to all patients with long-term medical conditions, such as CHD, hypertension, type 2 diabetes, HIV/Aids, asthma, arthritis and clinically diagnosed obesity.
2. Increasing and promoting the use of pedometers throughout health and social care as a motivational and developmental tool to raise awareness and to provide baseline and follow up information.
3. Increasing brief and opportunistic physical activity advice to patients with long-term medical conditions by health and social care professionals. This entails all professionals who work with this group being trained to identify the benefits to clients of increased participation, to signpost to appropriate local opportunities and to support the idea of increased participation in physical activity, using individual techniques such as Neurolinguistic programming and motivational interviewing and population level techniques such as social marketing.

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How can progress against this target be measured?

A service monitoring system will need to be developed and implemented, using the tables and guidance towards the back of this resource. The table includes suggestions on what to measure and the type of data to collect. This system will provide a way of monitoring the demographics of individuals participating in physical activity and the outcome (i.e. increased physical activity, and a change in physical activity levels).

This system should also encourage cross-regional information sharing, enabling regions to highlight strengths and weaknesses. Data collected should be similar and usable by partners such as, elderly care teams, case managers, Children's trust workers, health and social care teams focusing on reducing falls, charities such as Help the Aged and NCB, and Community Sports Networks and Local Area Agreement teams (LAAs). Monitoring systems therefore should be developed within a partnership framework, such as the Local Authority led CPA process currently in use, and which may include primary care activity indices, Single Assessment Process (SAP) and others.

It is important that the evidence and data used to track efficacy (broadly tracked participation, for example) should be of the same quality and longevity as other evaluations of interventions such as stop smoking services.

Click here for the service planning and monitoring table for this group

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Service planning and monitoring table for physical activity

The following tables could be used by primary care organisations during their Local Delivery Plan (LDP) service planning and refreshment. The most recent relevant health publication, 'Your health, your care, your say'[40] supports the approach adopted throughout this framework of improving infrastructure and providing interventions for self care and personal health responsibility opportunities.

The tables:

> Show how the relevant targets sit within each priority area.

> Suggest the interventions, which could be used to help meet these targets, and address health and social care standards.

> Identify which kinds of data need to be collected, and where it can be sourced.

> Show how the data can be used to demonstrate progress against desired outcomes.

> Identify skills and training, which may be needed.

It is noted that the content of the table may need to change to reflect local issues and priorities. However, the table provides an overview and potential traffic lighting system to identify key areas and outcomes.

Although it is recognised that there is a need for a specific monitoring tool for all partners to use when measuring physical activity interventions, it is not within the remit of this document to provide a comprehensive and 'one size fits all' tool. Monitoring outcomes must be agreed with all partners and must reach the needs of all partners, but may include some of the items suggested in the commissioner checklist as well as other items such as:

> Per capita spend on physical activity

> No of physical activity advisors in post

> Waiting times

> Existence of a multidisciplinary strategy

> Scale and types of professional training available.

> Incentive schemes for GPS and others

> Adherence and attrition rates (short, medium and long term)

> Medication change pre and post intervention.

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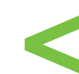
Service planning and monitoring table for physical activity

National Priority	PSA Target	Example of PCT Activity and relationship to Core (C) or Developmental (D) standards	Data items for deliverers to collect to demonstrate progress	Where the data items may be sourced	Annual outcome standards for performance monitoring	Skills, Training and Competences needed.
Health and well being of the population[7]	Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases	Offers free health walks (C23)	1. Number attending 2. Gender attending 3. Postcode of attendees 4. Ethnicity of attendees 5. Number of participants achieving 4 hours per week walking 6. Existing chronic illness of attendees 7. Age of attendees	For all data items a Service monitoring system needs to be implemented to collect participant information.	1. Year on year increase 2. Increase number of participants who are men 3. Increase number of participants who are from deprived areas 4. Increase number of participants who are from BME communities 5. Increase number of participants who are with at least one chronic illness 6. Increase number of participants who are aged 20-79	• All staff to have a knowledge of where interventions are offered • Health walk leader needs local knowledge
Health and well being of the population[7]	Tackling the underlying determinants of health inequalities: halting the year on year rise in obesity among children under 11	Works with education and local authority to increase children walking or bicycling to school (C22)	1. Partners in schools, school health and local councils: Local Area Agreement information 2. Number of participants who are of schools offering walking buses, bicycle buses, bicycle to school schemes, walk to school schemes 3. Number of pupils who continue to walk or bicycle to school on a regular basis	1. Local Area Agreement. (www.odpm.gov.uk) 2. School Travel Plan. 3. Service Monitoring System.	1. Annual consideration in LAA 2. Year on year increase in numbers of participating schools 3. Year on year increase in number of pupils who continue to walk or bicycle to school on a regular basis	• Knowledge of local partnerships and partnership opportunities
Health and well being of the population	Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases	Works with partners in local council and local employers to increase activity opportunities at work (C22)	1. Local Area Agreement information 2. Number of local employers offering activity opportunities at work 3. Number of employees taking opportunities 4. Gender, postcode, ethnicity, age of employees taking opportunities 5. Changes in sickness absence	1. Local Area Agreement. (www.odpm.gov.uk) 2. Employers. 3. Employers. 4. Service Monitoring System.	1. Annual consideration in LAA 2. Year on year increase in numbers of participating employers 3. Year on year increase in number of employees participating 4. Equity audit information 5. Sustained reduction in absenteeism	Cross professional training Involve local occupational health colleagues in partnerships Knowledge of local partnerships and partnership opportunities



Service planning and monitoring table for physical activity

National Priority	PSA Target	Example of PCT Activity and relationship to Core (C) or Developmental (D) standards	Data items for deliverers to collect to demonstrate progress	Where the data items may be sourced	Annual outcome standards for performance monitoring	Skills, Training and Competences needed.
Health and well being of the population[7]	Tackling the underlying determinants of health inequalities: halting the year on year rise in obesity among children under 11	Works with partners (school health, acute services etc) to offer increased physical activity interventions to children and their families (C23)	1. Number of children who are obese from child health/school health records 2. Number of attendees 3. Gender, age, ethnicity, postcode of attendees 4. Number of participants who are achieving no weight gain over 3 and 12 months post intervention	1. Individual School Records/School Nurses 2. Individual Schools. 3. Service Monitoring system. 4. Service Monitoring System.	1. Year in year stability or decrease in number of participants who are of children under 11 identified as obese [perverse indicator - inclusion policy at recruitment could influence] 2. Equity audit of attendees 3. 50% - 75% success rate at 3 months, 10% success rate at 12 months	Brief and opportunistic training for school staff Some school staff one to one or group training to be able to deliver services
Health and well being of the population7	Tackling the underlying determinants of health inequalities: Reducing adult smoking rates	Link brief and opportunistic stop smoking advice to physical activity interventions (D13)	1. Number of participants who are of smokers at physical activity interventions? 2. Number asked about quitting 3. Number of participants who are referred to LSSS	1. Service Monitoring System. 2. Service Monitoring System. 3. Local Stop smoking service for Region.	1. Year on year increase in numbers referred through PA interventions to LSSS	Brief and opportunistic training for stop smoking service staff Shared intelligence
Health and well being of the population[7]	Tackling the underlying determinants of health inequalities: Reducing adult smoking rates	Link PA interventions to LSSS (D13)	1. Number of participants who are of quitters referred to PA intervention to reduce withdrawal effects and increase dopamine/serotonin release	1. Local Stop Smoking Service.	1. LSSS data field: PA intervention offered/discussed - year on year increase in number of participants	Brief and opportunistic training for stop smoking service staff Shared intelligence

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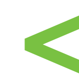
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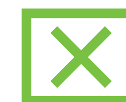
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Service planning and monitoring table for physical activity

National Priority	PSA Target	Example of PCT Activity and relationship to Core (C) or Developmental (D) standards	Data items for deliverers to collect to demonstrate progress	Where the data items may be sourced	Annual outcome standards for performance monitoring	Skills, Training and Competences needed.
Long term conditions[1]	To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk	A scheme is offered whereby all patients with CHD, hypertension, type 2 diabetes, HIV/Aids, and clinically diagnosed obesity are offered exercise opportunities (C23) Asthmatic patients are offered as above (D13)	1. Numbers of attendees with each condition 2. Attendee demographics: age, ethnicity, postcode, gender 3. Outcomes for attendees at 3 and 12 months 4. Attendee baseline physical activity levels 5. Attendee follow up PA levels 6. Referee details	1. Service Monitoring System. 2. Service Monitoring System. 3. Service Monitoring System.	1. 75% of potential referees refer to scheme, with year on year rise 2. Equity audit 3. 50% reach a stated outcome at 3 months, 15% at 12 months 4. Increase in physical activity levels to 2.5 hours per week 5. Increase in % referrals to programme who continue to Exercise after completion.	Brief and opportunistic training to referral staff Knowledge of local services and options for clients
Patient / User Experience	Increasing the proportion of older people being supported to live in their own homes	Physical activity scheme (such as Extend) for the elderly, available in their own homes or in a very local community setting (C6, C23)	1. Number of participants s seen in such a service 2. Attendee demographics: age, ethnicity, postcode, gender 3. Number of participants s experiencing falls	Service Monitoring System for all data items will need to be implemented.	1. Increase year on year number of participants s seen in such services 2. Falls prevention number of participants year on year 3. Decrease number of faller's year on year.	The service deliverers must be competent and confident to deliver the scheme
Health and well-being of the population	Halt the year on year rise in obesity among children under 11	Active parks and spaces (C22)	1. Numbers of parks or green spaces in the locality, recorded by deprivation 2. Promotion of the use of such spaces	1. Local Council, mapping exercises. 2. Local Council, CPA	1. Equity audit 2. Evidence of partnership work to achieve increased active spaces.	Local knowledge and mapping of Active parks
Health and well being of the population[7]	Improve the health of the nation	Increase and promote the use of pedometers as a motivational tool (C23)	1. Numbers of pedometers provided 2. Numbers of people able to give their average number of steps per day 3. Numbers of participants reaching 10,000 steps or other agreed target	For both of these a Service Monitoring system will enable the SHA to develop this information.	1. Year on year increase	Brief and opportunistic training for people giving out pedometers Technical training for people giving out pedometers

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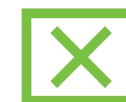

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Summary checklist for commissioners

Summary checklist for commissioners

Service commissioners may wish to use the summary checklist below as a mechanism for ensuring that physical activity services are suitably configured to contribute towards meeting agreed national or local targets. This can be used in tandem with the previous resource as a mechanism for 'refreshing' the Local Delivery Plan (LDP) process, or other planning mechanisms in the organisation. This checklist is not intended to be prescriptive and should not stifle innovation or the development of services to respond to specific local health needs. The aim is for the resource to complement and begin processes of change within organisations. The checklist is not designed to be a completed and static resource; however, it provides an overview of questions commissioners could consider allowing them to track the progress of physical activity interventions.

In addition, commissioners should ask for evidence from joint planning processes within LAAs or other systems areas that assess roads, pavements, shopping centres, public buildings and large employers, that health impact assessments have been undertaken to identify:

- Hidden subsidy of non active transport
- Places where active travel may be possible, but currently is not supported or developed fully
- Incentive schemes

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Service planning and monitoring table for physical activity

Is the Service Provider:	PCT is Already providing	PCT is Planning to provide in the next 12 months	PCT is Not planning to provide
Is the Service providing capacity to develop Physical Activity?			
Is an overall Physical Activity Target in place? e.g. 1% increase in physical activity levels year on year?			
Is the Service provider working in partnership to develop Physical Activity?			
Can the Provider demonstrate working links with County Sports Partnerships?			
Is the service provider linked into their local Community Sport and/or Physical Activity Network?			
Can the Provider demonstrate working partnerships looking at holistic area environmental issues relating to transport and opportunity?			

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EXIT

Service planning and monitoring table for physical activity

Is the Service Provider:	Is there an identified post/person responsible for this area of Physical Activity	Target group	PCT is already providing	PCT is planning to provide in the next 12 months	PCT is not planning to provide	National or local target identified	Confirmed by service provider that working to Regional Plan
Offering opportunities for physical activity to local employers/employees?							
Increasing the use of pedometers in the NHS?							
Ensuring service provision is supported and promoted in areas if high deprivation or other disadvantaged groups?							
Working with local schools on local travel plans?							
Working with partners on active parks and spaces schemes or similar?							
Working with partners in elderly care to offer opportunities for managed physical activity (eg extend)?							
Offering health walks for a minimum of 4 hours per week?							
Working with partners in primary care to offer exercise on prescription or similar referral scheme for those with long term conditions including but not limited to CHD, diabetes, clinical obesity, asthma, and hypertension?							

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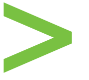
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Service planning and monitoring table for physical activity

Is the Service Provider:	Is there an identified post/person responsible for this area of Physical Activity	Target group	PCT is already providing	PCT is planning to provide in the next 12 months	PCT is not planning to provide	National or local target identified	Confirmed by service provider that working to Regional Plan
Working with partners to offer physical activity opportunities to obese children and young people?							
Working with partners on LAAs which reference physical activity?							
Working with partners on travel schemes, such as bicycle schemes?							
Collating, with partners local area knowledge about physical activity opportunities and promoting this to all staff for signposting clients?							
Working with partners to ensure physical activity is part of the Single Assessment Process (SAP)?							
Working with NHSS partners to ensure physical activity interventions are considered in NHSS plans?							

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ELC Consultancy

ELC Consultancy

ELC Consultancy is a small company, which provides external objective training, evaluations and research to the health and social care sector. We aim to provide timely cost effective capacity solutions across all areas of health and social care to support colleagues in delivering effective and appropriate interventions to benefit the public health and well-being.

To contact us to discuss this document or other issues please email research@ecconsultancy.co.uk

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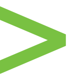

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