Moving Healthcare Professionals Programme

Final evaluation report

National Centre for Sport and Exercise Medicine and Ipsos

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Executive summary

Background

The Moving Healthcare Professionals Programme (MHPP) is a national programme led by the Office for Health Improvement and Disparities (OHID) – formerly Public Health England (PHE) – in partnership with Sport England. The MHPP aims to embed physical activity into clinical care for the prevention and management of long-term conditions at a system level. It aims to do this by increasing the capability, opportunity and motivation of healthcare professionals (HCPs) in promoting physical activity to their inactive patients who are at risk of, or living with, long-term health conditions. The MHPP builds on the evidence that shows HCPs are uniquely placed to support people to become more physically active, with the various health benefits this then brings. Healthcare interventions are identified in global guidance as a key area of influence in increasing population physical activity levels and this is reflected in national guidance frameworks[1,2].

Phase One of the MHPP took place between May 2017 and March 2019. Phase Two of the MHPP is due to conclude at the end of 2022, having begun in April 2019, comprised of eight workstreams:

- **Programme evaluation** (described below).
- **Physical Activity Clinical Champions (PACC):** A peer-to-peer training programme for HCPs, launched in 2014, that aims to increase their knowledge, skills and confidence to promote physical activity to their patients, enabling them to use very brief advice relating to physical activity.
- **Moving Medicine:** An online free-to-access resource developed by the Faculty of Sport and Exercise Medicine (FSEM), launched in 2018. The resource is designed to encourage HCPs to speak to patients about physical activity. It provides condition-specific information on the benefits of physical activity as well as guidance on how to structure conversations with patients.
- **Active Hospitals:** Four NHS trusts piloting 'whole hospital' approaches to embedding the promotion of physical activity in secondary care settings, overseen by the NHS Transformation Unit (NHS TU), and building upon a pilot undertaken by Oxford University Hospitals NHS Foundation Trust in 2017-19.
- **E-Learning:** Free-to-access E-Learning modules on physical activity and health, delivered by Health Education England (HEE) and hosted on the elearning for healthcare (elfh) portal, available since 2019[3]. The aim of the E-Learning resources is to increase HCPs knowledge of how, and why, physical activity is important, thus increasing their capability to discuss it with patients.
- **E-Advice:** A digital resource (consisting of a e-Prompt for HCPs to discuss physical activity with patients, and a patient-facing resource) designed as part of Phase Two to support the use of brief advice for physical activity in primary care, led by OHID's Behavioural and Social Sciences Team.

[1] International Society for Physical Activity and Health (ISPAH). ISPAH's Eight Investments That Work for Physical Activity. November 2020. https://ispah.org/wp-content/uploads/2020/11/English-Eight-Investments-That-Work-FINAL.pdf
[2] Public Health England (2014). Everybody active, every day. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf
[3] 10 E-Learning modules were also available on the British Medical Journal (BMJ) learning platform though the evaluation focused predominately on the HEE E-Learning modules given this platform was intended to be the home for NHS E-Learning at the time of evaluation scoping and funding for the BMJ modules was due to expire by the end of March 2020.

- **Activating NHS Systems:** A project designed to investigate approaches to develop whole system change and integration of physical activity into NHS/ integrated care systems (ICS) policy and care pathways. This project has been led by NHS Horizons since July 2021.
- **Undergraduate Curriculum:** Embedding physical activity promotion into the undergraduate curriculum for medical students. Changes in the work plan for this workstream meant that it was not included within the evaluation. This work has evolved beyond the original scoping of this workstream, in response to input and feedback from academic partners, students and medical schools. The result of this has led to the engagement with a wide range of stakeholders and a co-developed five to ten year plan that sets out the actions to be taken to embed physical activity within the undergraduate curricula.

Where workstreams have focused around a tool or product, these are referred to as MHPP 'assets'.

Programme evaluation

The National Centre for Sport and Exercise Medicine (NCSEM – Sheffield, and East Midlands), working in partnership with Ipsos, were commissioned to conduct an evaluation of Phase Two of the MHPP. The evaluation aimed to: (i) assess the impact of the programme and its constituent workstreams; (ii) understand the processes behind effective delivery; and (iii) enable continuous learning and improvement. A theory-driven, mixed methods evaluation approach was taken. Data were collected using surveys (with over 2,400 HCPs), in-depth interviews and discussion groups (collecting the views of over 140 individuals), and analysed alongside monitoring or management data. Workstream logic models underpinned the approach to data collection and analyses. Unless stated as otherwise, the survey data for each workstream is based on the following number of survey completes: 2,250 for the pre- and 263 for the post-training PACC survey, 70 for Moving Medicine, and 104 for E-Learning.

Key findings

They key evaluation findings, as they relate to the objectives of Phase Two of the MHPP, are outlined below.

Objective 1: Increase HCPs' awareness and knowledge of the importance of physical activity and skills to promote physical activity to patients, across clinical care settings to prevent and manage ill health, and reduce inactivity

Approximately 157,400 professionals have been trained or have accessed a training tool as part of Phase Two of the MHPP.

Overall, the workstreams have achieved their aim of increasing the capability and motivation of HCPs to promote physical activity. Principally this is seen through improvements in HCPs' knowledge, skills and confidence to promote physical activity following their engagement with an MHPP asset.

For some HCPs engaged by the programme, qualitative evidence shows they are more routinely discussing physical activity with patients, and those conversations are felt to be higher quality and more effective.

HCPs from across the workstream evaluations were able to provide anecdotal evidence of patients becoming more physically active following conversations about increasing their physical activity. HCPs provided examples of patients reporting better aerobic fitness, reduced pain, improved mental health/ mood, better management of fatigue, and greater enjoyment of physical activity.

Objective 2: Identify, test and evaluate interventions and effective delivery models to increase HCP awareness of physical activity and the skills to advocate to all of their patients

The assets are all different in nature by design, as such the scale of engagement with each MHPP asset during Phase Two is varied, as is the length of engagement. Headline engagement figures are that Moving Medicine attracted over 136,500 unique users during this Phase (including some non-HCPs). 16,640 HCPs attended a training session upwards of an hour through the PACC workstream. The HEE E-Learning modules attracted almost 3,600 unique users (including some non-HCPs). And in excess of 560 members of staff across the four Active Hospitals pilot sites received formal training on physical activity promotion.

Each of the three principal training tools evaluated (PACC, Moving Medicine and the HEE E-Learning) attract a different profile of HCP, thus helping to ensure a broad range of disciplines are engaged in the issue of physical activity promotion. PACC is predominantly used by doctors (which make up 42% of attendees based on monitoring data), whilst Moving Medicine most commonly attracts AHPs (44% of users based on survey data), and the HEE E-Learning modules primarily attract nurses/ midwives (35% of users based on monitoring data). Of the MHPP assets, PACC best targets HCPs who are less frequent promoters of physical activity.

The training tools have been very well received and are highly recommended by HCPs – most notably for Moving Medicine as 73% of users rated it 9 or 10 out of 10 meaning they would ‘definitely recommend’ it to others.

Objective 3: Understand the potential for sustainable implementation of interventions and delivery models to achieve large-scale change in clinical care

A number of stakeholders commented on what they observed to be a broadening of the organisations involved in conversations about the importance of physical activity. Many of these stakeholders attributed this development to the Activating NHS Systems workstream which was leading to new conversations between relevant parties in a way that had not been seen before. For example, the roundtable workshop with NHS England as part of this workstream brought together upwards of 30 senior representatives within the organisation to discuss the physical activity agenda.

Stakeholders described how the health system ‘had moved on’ in terms of there now being greater recognition – among both HCPs and patients – of the value of physical activity. The programme was also seen as facilitating more of a shared focus between the health and physical activity sectors, as well as providing a platform for raising the profile of the issue.

Whilst stakeholders acknowledged such changes in the system could not be solely attributed to the MHPP, they felt it had contributed to such progress.

Challenges to the programme

As with all complex, long-running and ambitious programmes, Phase Two of the MHPP has faced a number of challenges:

- The COVID-19 pandemic, which meant the programme (and evaluation) were paused in March 2020 until late summer 2020 (though the disruption to NHS services continued far beyond this).
- Staff turnover within the programme team, and transition of the programme into a new organisation following the dissolution of PHE.
- Some misalignment of ambitions between partnering organisations.

Despite these challenges, Phase Two of the MHPP has met its key objectives as evidenced by the evaluation.

Conclusions and implications

The MHPP is an ambitious programme, involving multiple partners, delivered in a complex and dynamic system. Phase Two has reached a large number of HCPs and has been delivered through the unprecedented circumstances of a global pandemic.

Implications for the specific workstreams from the evaluation findings are as follows:

- **PACC:** Future delivery of this workstream may involve curation by a central body with local commissioning of the training and management of PACCs (most likely by ICSs), and adaptation of the content to suit local population needs.
- **Moving Medicine:** In order to reach an audience who are less likely to advocate physical activity, and broaden engagement with the resource, a more comprehensive promotional strategy beyond that currently being used by the Moving Medicine team is required.
- **Active Hospitals:** To continue the momentum built through the Community of Practice, a single organisation is required to take responsibility for its curation and development going forwards to support further adoption and spread of the Active Hospitals initiative.
- **E-Learning:** A greater understanding is required of the modules' place – and HCPs' access to them – in a nationally coordinated training offer as HEE moves into NHS England.
- **E-Advice:** A larger pilot of the E-Advice tool is required to make an informed decision about its progression.

The following are implications for the programme more broadly:

- More comprehensive promotional activities, including cross-promotion between the assets, would enable the programme to have greater reach. Any such promotional activity should consider how the programme can 'preach beyond the converted'. This may include widening the target audience of the programme to non-HCPs such as social prescribing link workers.
- Securing the programme's ambition of embedding physical activity promotion into the undergraduate curriculum would be an effective means of achieving scale.
- Whilst stakeholders recognised the value and need for national bodies to collaborate on the physical activity agenda (of which MHPP is a part), some stressed the importance of clear – and visible – leadership on the issue. By this, stakeholders meant they wanted to see a central body responsible for: convening organisations across the system to a shared agenda; considering the MHPP assets as a whole; and setting a nationally coordinated training offer.
- ICSs, Active Partnerships, and OHID regions and places, have much to offer in terms of embedding the promotion of physical activity and promoting the MHPP assets.
- Efforts to better align the language used around physical activity promotion between the health and physical activity sectors should facilitate future collaboration.

- A concerted effort to review the actual and potential impact of the MHPP on health inequalities, and identify opportunities to lessen such inequalities, is warranted.
- Future MHPP developments would be complemented by other strategic interventions at policy level across known areas of influence as described in global guidance[4]. Interventions that create structural change, focus on reducing inequalities and enable a greater focus on the wider determinants of health will collectively contribute to long-term system change.

[4] International Society for Physical Activity and Health (ISPAH). ISPAH's Eight Investments That Work for Physical Activity. November 2020. https://ispah.org/wp-content/uploads/2020/11/English-Eight-Investments-That-Work-FINAL.pdf

1 Background

1.1 Introduction to the Moving Healthcare Professionals Programme

The Moving Healthcare Professionals Programme (MHPP) is a national programme led by the Office for Health Improvement and Disparities (OHID) – formerly Public Health England (PHE) – in partnership with Sport England. The MHPP aims to embed physical activity into clinical care for the prevention and management of long-term conditions at a system level. It aims to do this by increasing the capability, opportunity and motivation of healthcare professionals (HCPs) in promoting physical activity to their inactive patients who are at risk of, or living with, long-term health conditions. The overall aim of the programme is to reduce inactivity at a population level and consequently improve health and quality of life outcomes.

Phase One of the MHPP delivered six workstreams and took place between May 2017 and March 2019. Phase Two of the MHPP comprises eight workstreams. The programme is due to conclude at the end of 2022, having begun in April 2019.

1.2 The MHPP workstreams

The eight MHPP workstreams are listed below, along with a brief description of how they have evolved since the programme's inception where relevant:

- **Programme evaluation:** A process and impact evaluation of the workstreams listed below (with the exception of Undergraduate Curriculum). The National Centre for Sport and Exercise Medicine (NCSEM – Sheffield, and East Midlands) in partnership with Ipsos were commissioned to undertake this evaluation.

- **Physical Activity Clinical Champions (PACC):** A peer-to-peer training programme for HCPs that aims to increase their knowledge, skills and confidence to promote physical activity to their patients, enabling them to incorporate very brief advice relating to physical activity within their clinical practice.

- **Moving Medicine:** An online free-to-access resource designed to encourage HCPs to speak to patients about physical activity. It provides condition-specific information on the benefits of physical activity as well as guidance on how to structure conversations with patients. The resource is delivered by the Faculty of Sport and Exercise Medicine (FSEM).

- **Active Hospitals:** Focusing on 'whole hospital' approaches to embedding the promotion of physical activity into routine care in secondary care settings. The NHS Transformation Unit (NHS TU) are the leadership provider for this workstream. It is presently being piloted in four NHS trusts – one more than originally envisaged – in 18 care pathways. It builds upon a pilot undertaken by Oxford University Hospitals NHS Foundation Trust as part of Phase One in 2017-19.

- **E-Learning:** Provision of free-to-access E-Learning on physical activity and health for HCPs. The aim of the E-Learning resources is to increase HCPs knowledge of how, and why, physical activity is important, thus increasing their capability to discuss physical activity with patients in practice. The resources are delivered by Health Education England (HEE) and hosted on the elearning for healthcare portal (elfh). In addition, 10 E-Learning modules primarily targeting General Practitioners (GPs) are available on the British Medical Journal (BMJ) learning platform.

- **E-Advice:** A digital resource designed to support the delivery of brief advice for physical activity in primary care. The resource was piloted in one GP practice. The scale and ambition of this workstream was pared back to align with timeframes. The workstream was overseen by the Behavioural and Social Sciences Team at OHID.

- **Activating NHS Systems:** This workstream has seen the greatest reimagining since the programme's inception; evolving to meet the needs, opportunities and current thinking on system change. Originally called 'Scalable approach' and envisaged as a pilot in two areas, this workstream has evolved to raise the visibility, and embed the importance of, physical activity across the NHS, as part of a whole systems approach. This workstream is being led by NHS Horizons.

- **Undergraduate Curriculum:** This workstream had the intention of building strategy and policy to increase the frequency and consistency of physical activity within undergraduate medical school curricula. Changes in this workstream meant it was not in scope for the evaluation. This workstream has evolved beyond original intentions in response to input and feedback from academic partners, students and medical schools. The result of this has led to the engagement with a wide range of stakeholders and a co-developed five to ten year plan that sets out the actions to be taken to embed physical activity within the undergraduate curricula.

Where workstreams have focused around a tool or product, these are referred to as MHPP 'assets'.

The programme and evaluation were both paused in March 2020 until late summer 2020 due to the COVID-19 pandemic. During this pause, areas of the programme were adapted to account for changes needed due to the pandemic. For example, PACC training was transitioned from face-to-face delivery to online delivery, before moving to the current hybrid approach. In response to these changes, it was necessary for the evaluation team to redevelop the evaluation plans to adjust the logic models and refine the methodological approaches.

1.3 The programme theory

The evaluation scoping report can be viewed for greater detail on the theory and rationale behind the MHPP, though this is briefly outlined below.

The MHPP builds on the evidence that shows HCPs are uniquely placed to support people to become more physically active, with the various health benefits this then brings. Healthcare interventions are identified in global guidance as a key area of influence in increasing population physical activity levels and this is reflected in national guidance frameworks[5,6].

International evidence shows that supporting HCPs to deliver brief advice to patients is an effective way to target those with long-term conditions and address physical inactivity at a population level[7]. This is now embedded in clinical guidance across many long-term condition care pathways[8]. Specific guidance

[5] International Society for Physical Activity and Health (ISPAH). ISPAH's Eight Investments That Work for Physical Activity. November 2020. https://ispah.org/wp-content/uploads/2020/11/English-Eight-Investments-That-Work-FINAL.pdf
[6] Public Health England (2014). Everybody active, every day. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf
[7] Investments that Work for Physical Activity, Global Advocacy Council for Physical Activity and International Society of Physical Activity and Health and Global Advocacy for Physical Activity (2011)
[8] NICE Guidance Physical activity Products. https://www.nice.org.uk/guidance/lifestyle-and-wellbeing/physical-activity/products?ProductType=Guidance&Status=Published

(PH44) recommends that all adults interfacing with primary care are assessed for inactivity, and if appropriate, receive brief advice to increase their activity levels[9]. Recent evidence[10] suggests that physical activity interventions delivered by HCPs in primary care increase physical activity in patients by an average of 14 minutes per week compared with controls. This clearly represents a major opportunity to influence the activity levels, and therefore the health of, individuals who interface with health and care systems. Indeed, the unique and critical role of HCPs in increasing population physical activity and addressing physical inactivity is explicitly identified in both national and international healthcare policy[11,12,13].

However, despite the efficacy of brief advice for physical activity both in increasing physical activity and associated health benefits, as many as 72% of GPs do not speak about the benefits of physical activity to patients[14]. A recent review[15] concluded that brief interventions to promote physical activity are not delivered frequently or consistently in primary care.

The focus of research to date has been on overcoming contextual barriers relating to individuals, by exploring and improving the ways in which individual HCPs impart information and advice to patients. Empirical evidence supports the influence of individual-level barriers including lack of knowledge and skills. For example, a recent survey[16] of 839 GPs identified that 98.9% of responders believed that physical activity was important for the prevention and management of health conditions. Yet over a quarter (26.5%) had not heard of the UK Chief Medical Officer (CMO) guidance. Despite this, most participants (74.1%) reported being confident in discussing physical activity with their patients.

The survey also highlighted that key barriers include time available, perceptions of patients' attitude, factors associated with COVID-19, the patients' first language (if not English) and patients' perceptions of risk. A review[17] of HCPs' perceptions of physical activity promotion highlighted knowledge, confidence, and perceptions of role amongst other important factors that influence HCPs' engagement with physical activity promotion.

It is acknowledged that all physical activity promotional opportunities presented through healthcare should be fully explored and that future efforts are not limited to only brief interventions. Current approaches seek deeper integration of physical activity within all viable aspects of clinical care.

The MHPP aims to increase the capability, opportunity and motivation of HCPs to embed physical activity promotion into routine clinical practice across various domains of healthcare, thus realising the collective potential of HCPs to support people to become more active at scale.

[9] NICE Guidance Physical activity: brief advice for adults in primary care (2013). https://www.nice.org.uk/guidance/ph44
[10] Kettle et al. (2021). Effectiveness of physical activity interventions delivered or prompted by health professionals in primary care settings: systematic review and meta-analysis of randomised controlled trials. BMJ 2022;376:e068465
[11] Towards an Active Nation, Sport England (2016)
[12] Investments that Work for Physical Activity, Global Advocacy Council for Physical Activity and International Society of Physical Activity and Health and Global Advocacy for Physical Activity (2011)
[13] Global Action Plan on Physical Activity, World Health Organization (2018).
[14] Health Survey for England (2017)
[15] Hall et al. (2022). Delivering brief physical activity interventions in primary care: a systematic review. British Journal of General Practice 2022, 72 (716).
[16] Lowe, A. et al. (2022). Physical activity promotion by GPs: a cross-sectional survey in England. BJGP Open 26 July 2022; BJGPO.2021.0227.
[17] Albert, F.A., Crowe, M.J., Malau-Aduli, A.E.O., and Malau-Aduli, B.S. (2020). Physical Activity Promotion: A Systematic Review of The Perceptions of Healthcare Professionals. In J Environ Res Public Health, 2020 Jun; 17)12_: 4358.

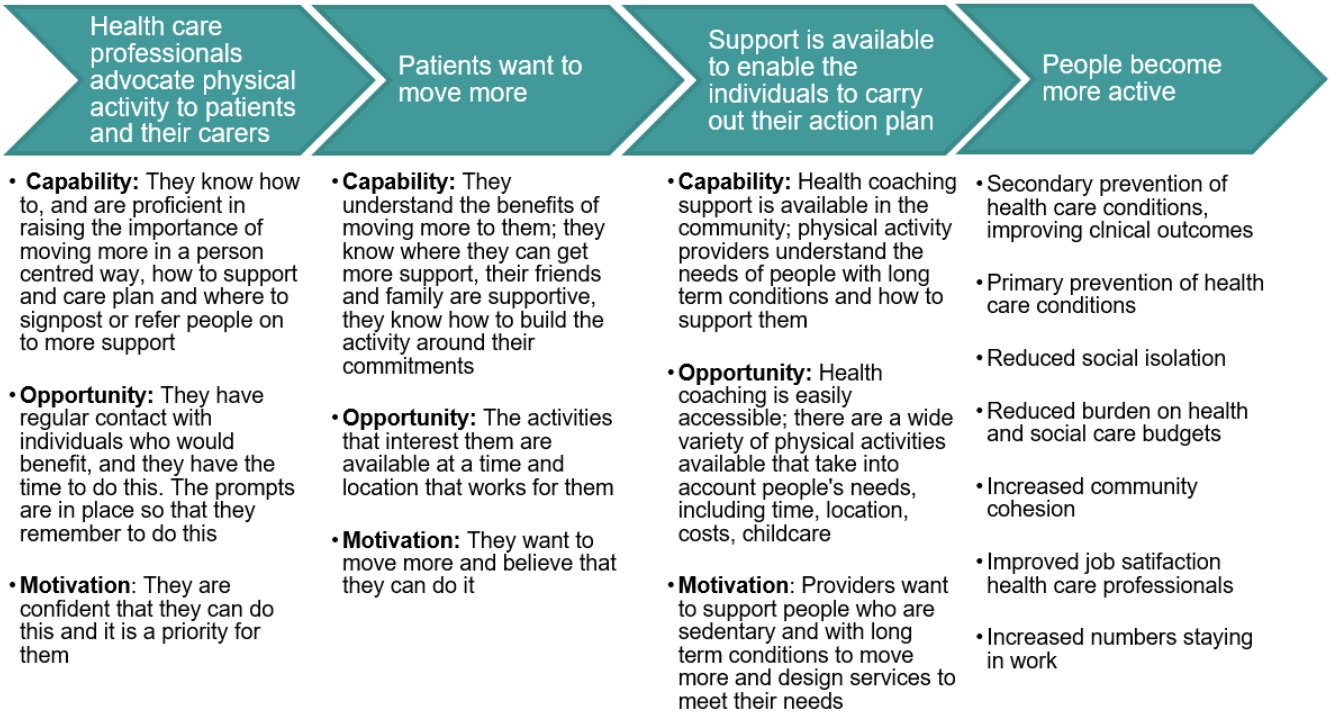
1.3.1 Programme theory of change

Figure 1.1 illustrates the programme's overarching theory of change, as devised by PHE in 2019 and presented in the evaluation Invitation to Tender. This proposes the sequence of requirements needed to create the behaviours that will result in more people being active. It also identifies potential benefits that will be achieved across key outcomes within the Department for Digital, Culture, Media and Sports' Sport Strategy[18] (i.e. physical wellbeing, mental wellbeing, individual development and social and community development).

The theory of change shows that the hypothesised process that leads people to become more active is very complex. It is based on causal chains with many stages, interdependencies, and assumptions. The MHPP workstreams primarily target the first stage of this process; by aiming to improve the capability, opportunity, and motivation of HCPs to promote physical activity to their patients.

This hypothesis is based on the COM-B model of behaviour change[19]; a behaviour will only occur when an individual has the capability (psychological and physical) and opportunity to engage in that behaviour, and is more motivated to carry-out that behaviour than any other. In this case, capability represents an attribute of a person that makes a behaviour possible, while opportunity is a feature of an environmental system that makes a behaviour possible. Finally, motivation comprises the mental processes that energise and direct behaviour.

Figure 1.1: Programme theory of change



1.4 The MHPP Phase Two objectives

The objectives of the MHPP Phase Two were to:

[18] Department for Culture, Media and Sport (2015) Sporting Future: a new strategy for an active nation https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/486622/Sporting_Future_ACCESSIBLE.pdf
[19] West, R., & Michie, S. (2020). A brief introduction to the COM-B Model of behaviour and the PRIME Theory or motivation. Qeios. doi:10.32388/WW04E6.2.

- Objective 1: Increase HCPs' awareness and knowledge of the importance of physical activity and skills to promote physical activity to patients, across clinical care settings to prevent and manage ill health, and reduce inactivity.
- Objective 2: Identify, test and evaluate interventions and effective delivery models to increase HCP awareness of physical activity and the skills to advocate to all of their patients.
- Objective 3: Understand the potential for sustainable implementation of interventions and delivery models to achieve large-scale change in clinical care.

1.5 Purpose of this report

This report concludes the evaluation of the MHPP Phase Two. Interim and final evaluation reports have been produced for each of the individual workstreams. Further detail on each of the individual workstreams can therefore be found in these reports.

This report provides key findings on individual workstreams, as well as assesses the impact of the programme as a whole, and opportunities regarding its future development.

This report has been co-developed by Ipsos and the NCSEM (Sheffield) based on independent evaluation evidence. It has been reviewed by OHID and Sport England with clarity added where required.

2 Evaluation approach

This chapter outlines the evaluation aims, objectives and questions before setting out the principles which underpinned the evaluation and the evaluation activities completed at the programme level.

2.1 Evaluation aims and objectives

The NCSEM conducted the evaluation of Phase One of the MHPP which primarily focused on lessons learned during the implementation of the workstreams. In late 2019, PHE commissioned the NCSEM (Sheffield, and East Midlands), working in partnership with Ipsos, to conduct an evaluation of Phase Two of the MHPP. The overall aim of the evaluation was to explore the MHPP implementation processes as well as its impact on HCPs, health systems, and (where possible) patients. Specifically, the overarching evaluation objectives were to:

- **Understand the processes** behind effective delivery. This included success factors, barriers and learnings, alongside what is required to support scale, spread and sustainability of individual workstreams and the programme overall.
- **Assess the impact** of the programme and its constituent workstreams, overall and on specific outcomes, including increasing the capability, opportunity and motivation for HCPs to integrate physical activity as a routine part of clinical care for the prevention and management of long-term conditions. Where possible, the intention was to measure the effectiveness in increasing patient physical activity levels, reducing sedentary behaviour, and improving health and well-being outcomes.
- **Enable continuous learning and improvement** to inform ongoing delivery and decision-making, including implementing the programme and workstreams effectively at scale.

The evaluation primarily focused on proximal indicators of change recognising the limitations associated with recording, and attributing, the programme's intended longer-term changes.

2.2 Key evaluation questions for the programme

The key evaluation questions, as set out in the evaluation Invitation to Tender, were as follows:

- Understanding the processes:
  - What has been the reach, acceptability, appropriateness, feasibility, implementation (including fidelity and adaptation) and usage of the programme resources?
  - What are the barriers and enablers to use of the MHPP resources and processes?
- Assess the impact:
  - What is the impact of the overall programme, synthesising the impact of individual workstreams? This includes impact on HCPs, organisations, health systems and patients.
  - What is the impact of the programme on the capability, opportunity and motivation of HCPs to advocate physical activity to their patients? How, if at all, has the programme influenced HCPs' behaviour?
  - Has the programme led to an increase in physical activity among patients?

  - What is the impact on awareness of the importance of physical activity for health at a system level across different HCP groups in England?

- Enable continuous learning and improvement:

  - What value, if any, has been added through collaboration (including with other programmes and campaigns such as We Are Undefeatable), shared learning and increased stakeholder relationships across the workstreams? To what extent are these stakeholder relationships critical to scaling workstreams?

2.3 Evaluation methods

The evaluation activities undertaken for each workstream are detailed in the individual workstream reports. They have principally comprised a mixed methods approach of qualitative interviews and discussion groups (gathering the views of over 140 individuals), surveys (with over 2,400 HCPs), and analysis of monitoring or management data. Unless stated as otherwise, the survey data for each workstream is based on the following number of survey completes: 2,250 for the pre-training PACC survey, 263 for the post-training survey, 70 for Moving Medicine, and 104 for E-Learning.

At an overarching level, the following evaluation activities have been completed:

- **An evaluation scoping report** was produced in March 2020. This report summarised the programme theory and set out a framework for the evaluation of the programme and its constituent workstreams. It was primarily based on familiarisation interviews with members of the PHE MHPP team, delivery teams and key external stakeholders.

- **Evaluation plans** were drawn up for the individual workstreams. These plans were drafted in consultation with PHE, alongside a review of programme and workstream documentation. The plans detailed the rationale and theory behind each workstream, and the intended outcomes and impact – all of which was depicted in separate logic models. The plans also outlined the proposed evaluation questions and corresponding activities. These plans were revisited following the programme pause as a result of COVID-19 to ensure they remained relevant in the new context.

- **Programme documentation** has been reviewed throughout the evaluation to ensure the evaluation team have remained appraised of the programme's evolution. This has been supported by monthly meetings with the PHE/ OHID team and regular contact with the workstream leads.

- **A review of relevant literature** has been ongoing throughout the evaluation to ensure relevant publications are fed into the evaluation approach and interpretation of findings.

- **Stakeholder interviews** have taken place, both as part of the workstream evaluation activities, but also at the programme level. Most recently (in July/ August 2022), nine stakeholders (both external to the programme and including representatives from OHID and Sport England) have been interviewed to gain reflections on the programme as a whole and its place in the wider system.

- **Presentations to the MHPP Advisory Board** have been completed at key points in the programme (March 2020, June 2020, December 2020, March 2021, March 2022 and September 2022) to allow for reflections on evaluation activities and provide early evaluation findings.

Academic advisory input into the evaluation has been received from Dr Charlie Foster – Professor of Physical Activity and Public Health, University of Bristol, and Dr Nick Cavill – Independent Consultant, Cavill Associates.

Ethics approval was received from either Sheffield Hallam University's or Loughborough University's ethics review board for each of the individual workstream evaluations, as well as the overarching programme evaluation.

2.3.1 The collection of patient data

Over the duration of the evaluation, significant consideration was given to the question of if, and how, patient outcomes could be assessed as part of the MHPP evaluation. This involved considering aspects such as: the feasibility of data collection with patients; the likelihood of a detectable change in patients; the meaning of any such data collected; the intended beneficiaries of the MHPP; and the need to balance resource requirements across the evaluation as a whole.

It was agreed with OHID and Sport England that the evaluation should remain focused on understanding and measuring the short-to-medium term outcomes for HCPs given they were the intended beneficiaries of the programme. Data collection directly from patients was ruled out for workstreams where the length of the causal chain between the intervention and the impact on patient outcomes was too long for data collection to meaningfully strengthen conclusions, and where it was not practical to capture the impact on patients.

A small number of qualitative interviews were conducted directly with patients who were involved in activities as part of the Active Hospitals workstream. Aside from this, other activities were undertaken to provide insight into patient-level changes and these included: quantitative and qualitative evidence from HCPs about the conversations they were having with patients regarding physical activity and the impact of this; evidence in monitoring data (for example, data captured by the pilot trusts in Active Hospitals regarding conversations between HCPs and patients about physical activity); interviews with wider stakeholders to understand the likely longer-term impact of the programme on patients; and reviews of relevant literature which could inform understanding of the causal chain between the MHPP interventions and impacts at the patient level.

OHID and Sport England explored alternative options to secure data on patient outcomes outside of the programme evaluation. Though this was not feasible, there remains an interest in understanding the impact of the programme on patients.

3 The system context

The MHPP suite of assets have been delivered and evaluated within a complex and changing system. Many critical events and developments have occurred during the course of the evaluation. The impacts of these developments are variable in the magnitude, timeframe and visibility. It would be impossible to describe the landscape exhaustively, but some key developments are highlighted below.

3.1 Background

The Government's white paper 'Levelling Up the United Kingdom'[20] was published in February 2022, identifying that health (as part of human capital) is a key factor that will help to drive the levelling up agenda. It identifies improving health and wellbeing within its key missions and acknowledges the detrimental role that inequalities in health have on individuals' life chances, on communities and on the economy; recognising the complex relationship between health, wellbeing and the economy.

The NHS continues to tackle inequalities by (i) influencing multi-agency action to address social determinants of health (the role of integrated care systems (ICSs) working with local authorities and local communities is particularly critical here), (ii) recognising and fulfilling its responsibilities as a significant economic actor in its own right, and (iii) by tackling inequalities in healthcare provision, this is acknowledged as the NHS' direct responsibility and means tackling the relative disparities in access to services, patient experience and healthcare outcomes[21]. Core20PLUS5 for example, identifies '5' focus clinical areas requiring accelerated improvement: maternity care, severe mental illness, respiratory disease, cancer, and cardio-vascular disease[22].

The COVID-19 pandemic and the necessary measures to manage the virus resulted in further reductions in population physical activity levels, particularly for communities with the highest health needs[23,24]. It also raised awareness of how physical activity can mitigate against some of the critical risk factors for poor outcomes such as overweight and obesity and diabetes. It created unprecedented pressures on services, with persistent challenges evident across the system, notable examples including General Practice and elective care backlogs.

The policy landscape has seen developments including the five-year review of the national framework for physical activity, Everybody Active, Every Day (2014). The review highlighted key developments including the publication of the revised UK CMO guidance in 2019 and the renewed focus on target groups including those who experience economic disadvantage, minority ethnic groups, older people and those with disabilities and health conditions.

[20] Department of Levelling Up, Housing and Communities (2022). Levelling Up the United Kingdom. https://www.gov.uk/government/publications/levelling-up-the-united-kingdom
[21] NHS England. (2021). 2021/22 priorities and operational planning guidance: Implementation guidance. https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf
[22] NHS England. (2021), CORE20PLUS5: An Approach to Reducing Health Inequalities. https://www.england.nhs.uk/wp-content/uploads/2021/11/core20plus5-online-engage-survey-supporting-document-v1.pdf
[23] Tison G, Avram R, Kuhar P, Abreau S, Marcus G, Pletcher M, et al. (2020). Worldwide effect of COVID-19 on physical activity: a descriptive study. Ann Intern Med. https://doi.org/10.7326/M20-2665.
[24] Sport England. (2020). Active lives adult survey mid-March to mid-May 2020: coronavirus (COVID-19) report. https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/2020-10/Active%20Lives%20Adult%20May%2019-20%20Coronavirus%20Report.pdf?2L6TBVV5UvCGXb_VxZcWHcfFX0_wRal7.

Sport England's 10-year strategy 'Uniting the Movement'[25] identifies that connecting physical activity with health and wellbeing is critical to achieving change at the population level. This has been a major lever for integration and partnership working across sectors.

The Health and Care Act[26] (2022), enabled 42 ICSs to be formally established across England on a statutory basis. They will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, affording increased opportunities for joined up working across previously disjointed systems, organisations and programmes.

Recent work has acknowledged the need to engage health system leaders in whole systems approaches to increasing physical activity. Opportunities for doing so include supporting health system leaders to go beyond healthcare and recognise the importance of wider and more complex determinants of health, recognising and facilitating shared system leadership and taking time to build relationships and develop a shared vision. Barriers include capacity within healthcare, culture within the NHS and the fact that promoting physical activity is often not seen as 'core business'[27].

The MHPP has been delivered against an evolving policy landscape and seeks to contribute positively to the long-term challenge of embedding physical activity promotion within health systems.

[25] Sport England. (2020). Uniting the movement: our 10-year vision to transform lives and communities through sport and physical activity. https://www.sportengland.org/why-were-here/uniting-the-movement.
[26] Department of Health and Social Care .(2022). *Health and Care Act 2022.* https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted
[27] Bird, E.L., Evans, D., Gray, S. *et al.* Opportunities to engage health system leaders in whole systems approaches to physical activity in England. *BMC Public Health* 22, 254 (2022). https://doi.org/10.1186/s12889-022-12602-5

4 Key achievements

The key achievements of Phase Two of the MHPP can be summarised as follows:

- Phase Two of the MHPP was an ambitious programme, involving multiple partners, delivered within a complex and dynamic system. There were additional challenges as it was delivered through the unprecedented circumstances of a global pandemic.
- Approximately 157,400 professionals have been trained or accessed a training tool in Phase Two (April 2019 to August 2022). Moving Medicine and PACC are the greatest contributors to this figure.
- HCPs report that the training assets have positively impacted their knowledge, skills and confidence to promote physical activity. This has led to a greater capability and motivation to enter into conversations with patients about physical activity and some HCPs report these conversations to be higher quality and more effective.
- The MHPP training assets have been well received and are highly recommended by users.
- Training resources reach different parts of the NHS workforce. Each of the training assets attracts a different profile of HCP, showing they meet the needs of a broad audience.

PACC

- The pandemic necessitated a different approach to PACC training, and it successfully transitioned from face-to-face to online delivery (before moving to the current hybrid approach).
- 16,640 HCPs have been trained through the PACC programme in Phase Two, in spite of the change in delivery mode, and the workforce pressures facing HCPs as a result of COVID-19.
- PACC in particular attracts HCPs who do not regularly promote physical activity to their patients. This suggests that new people are accessing the resources and this has the potential to extend reach to previously unengaged HCPs.

Moving Medicine

- Moving Medicine is very highly recommended by users with 73% of HCPs giving the resource an advocacy score of 9 or 10 (on a scale of 0-10 with 10 being ‘definitely would recommend’).
- The Moving Medicine website has had over 136,500 unique users during Phase Two (April 2019 to August 2022), attracting approximately 3,300 users per month.

Active Hospitals

- The Active Hospitals programme has built upon the initial pilot in Phase One to provide further evidence of successful approaches to being an Active Hospital. Four additional pilot sites have been successfully launched.
- The Active Hospitals Community of Practice has been shown to be a valuable vehicle for sharing learning and connecting trusts working on embedding the promotion of physical activity.

E-Learning

- The HEE E-Learning resources helped to increase the capability of HCPs to have conversations about physical activity with patients, specifically their confidence, knowledge and skills around how to have these conversations.
- Nine in ten survey participants report that the HEE E-Learning modules positively impacted their confidence to have brief conversations with patients about physical activity.

E-Advice

- The Discovery phase of this workstream re-affirmed the value of a digital intervention such as an e-Prompt to help with the promotion of physical activity.
- This workstream has provided a better understanding of the requirements and constraints of embedding a digital tool within primary care; laying the foundation for potential future activities.

System change

- The programme has signalled, and facilitated, greater collaboration between the health and physical activity sectors.
- In recent months, greater traction has been seen in the conversations and connections being realised across the system in support of physical activity promotion.
- There has been a broadening of the organisations involved in conversations about the importance of physical activity.

5 The MHPP workstreams

This chapter takes each of the MHPP workstreams in turn and provides a condensed summary of evaluation findings. Full details can be found in the respective workstream evaluation reports.

5.1 Physical Activity Clinical Champions (PACC)

5.1.1 Workstream aims and objectives

The peer-to-peer training programme, delivered by a national network of trained HCPs known as PACCs, was originally launched in 2014.

The long-term aim of the PACC training programme is to contribute to increased population levels of physical activity by increasing the proportion of HCPs integrating conversations about physical activity into routine clinical practice in England. The training seeks to achieve this by increasing the capability, opportunity, and motivation of HCPs to deliver brief advice on physical activity to patients who are at risk of, or living with, long-term conditions.

5.1.2 Workstream evolution

The original intention for Phase Two was for a new delivery provider to be commissioned to take forward the PACC programme in Q2 2020. A scoping exercise undertaken early in Phase Two did not identify a suitable delivery provider at that time and thus it was agreed that project delivery would remain in-house for the duration of Phase Two and options for transferring to a new provider would be considered towards the end of the programme.

The aim for Phase Two was for PACCs to deliver training to 5,000 trainee HCPs and 12,000 qualified HCPs. The decision was taken to remove this target given the pandemic and programme pause.

PACCs rapidly transitioned from face-to-face to online delivery in response to the restrictions enforced to limit the spread of COVID-19. A hybrid model is currently being implemented with both face-to-face and online training available.

In recent months, following delivery of the final PACC evaluation report, OHID have completed a new round of PACC recruitment (recruiting a further 27 PACCs) and undertaken a refresh of the training slides reflecting feedback from key stakeholders, end users and a literature review (secured in addition to the evaluation). OHID have recently received re-accreditation for the training with the Royal College of General Practitioners (RCGP) and have applied for accreditation with the Personalised Care Institute. A pilot to offer embedded PACCs in Active Hospitals is underway with three Active Hospitals taking part alongside an interested hospital who is part of the Community of Practice.

5.1.3 Evaluation approach

The following evaluation activities were completed: a baseline survey for HCPs completed immediately before PACC training (n=2,250); a follow-up survey with HCPs completed 4-6 weeks after the PACC training (n=263 of the 1,583 HCPs who agreed to be re-contacted); in-depth interviews with HCPs who attended the training (n=10); four focus groups with PACCs (n=18); in-depth interviews with Lead PACCs (PACCs with responsibility to oversee the national cohort of PACCs in their professional group) and experienced PACCs (n=2); analysis of monitoring data collection by PACCs; and in-depth interviews with MHPP-wide stakeholders who were interviewed as part of other workstreams but who provided insight into the PACC workstream.

All fieldwork took place between April 2021 and June 2022. The final evaluation report was delivered in July 2022, following two interim reports in November 2021 and April 2022.

5.1.4 Process evaluation findings

Despite the workforce pressures resulting from the COVID-19 pandemic, a sizeable number of PACCs have been recruited and retained – there are presently around 60 PACCs delivering training (with 50% being medics, and nurses, midwives and AHPs being evenly represented in the remaining roles). The PACCs have trained 16,640 HCPs during Phase Two of the programme (April 2019 to August 2022). This includes both qualified and trainee HCPs and is very close to the target originally set (though later removed as a consequence of the pandemic) for the PACC workstream. This is in addition to the 16,675 HCPs trained during Phase One of the programme (May 2017 to March 2019). It was suggested that the reach of the PACC training could be extended, particularly to more deprived areas, through dedicated marketing support and a more systematic approach to promotion such as through a central website providing information about the programme. OHID's recent round of PACC recruitment specifically sought to increase the number of PACCs in more deprived areas.

As was the case during Phase One, throughout Phase Two, the training was most commonly delivered to doctors (making up 42% of attendees) compared to nurses/ midwives (28%), and Allied Health Professionals (AHPs) (25%). This reflects the higher number of PACCs who are doctors themselves, and that the programme was initially piloted with GPs. PACC training therefore attracts (or is targeted at) a different profile of HCPs compared to Moving Medicine and the HEE E-Learning modules which are predominately used by AHPs and nurses/ midwives respectively. Relative to the size of the workforce, a small proportion of nurses attend PACC training compared with doctors or AHPs. Recruitment of more nurse PACCs to deliver the training may help improve this balance.

The training appears to be attended by HCPs who engage in relatively low levels of physical activity themselves (31% perform moderate intensity physical activity for at least 30 minutes on five or more days a week), and those who do not regularly promote physical activity to their patients (with only 28% of attendees at the baseline survey saying they do this 'nearly always'). This suggests the programme is not just attracting those who already routinely talk to their patients about physical activity and distinguishes the training audience from Moving Medicine and the HEE E-Learning resources which are used by HCPs that more regularly promote physical activity.

The evaluation data suggests that the PACC training is very well received by attendees. A high proportion (56%) rate the training as 9 or 10 out of 10, meaning they would 'definitely recommend' it to others.

5.1.5 Impact

The Phase One evaluation identified a significant improvement in skills, knowledge and confidence of HCPs to discuss physical activity with patients following PACC training. The Phase Two evaluation evidence suggests that this impact has continued; 43% of attendees report improved knowledge of how to promote physical activity (pre to post training), 40% report increased skills, and 47% report increased confidence.

Whilst positive shifts are observed at an overall level, there is a proportion of attendees who report no change in their knowledge (51%), skills (55%), or confidence (48%) to promote physical activity (pre to post training). These attendees are often those who have pre-existing knowledge, skills, or confidence prior to the training. This may imply that, while the training is impactful for those with little or no pre-existing knowledge, skills, or confidence, it is not sufficiently advanced for those with more substantive

pre-existing knowledge, skills, or confidence. There are therefore opportunities to increase the positive impact on HCPs' knowledge, skills and confidence through providing more advanced content in the training, such as a greater focus on motivational interviewing techniques. OHID has recently released updated training content in recognition of this finding.

No statistically significant differences were found in the pre and post training survey data in support of the training significantly increasing the *frequency* of conversations about physical activity with patients. However, the interviews revealed the training helping to improve the *quality* of conversations with patients. It is worth noting that barriers to having physical activity conversations, such as time constraints, remain even after the training has been completed.

A number of interviewees were able to provide anecdotal examples of patients becoming more physically active following a conversation they had as a result of the PACC training.

5.2 Moving Medicine

5.2.1 Workstream aims and objectives

FSEM developed and launched the 'Moving Medicine' online resource (https://movingmedicine.ac.uk/) in 2018, aiming to provide HCPs with up-to-date information about physical activity, with practical step-by-step guides to help HCPs engage in quality conversations with patients. Patient-facing information and resources are also available on the website for HCPs to share with their patients.

5.2.2 Workstream evolution

Funding for this workstream was scheduled to stop at the end of March 2021, though PHE and Sport England decided to extend the funding until October 2022 to enable FSEM to develop four additional modules, refresh the 10 modules developed in Phase One of the MHPP, pilot two microsites, and develop a more comprehensive communication strategy. A communications specialist was employed by FSEM in December 2021.

In recent months, two microsites have been developed in addition to the one for Oxford (for Birmingham, and Calderdale – available through the main website), with information specifically tailored to these regions.

A review of modules on the website is presently underway by FSEM and OHID, with updates being made to Phase One adult consultation guides, new modules are being developed, and discussions are ongoing as to how best to ensure the sustainability of the resource. FSEM are presently considering a number of options (some of which are beyond the bounds of the MHPP) for the continuation of the resources, including: building on the paid-for training available on the website; developing further paid-for microsites; developing further paid-for international versions of the website; and securing funding for the continued development, hosting and promotion of the site.

5.2.3 Evaluation approach

The following evaluation activities were completed: a pop-up survey on the website (n=79, 70 HCPs); in-depth interviews with website users (n=14); in-depth interviews with Moving Medicine Ambassadors (users of the website who have joined a closed Facebook group to share learning on how to improve physical activity conversations across the NHS) (n=2); in-depth interviews with stakeholders (n=4, two FSEM representatives and two individuals involved in the development of the resource); and analysis of website performance data on Google Analytics.

All fieldwork took place between March 2021 and March 2022. The final evaluation report was delivered in April 2022, following an interim report in September 2021.

5.2.4 Process evaluation findings

The Moving Medicine website has had over 136,500 unique users[28] during Phase Two (April 2019 to August 2022), attracting approximately 3,300 users per month. Over this time period, the average number of pages viewed per session is 3.15 pages, and the average session duration is 2 minutes 38 seconds[29].

The website appears to attract a broad range of HCPs (and some non-HCPs), though AHPs make up the largest proportion of users (44%) (followed by doctors, 31%). Moving Medicine therefore appears to target a different profile of HCPs compared to other MHPP workstreams, with PACC most commonly attracting doctors, and the HEE E-Learning modules appealing most to nurses and midwives. A high proportion (60%) of the survey respondents 'nearly always' promote physical activity to their patients, suggesting that the resource attracts (or is known by) HCPs who are already engaged with the subject matter.

There are some signs that engagement in the website is waning over time with an increase in bounce rate (the proportion of users who click away from the website after only visiting one webpage), a decline in the time spent on the site, and a decline in the number of pages viewed per visit. Such declines are seen among both new and returning users. These trends could reflect the unique time-pressures facing HCPs during the COVID-19 pandemic, or perhaps be a consequence of promotional activities targeting different HCPs with varying levels of interest, though it is not possible to give a definitive explanation for these trends based on the available data.

The Moving Medicine resources were viewed positively among HCPs. Compared to PACC and the HEE E-Learning modules, the Moving Medicine resources are the most highly recommended, with 73% of those completing the survey rating it 9 or 10 out of 10 (on a scale of 0-10 with 10 being 'definitely would recommend'). Users of the website have suggested improvements though if no further changes were made, the resources would still be popular among HCPs and would remain a welcome addition to the sector.

A common view among those interviewed was that more could be done to raise awareness of the Moving Medicine resources through a more comprehensive promotion strategy beyond that currently being implemented, with most users presently being informed about it through word-of-mouth. Broadly, it was recognised that promotional activities would need to be multifaceted to reach HCPs less well connected to the physical activity agenda and to 'preach beyond the converted'. And that Moving Medicine would need the professional bodies to come behind it in a significant way to gain traction on a greater scale than seen presently.

5.2.5 Impact

Moving Medicine was awarded the patient-centred care award at the Royal College of Physicians' Excellence in Patient Care Awards 2020.

[28] Google Analytics defines 'users' as unique visitors who have initiated a session on the website. They can be both new and returning.
[29] It should be noted that Google Analytics assigns a session duration of 0 seconds if Analytics cannot calculate the time spent by a user on the website and thus this figure is likely to be inaccurate.

Feedback on the website was overwhelmingly positive and HCPs articulated how their practice has been positively impacted as a result of engaging with it, most notably an increased confidence to discuss physical activity, a better understanding of how to broach the subject of physical activity with patients and how to have better quality conversations as a result. The majority of survey participants reported that use of the consultation guides had increased their knowledge of how to have brief conversations about physical activity (93%), and the consultation guides had increased their skills to engage in brief conversations about physical activity with patients (94%). Nearly all (96%) of the survey participants reported that using the consultation guides had positively impacted their confidence to have brief conversations with patients about physical activity. Of those who felt motivated to promote physical activity to their patients, 81% attributed this to Moving Medicine to 'at least some extent'.

Generally, the HCPs interviewed felt the approach they had learned through Moving Medicine was effective at encouraging patients to become active. The HCPs interviewed could not attribute changes in their patients' behaviour directly to their use of the Moving Medicine resources. However, they provided anecdotal examples where, following a conversation about physical activity, patients had started walking more or joined a gym and reported improved mental and physical health as a result.

5.3 Active Hospitals

5.3.1 Workstream aims and objectives

Between May 2017 and March 2019 (MHPP Phase One), Oxford University Hospitals NHS Foundation Trust (OUH) undertook a feasibility and acceptability pilot of a Sport and Exercise Medicine-led 'Active Hospitals' concept. The NHS Transformation Unit (NHS TU) were commissioned to oversee the development of the Active Hospitals workstream in Phase Two. After an EOI and further procurement exercise, four additional NHS trusts were recruited to develop and test further approaches to the Active Hospitals concept, looking to embed the promotion of physical activity into routine care.

5.3.2 Workstream evolution

Funding and support for the trusts was due to end in August 2022. This remains the case with the exception of Nottingham which will continue to receive support for their activities from OHID until the end of 2022, given their delayed start whilst waiting for a project manager to take up post. The Community of Practice will continue to be managed by OHID until the end of 2022.

5.3.3 Evaluation approach

The evaluation was split into two stages. Stage One took a 'deep dive' into the implementation and delivery of the Active Hospitals project within each of the four sites to inform the development of logic models and subsequent evaluation plans. Stage Two was designed to address the evaluation questions having secured an understanding of the activities happening within each trust as part of Stage One.

The following evaluation activities were completed in Stage One: in-depth interviews with members of staff working across the participating trusts (n=23); a document review of relevant documentation including project plans and progress updates; monthly meetings with the NHS TU; and attendance at the monthly steering group meetings between the NHS TU and trusts.

The following evaluation activities were completed in Stage Two: in-depth interviews with members of staff working across the participating trusts (n=33); a review of evaluation data collected by trusts (such as the number of staff trained, and number of patients spoken to about physical activity); a continuation of the document review; in-depth interviews with the NHS TU (n=2 convening the views of 3 representatives); in-depth interviews with members of the Community of Practice (n=4); in-depth

interviews with patients (n=3); monthly meetings with the NHS TU; and attendance at the monthly steering group meetings between the NHS TU and trusts.

Fieldwork for Stage One took place between April and August 2021, and fieldwork for Stage Two was completed between March and November 2022. The final evaluation report was delivered in August 2022 with findings from the qualitative patient interviews added after this.

5.3.4 Process evaluation findings

There is substantial variation in the Active Hospitals activities piloted by the four trusts though they can broadly be grouped as: workforce (for example, recruitment to support activities, and staff training), infrastructure (for example, incorporating physical activity calculations into electronic records, and mapping physical activity services in the community), promotional (for example, developing a branding concept, and increasing social media and web presence), and culture (including environment) (for example, developing 'active wards', and running events to promote staff activity).

In excess of 560 members of staff across the four pilot sites have received formal training on physical activity promotion. Training has included the MHPP Physical Activity Clinical Champion (PACC) programme, the Active Conversations course on Moving Medicine, the MHPP E-Learning modules hosted by Health Education England, and Making Every Contact Count (MECC) training. Over 7,300 patients have been spoken to about physical activity, and over 5,700 conversations about physical activity with patients have been recorded (not necessarily with individual patients). Over 2,900 patients have been signposted to resources or support services relating to physical activity (such as leaflets and links to local services) and over 910 patients have been referred to a specialist or support service to increase their levels of physical activity. These figures are likely to underestimate actual numbers as data collection mechanisms in the trusts were not always comprehensive or in place across all participating pathways.

A number of factors have been shown to be important implementation enablers and contributors to the sustainability of Active Hospitals activities. These include: senior engagement and support (as also seen in the Phase One evaluation); the involvement of multi-disciplinary teams; early buy-in from clinical leads; passionate individuals to spearhead activities (particularly those with a pre-existing interest in physical activity); a flexible approach to change; and infrastructure changes to embed activities.

5.3.5 Impact

The Active Hospitals programme impacted most on HCPs' awareness of the benefits of physical activity and how to broach it with patients, and their confidence to do so. The training they have received (particularly the PACC training) has been instrumental to this. Knowing where to signpost or refer patients to for those who require more intensive support has also helped increase the confidence of HCPs to broach the topic of physical activity.

The Active Hospitals workstream focused on creating a more positive culture supporting physical activity amongst staff and within care pathways in the secondary care environment. Some early indications were evident of this with physical activity being given greater prominence in the pilot pathways, and changes to pathway infrastructure helping HCPs to consider their patients' physical activity needs.

There is qualitative evidence (alongside some survey data looking at likelihood/ willingness to promote physical activity) to suggest that HCPs are more frequently discussing physical activity with their patients, and that these conversations are of a better quality. This has been helped by an increased focus on physical activity in the participating pathways, electronic prompts to discuss it with patients, and

better awareness of where to signpost patients who need further support. There are indications that more work is needed to ensure these conversations are taking place consistently across all HCPs within pathway teams, even when staff capacity is challenged or staff members championing the cause are not present. Based on survey data and interview findings, the Active Hospitals programme has not appeared to impact on the physical activity levels of staff working in the participating pathways.

Staff from all four pilot sites were able to provide anecdotal evidence of patients becoming more physically active following conversations about, and support with, increasing their physical activity. The pilot sites collected some – though limited – data on patient outcomes which showed positive shifts. For example, 32 of 36 patients having 1:1 sessions with the exercise and physical activity therapist at Sheffield Children's showed an improvement in at least one of the pre and post physical tests (these being a 2-minute sit to stand, 2-minute standing march, and handgrip dynamometry). North Tees and Hartlepool are collecting quantitative data on patients' self-reported physical activity levels using the Health Call application which they will report upon in future.

The Community of Practice has proved to be an effective way of connecting trusts working on embedding the promotion of physical activity, and sharing learning and extending practices beyond the four pilot trusts, and has been a welcome addition to the programme.

There is good momentum in each of the pilot sites to continue Active Hospitals activities. All four sites are seeking further funding to aid their continuation or growth, though aspects of the programme have already become embedded as business as usual and will continue irrespective of whether further funds are secured or not (such as amends made to electronic data management systems to prompt physical activity discussions, and amended trust strategies which place a greater focus on physical activity). There are good indications to suggest that Active Hospitals activities are transferable to non-participating pathways in the pilot sites, but also more broadly to trusts not involved in the pilot. The four pilot sites have however had a historic focus on physical activity meaning other trusts without such a focus may not have the same endorsement of the programme and its aims.

5.4 E-Learning

5.4.1 Workstream aims and objectives

Since September 2019, 10 E-Learning modules on Physical Activity and Health have been available open access on the Health Education England (HEE) elearning for healthcare (elfh) platform (https://www.e-lfh.org.uk/). Since 2014, 10 E-Learning modules relating to physical activity, and primarily targeting GPs, have also been available on the British Medical Journal (BMJ) learning platform. The E-Learning modules provide a mechanism for continuing professional development as part of the MHPP for those HCPs who prefer to study remotely.

5.4.2 Workstream evolution

A review and refresh of the modules' content on the elfh platform has recently been completed, with a communications push planned for October 2022. This was part of a wider review of online continuing professional development products, including on the BMJ platform and All Our Health.

5.4.3 Evaluation approach

The following evaluation activities were completed: a survey on HEE's elfh platform (n=104); in-depth interviews with users (n=7); in-depth interview and email exchange with HEE representatives (n=3); and analysis of monitoring data available on the elfh platform and the BMJ learning platform.

The evaluation focused predominately on the HEE E-Learning modules (rather than those on the BMJ learning platform) given this platform was intended to be the home for NHS E-Learning at the time of evaluation scoping, and funding for the BMJ modules was due to expire by the end of March 2020.

All fieldwork took place between August 2021 and June 2022. The final evaluation report was delivered in July 2022, following an interim report in April 2022.

5.4.4 Process evaluation findings

Between September 2019 and August 2022, the Physical Activity and Health modules on the HEE elfh platform had over 23,700 session launches and almost 3,600 unique users. In a typical month, the modules have around 600 launches and 260 completes. On average, 43% of module launches end in a module complete meaning there is some attrition with not all HCPs going on to complete the module they initially open. The BMJ E-Learning modules have a higher completion rate with 86% of users going on to complete the module they initially access, equating to approximately 320 module completes per month.

HEE E-Learning monitoring data (which includes non-HCPs) shows the resources appear most popular among nurses, with them making up just under one in five active users (19%). AHPs are a close second making up 17% of active users, followed by one in ten doctors (10%). Thirty four percent of active users fell into the ‘other’ category, and this included non-HCPs and professions such as teachers/ lecturers, administrators and personal trainers. A reasonably high proportion of the HEE E-Learning module users are students (16%). This is distinct to the profile of HCPs attracted to PACC training and Moving Medicine which are predominantly doctors and AHPs respectively. HCPs most commonly hear about the HEE E-Learning modules via colleagues (42%), suggesting a more comprehensive promotional strategy could be put in place.

A high proportion (49%) of the survey respondents ‘nearly always’ promote physical activity to their patients, suggesting that the HEE E-Learning modules attract (or are known by) HCPs who are already engaged with the subject matter.

The evaluation data suggests that the HEE E-Learning modules are viewed positively among HCPs, with favourable comments on their format, length and content. Nearly half of HCPs (47%) rate the resources 9 or 10 out of 10, meaning they would ‘definitely recommend’ them to others. This is broadly in line with the advocacy ratings given for PACC training, though lower than for Moving Medicine which is very highly recommended by users. On average, users score the HEE E-Learning modules 4.4 out of 5 (on a scale of 1-5 with 1 equating to ‘Poor’ and 5 equating to ‘Excellent’).

5.4.5 Impact

There is evidence that the HEE E-Learning resources are helping to increase the capability of HCPs to have conversations about physical activity with patients, specifically their confidence, knowledge and skills around how to have these conversations. For example, more than four in five survey participants reported that the modules increased their skills to engage in brief conversations about physical activity with patients (86%), with two in five (40%) saying the modules had ‘greatly’ increased their skills. 88% of users surveyed said the modules had increased their knowledge of how to have brief conversations about physical activity. Nine in ten survey participants reported that the modules had positively impacted their confidence to have brief conversations with patients about physical activity (89%). A very high proportion of HCPs (92%) attributed feeling motivated to promote physical activity to patients to the modules (at least to some extent).

Interview participants described how the resources had improved their understanding about physical activity and boosted their confidence to build conversations about physical activity into their clinical care of patients. Some anecdotal examples of patients becoming more physically active following conversations about it with their HCP were also provided by those interviewed.

5.5 E-Advice

5.5.1 Workstream aims and objectives

In Phase One of the MHPP, a paper-based physical activity clinical advice pad, similar to a prescription, was developed and piloted. The aim of this was to increase the likelihood of clinicians promoting physical activity to their patients by providing a prescription template for written guidance to patients. The evaluation findings, combined with policy and evidence developments, resulted in the identification of a need for an electronic version of the resource. As part of Phase Two, the Behavioural and Social Sciences Team (BeSST) at OHID then went on to develop and test a simple digital resource to support the delivery of brief advice for physical activity in primary care. The digital resource had two aspects to it:

- An e-Prompt for HCPs to encourage them to raise the topic of physical activity with their patient; and
- A patient facing resource with recommendations about physical activity which the HCP could print or send electronically to their patient.

5.5.2 Workstream evolution

The scale and ambition for the workstream were reduced given the timeframes for implementing a digital intervention in central GP software systems (12-18 months) far exceeded those available for the workstream. The digital resource was tested in one GP practice, the purpose being to understand if the content of the resource was appropriate and useful for HCPs.

5.5.3 Evaluation approach

The following evaluation activities were completed: in-depth interviews with representatives of the BeSST at OHID (n=2); and an in-depth interview with the lead GP from the pilot practice (n=1). The two nurses who used the resource were invited to interview but did not respond.

All fieldwork took place in May 2022. The final evaluation report was delivered in July 2022.

5.5.4 Process evaluation findings

OHID's BeSST followed the design principles as set out by the Government Digital Service (GDS). This involved a 'Discovery phase' of further research and consultation, with the intention being to progress to the testing of different propositions in the 'Alpha phase'. The Discovery phase re-affirmed the need for a digital resource such as an e-Prompt to help with the promotion of physical activity. Not all HCPs will have the time or interest to engage with the training assets available through the MHPP, and thus an e-Prompt may help these professionals to promote physical activity.

The digital resource was tested at one GP practice in the chronic obstructive pulmonary disease (COPD) pathway for six weeks. The lead GP for the participating practice embedded the e-Prompt into their software system (EMIS). This required them to write and code it into the system to trigger the e-Prompt when required, and link it to the patient facing resource saved on their website. The digital resource was used by three members of staff, with at least nine patients. Whilst numbers were limited, the lead GP thought the digital resource was well received by the two nurses who predominantly used it.

The expertise to develop and implement different digital prototypes was not held within OHID's BeSST, and it was the view of both BeSST representatives interviewed that an experienced technical supplier could have been commissioned to undertake such work. Additionally, the complexity of the software systems in primary care (both the diversity of software programmes used but also the additional GP practice customisation and templates) led the BeSST team to conclude that a 'broker' was required who knew the primary care digital landscape well, and who could be the conduit between the BeSST and a technical supplier.

Moving forwards, were the digital resource to be piloted further, there are two options for how this is done within the constraints of primary care where there is no uniform software system. Either multiple software suppliers are engaged in the process of embedding the digital resource centrally (which, whilst effective at scaling the resource, would be costly and time consuming), or local systems are amended on an individual basis (which, whilst less costly than a centralised approach, would have limitations in scale and relies upon the will and technical abilities for amendments to be made to software systems locally).

Standardisation of a digital product is challenging in an environment where GP surgeries use different software systems. This could prove a limiting factor in any future ambitions to scale the intervention. Further work to understand the diversity of the software and local templates used across GP practices, and the costs of implementation, would be an important step in understanding the extent to which this presents a challenge to embedding a digital intervention more broadly.

5.5.5 Impact

The lead GP believed that the nurses who predominantly used the digital resource would have been discussing physical activity with their COPD patients as standard. However, the GP felt the e-Prompt would have encouraged the nurses to bring up the topic of physical activity earlier in the review, and the patient facing resource would have helped patients consolidate the advice given to them.

It is not possible to conclude the impact of the digital resource on patients themselves. All of the patients that the lead GP spoke to regarding physical activity were amenable to discussing it, although nothing further is known about action subsequently taken (or not taken).

5.6 Activating NHS Systems

5.6.1 Workstream aims and objectives

NHS Horizons were commissioned in July 2021 to support a whole systems approach to embedding physical activity as a 'norm' for prevention in the NHS. The workstream has involved a number of design and collaboration events (see below) and the building of connections and relationships across the system. It has been iterative in design, with activity following momentum to design and action deliverables.

5.6.2 Workstream evolution

Since its conception, the focus of Activating NHS Systems has changed considerably. Initially the workstream (formerly 'Scalable Approach') had planned to 'shift HCP skill and practice at scale', with a primary focus on two local health systems (one urban, one rural) to systematically integrate the promotion of physical activity in these areas. The workstream has therefore changed entirely from its original conception, in recognition of what would be of greatest value to the system based on priorities, needs and emerging evidence on system change.

5.6.3 Evaluation approach

The following evaluation activities were completed: in-depth interviews with stakeholders external to the programme (n=3), and in-depth interviews/ focus groups with representatives from OHID, Sport England and NHS Horizons (2 focus groups and 1 in-depth interview, capturing the views of 6 individuals).

The evaluation focused on collating information on the opportunities, barriers and facilitators to a whole systems approach to promoting physical activity within the NHS, and gathering the perceived value of activities conducted thus far.

All fieldwork took place in July/ August 2022. The final evaluation report was submitted in September 2022.

5.6.4 Process evaluation findings

Four Activating NHS Systems design and collaboration events (both in person and online) have taken place since September 2021 to convene stakeholders across the system, and discuss new ways to approach systems working and how to enable the sustainable spread and adoption of physical activity across the NHS. These consisted of: (i) an Accelerated Design Event, (ii) an event in Cambridge entitled 'Designing an Active Future', (iii) a workshop on the value of data in a whole systems approach, and (iv) a roundtable with NHS England to align senior leaders and programmes within the organisation in their approach to physical activity. A further roundtable with NHS England is planned for late 2022. NHS Horizons, alongside OHID, Sport England and partners, is presently engaging ICS leaders to discuss how best to ensure physical activity is a key priority throughout their development.

The evaluation interviews revealed a number of barriers to successfully delivering a whole systems approach. Principally these focused around the challenge of aligning local and national organisations' agendas, across different sectors, to ensure there is a consistent approach towards physical activity promotion. Key to this is facilitating greater connection between the physical activity sector and the NHS, and ensuring common language is used between the two.

Other facilitators of a whole systems approach, as articulated in the evaluation interviews, focus around collaboration and communication. Activating NHS Systems was seen as an opportunity to ensure the importance and relevance of physical activity is well understood in the set-up and prioritisation of ICSs. The whole systems approach relies on greater connectivity and collaboration between organisations, particularly those working at the local level, and between the physical activity sector and health sector, and ensuring organisations are linked in with local Active Partnerships. It was suggested that one body needed to be responsible for convening such collaboration and should have the appropriate funds to do so. It was also suggested that building a physical activity narrative using health inequalities as a focus would help bring organisations together.

5.6.5 Impact

Through the Activating NHS Systems workstream, NHS Horizons have produced a theory of change which provides a physical activity narrative that the NHS can use in partnership with OHID and Sport England to bring coordination to the work of systems. The series of events held thus far have convened individuals from across the health and physical activity sectors to begin discussing how a whole systems approach to the promotion of physical activity could be best achieved. These activities were thought to be valuable for the purpose of bringing different stakeholders and partners together. However, clearly communicated objectives of each of the activities and broadening the attending stakeholders to include the community voice were perceived to be important to achieve further impact.

6 Interplay between the workstreams

This chapter examines the interplay between the workstreams within the MHPP, looking at the design of the programme, the extent of interplay observed, and the opportunities for greater integration. It draws on data from the individual workstream evaluations, alongside findings from the programme-level qualitative interviews.

6.1 Design of the MHPP

A small number of stakeholders described a clear vision for how the workstreams interconnect and their respective roles within the programme as a whole. However, this vision was not uniformly shared by other stakeholders, and indeed, overall, the interview findings showed ambiguity over how the workstreams were originally intended to interplay with one another.

The clearest depiction of the vision for the programme, and its constituent workstreams, is in the paper written by Brannan et al. (2019)[30]. This paper sets out how the MHPP programme was devised as a 'whole-system educational approach' to embed physical activity promotion into clinical practice. This led to different work packages being aligned to the three core domains of medical education: undergraduate education, postgraduate education, and continuing professional development. It was recognised that a suite of different educational tools would be needed as no single educational approach used in isolation has been shown to provide effective and lasting change among HCPs. The Undergraduate Curriculum workstream was originally devised as an upstream intervention to support the clinicians of tomorrow. Moving Medicine was devised as a means to develop the clinicians of today through the provision of resources and postgraduate education. PACC was conceived to provide face-to-face peer education and was considered by one stakeholder involved in the programme's inception as a means of 'activation training' such that HCPs could see how to utilise the content of Moving Medicine in practice. And E-Learning was an additional mechanism to aid continuing professional development for those who preferred to study remotely.

In this way, the programme was described as providing a 'spiral curriculum'[31] meaning HCPs have the chance to revisit the topic of physical activity promotion at multiple points in their career (and at multiple points within their undergraduate training). Beyond this, however, little is documented about the intended interface between the workstreams as part of the programme's overall design. Active Hospitals and E-Advice were absent from the paper cited above. One stakeholder noted that there was "an assumption" that the workstreams would come together in a more holistic way with time, but that the intention, and the means, of this were never explicitly stated.

6.2 Integration of the workstreams

There are two main ways in which the MHPP workstreams have interfaced. One is that the PACC training has made reference to Moving Medicine and the HEE E-Learning resources available to help support HCPs in their promotion of physical activity. The second is that HCPs working in the four Active Hospitals pilot sites have been encouraged to attend PACC training sessions, and visit Moving Medicine and/ or the HEE E-Learning resources. The PACC and Active Hospitals workstreams have been working

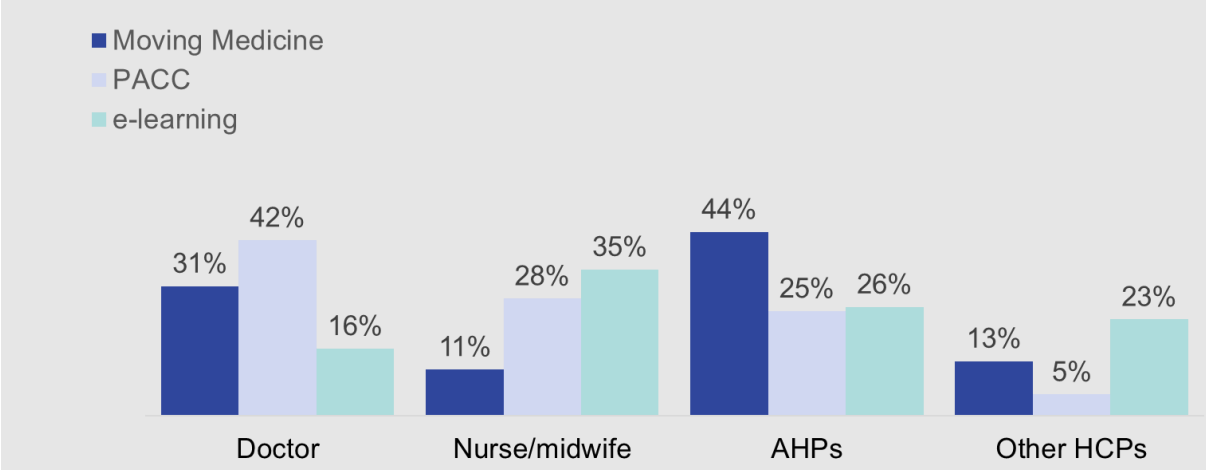
[30] Brannan et al. (2019) Moving healthcare professionals – a whole system approach to embed physical activity in clinical practice. *BMC Medical Education*
[31] Harden, R.M. (1999). What is a spiral curriculum?, Medical Teacher, 21:2, 141-143.

together to pilot embedded PACCs within Active Hospitals trusts, and 16 HCPs were trained in August 2022 to deliver the PACC training to colleagues.

PACC and the E-Learning resources are not referenced on Moving Medicine. PACC and Moving Medicine are not referenced as part of the E-Learning resources. The E-Advice workstream is not connected to any of the other workstreams given it is not yet ready for integration.

Each of the three principal training tools evaluated (PACC, Moving Medicine and E-Learning) appear to target (or attract) a different profile of HCP, thus helping to ensure a broad range of disciplines are engaged in the issue of physical activity promotion. As shown in Figure 6.1, PACC is predominantly used by doctors, whilst Moving Medicine most commonly attracts AHPs, and the E-Learning modules attract nurses/midwives[32].

Figure 6.1: Profile of HCPs engaging with different MHPP workstreams



Base: Moving Medicine: 70 HCPs surveyed, PACC training: 15,836 trained HCPs in audit data, HEE E-Learning: 2,155 HCPs in monitoring data

The evaluation evidence available suggests that HCPs have low levels of awareness of the different MHPP workstreams beyond the one that they are engaging with. Just under a quarter (23%) of HCPs who attended the PACC training have also viewed the Moving Medicine website, despite it being mentioned as part of the training. Only five percent of those using the E-Learning resources had heard about them during PACC training, likewise only seven percent of those using Moving Medicine had heard about it during PACC training. Whilst not all these HCPs will have attended PACC training, the qualitative interviews with HCPs across the different workstreams also highlighted a lack of knowledge of the training assets on offer through the programme.

Some of the stakeholders interviewed saw the workstreams as being distinct from one another from the programme's inception. They saw this plurality as beneficial, as it enabled different workstreams to be tailored to the needs of different parts of the workforce. These stakeholders emphasised the importance of the programme fitting into HCPs' existing working practices; something that could not be achieved by a fully integrated programme.

[32] Note, a high proportion of users of the HEE E-Learning modules are non-HCPs which are not shown in the chart. Additionally, caution should be taken when interpreting the profile data for Moving Medicine as this is based on survey data and thus reflects the profile of those responding to the survey rather than the known profile engaging with the resource. The PACC and ELearning profile data are more reliable as they are based on audit/ monitoring data of attendees and users.

Others felt that, over time, the MHPP had become less of an overarching programme and more of a series of individual workstreams. These stakeholders described a lack of collaboration between the different work packages and a loss of interface between them. A number of individuals involved in the implementation and delivery of individual workstreams expressed a wish that there could have been greater collaboration between the different programme assets.

"Obviously, we've seen the Advisory Board and sadly, what usually happens then is, each of your workstreams that are obviously trying to work really, really hard, come and present lots of slides, lots of how they're doing. And it's all very energetic. But actually, I don't think there's a cross fertilisation. It's not evident in what is said."
(Stakeholder 6)

"Looking back, if we were invited to some summary meetings or show and tells or [similar]…, it would have been so helpful, I think, to shape the project, so it's not in a silo. Because then, instead of those different strands being separate, they could be complementary."
(Stakeholder 19)

Though some of the stakeholders interviewed concluded there could have been greater interaction between the different workstreams, those involved in the administration of the programme as a whole felt the priority was initially given to developing individual assets rather than focusing on how they came together. Particularly given the context of the pandemic, it was felt that focusing on workstreams independently had enabled greater progress than would have otherwise been achieved. Linked to this was the need to commission organisations that had skills and expertise which were specific to particular workstreams.

"The intention at the beginning I think was, we knew we had to segment the work in order for us to progress. And we would also need to do that in order to procure and commission relevant expertise rather than trying to group it all together. So, I think there was an element of knowing that, at that point when we were planning it, they needed to be separate."
(Stakeholder 2)

Additional barriers to greater integration between the workstreams, as discussed by stakeholders, were: the misalignment of ambitions between partnering organisations; the transition from PHE to OHID, and changeover of staff. These are discussed in greater depth in Chapter 8.

Since March 2022, the OHID team have been working to more closely align the programme's workstreams through, for example, clearer cross-referencing between them.

6.3 Further opportunities

There are a number of opportunities for greater integration between the workstreams, some of which OHID have already taken action to address in recent months:

- **Better cross-promotion between workstreams:** HCPs engaging with one of the MHPP training assets could also benefit from being signposted to the full suite of MHPP resources on offer. Not only would this help HCPs to consolidate and extend their own learning, but it would better equip HCPs to share knowledge of the MHPP resources with colleagues, thereby acting as a conduit for transmitting knowledge across the system. Stakeholders most commonly mentioned the synergy between PACC and Moving Medicine, wanting to see Moving Medicine taking greater prominence in the PACC training. The PACC slides have recently been updated with the intention being that a greater emphasis is placed on Moving Medicine and other MHPP assets. Intentions are for each of the training tools to be made available on a central MHPP webpage hosted by Sport England.

"One of the things we're going to try and do within the revamp of the slides is looking at our signposting and how we make that better, so that there is more of coherent, joining, pulling everything together… I think it'd be fair to say that some of the PACCs don't realise that Moving Medicine is part of MHPP, and part of what we want to do is be signposting it to people if they wanted a deeper dive into things. And so that's something which we're looking to change with regards to the slide review."
(Stakeholder 7)

- **A more comprehensive learning programme:** Some stakeholders wanted to move beyond cross-promotion alone, towards a more clearly articulated narrative about how the workstreams fit together and interconnect, so as to provide a comprehensive programme of learning.

  "I would like to see much closer integration and a more cohesive narrative between the different packages in the context of understanding our system."
  (Stakeholder 4)

- **Training assets embedded into the undergraduate curriculum:** Having elements of the MHPP embedded into the undergraduate curriculum would significantly elevate the reach and impact of the programme. It is understood that this is a hope for the programme, though it may take time to be realised.

- **The role of MHPP workstreams within a systems approach:** Stakeholders recognised individual MHPP workstreams as key facilitators for embedding a systems approach to the promotion of physical activity. However, notably absent from discussions as part of Activating NHS Systems, or stakeholders retelling of it, is how individual MHPP workstreams should be placed within the system to best contribute to a systems approach to the promotion of physical activity. As discussions within Activating NHS Systems mature, these considerations will become increasingly important.

- **Understanding the additive value of programme assets:** What is not yet known at this stage of the programme's evolution is what the additive value of the workstreams are. Some stakeholders stressed that understanding the additive value of the individual workstreams should be the next stage of the programme. For example, providing a cluster of GP practices with multiple training assets from the programme and seeing how the behaviour of HCPs differs from practices that are exposed to individual assets. This would allow for a deeper appreciation of how the different training assets could be packaged together.

  "I don't know the extent to which we've really explored the additive value of the interaction of these components together… I think the biggest point I'd make is, moving on next is really about deepening the understanding of the interconnectivity and how these things relate to one another in getting the best value of out of the individual packages."
  (Stakeholder 4)

7 Overall impact of the MHPP

This chapter reflects on the overall impact of the MHPP, looking initially at the outputs and outcomes achieved as per the workstreams' logic models, before giving consideration to the wider impact as perceived by programme stakeholders. It draws upon findings from the individual workstream evaluation reports, as well as the Activating NHS Systems and programme-level stakeholder interviews.

7.1 Outputs

An evaluation logic model was co-created for each of the MHPP workstreams, with the exception of Activating NHS Systems where the iterative nature of this workstream was not conducive to such an approach. The logic models depicted several measures of output which would provide early indications of success for the workstreams. Table 7.1 below shows these intended outputs against the evaluation evidence in support of them. The two outputs of most note are as follows:

- **Approximately 157,400 professionals have been trained or accessed a training tool** in Phase Two of the MHPP (April 2019 to August 2022)[33]. Moving Medicine is the greatest contributor to this figure (with over 136,500 unique users accessing the website), followed by PACC with over 16,600 HCPs attending a training session. It is important to note, this overall figure includes some non-HCPs that it is not possible to remove from monitoring data for Moving Medicine and E-Learning, and the figure does not account for individual professionals who may have engaged with more than one workstream.

- **Looking at just Active Hospitals and E-Advice, over 7,300 patients have had an evidence-informed conversation about physical activity with an HCP** as part of Phase Two of the MHPP. In addition to this, **over 5,700 conversations about physical activity with patients have been recorded** (not necessarily with individual patients). These figures significantly underestimate the number of patients engaged by the programme and the number of conversations about physical activity which have resulted from it. It was only possible for these data to be recorded for the Active Hospitals and E-Advice workstreams. The data were not always captured for all of the participating pathways within the Active Hospitals workstream, and some pilot sites had less comprehensive means of data collection and subsequently a less accurate record of achieved outputs.

The number of HCPs trained, or who accessed a training tool, as part of the MHPP Phase Two is significant. This is particularly so given the challenges faced by the programme as a result of the COVID-19 pandemic (discussed more in Chapter 8). Stakeholders acknowledged that as a proportion of the workforce, the number of HCPs engaged by the programme was relatively small, though the programme had been successful at training HCPs at a scale not seen before.

An academic survey of 839 GPs in England (January 2021, funded through the NIHR) found relatively low awareness and usage of various MHPP assets: 2.9% had used the HEE E-Learning modules; 2.4% had used the BMJ E-Learning modules; 1.4% had used the Moving Medicine consultation guides; and 1.2% had attended PACC training[34]. This reflects findings from the individual workstream evaluations

[33] Note, this figure excludes HCPs engaged through the Activating NHS Systems and Undergraduate Curriculum workstreams.
[34] Lowe, A. et al (2021) Physical activity promotion by GPs: a cross-sectional survey in England. BJGP Open. https://doi.org/10.3399/BJGPO.2021.0227

whereby HCPs and stakeholders interviewed often felt the MHPP assets were not as well known or utilised as they could be.

Table 7.1: Achieved outputs from Phase Two of the MHPP

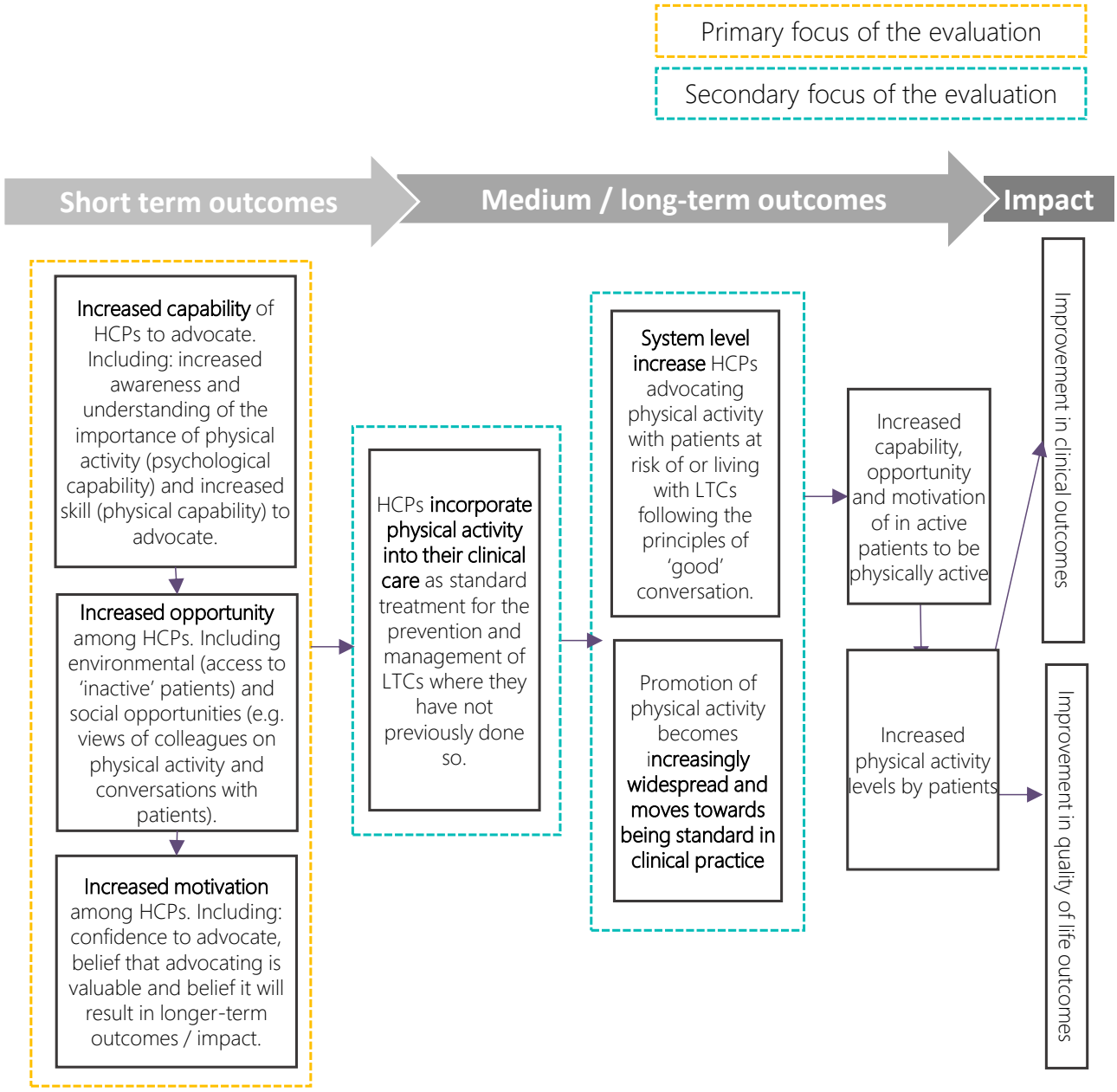
	PACC	Moving Medicine	Active Hospitals	E-Learning	E-Advice	TOTAL
Dates for data collection	*Apr-19 – Aug-22*	*Apr-19 – Aug-22*	*Mar-21 – Jul-22*	*Sept-19 – Aug-22*	*Feb-22 – Mar-22*	
No. of HCPs trained/ accessing tool	16,640 (Excludes non-HCPs)	136,582 (Includes non-HCPs)	568	3,599 (Includes non-HCPs)	3	157,392
No. of HCP training sessions	861	N/A	N/A	N/A	N/A	861
No. of modules completed	N/A	N/A	N/A	10,285	N/A	10,285
New or updated resources	Yes	Yes	N/A	Yes	Yes	
No. of patients spoken to about physical activity	N/A	N/A	7,323 (and 5,781 physical activity related contacts)	N/A	9	7,332 (and 5,781 physical activity related contacts)
No. of patients with physical activity assessed and recorded	N/A	N/A	7,406	N/A	N/A	7,406
No. of patients signposted to resources or support services	N/A	N/A	2,930	N/A	N/A	2,930
No. of referrals	N/A	N/A	915	N/A	N/A	915
No. of referrals attended	N/A	N/A	875	N/A	N/A	875
Pathways/ operating procedures include physical activity	N/A	N/A	Yes	N/A	N/A	
No. of trusts participating in the Community of Practice	N/A	N/A	24	N/A	N/A	24
Published toolkit	N/A	N/A	Yes: Active Hospitals Collaborative Forum	N/A	N/A	
No. of PACCs recruited/ no. of PACCs trained/ no. of active PACCs/ remodelled national network of PACCs	33 active PACCs 27 recently recruited (excl. 16 embedded in hospitals)	N/A	N/A	N/A	N/A	60
CPD accreditation	Re-accredited by the RCGP. Application made to the Personalised Care Institute	N/A	N/A	N/A	N/A	
Marketing and comms plan	Yes	Yes	N/A	Yes	N/A	

7.2 Outcomes and impact

Across the MHPP workstreams (with the exception of Activating NHS Systems), the logic models all set out a number of similar intended outcomes and impacts for the programme. These are shown in Figure 7.1. It was agreed that the primary focus of the evaluation would be on the intended short-term outcomes

(those targeting the capability, opportunity and motivation of HCPs to promote physical activity), with the longer-term outcomes and eventual impacts having a secondary focus given their place further along the causal chain.

Figure 7.1: Intended outcomes and impact for the MHPP workstreams



The intended outcomes and impact are addressed below, with an examination of evaluation evidence in support of their achievement. This discussion relates to PACC, Moving Medicine, Active Hospitals and E-Learning. The E-Advice pilot was too small to generate sufficient evaluation evidence for inclusion in the discussion below.

7.2.2 Short-term outcomes

- **Increased capability of HCPs to promote physical activity:** Positive impacts on HCPs' capability to promote physical activity were observed for all four workstreams of relevance (PACC, Moving Medicine, Active Hospitals and E-Learning). Indeed, one of the greatest impacts of the four workstreams appeared to be on HCPs' knowledge and skills of how to promote physical activity.

For example, the majority of survey participants reported that use of the Moving Medicine consultation guides had increased their knowledge of how to have brief conversations on physical activity with patients (93%), with half (51%) saying the consultation guides 'greatly' increased their knowledge, with the respective figures for E-Learning being 88% and 45%. Staff working within the Active Hospitals pilot sites also reported increased knowledge and skills in relation to the promotion of physical activity. The training they received (predominately PACC training) was instrumental in increasing knowledge and skills regarding physical activity promotion.

The proportion of HCPs who said they had 'good' or 'advanced' knowledge of how to promote physical activity increased from 41% before the PACC training to 72% after. However, after the training, just over one in four (28%) described their knowledge as 'basic', suggesting more advanced content could be included. OHID have recently issued an updated slideset in recognition of this finding, with new additions around Active Travel, inequalities and the practicalities of having conversations about physical activity with patients.

The PACC training does however appear to better attract HCPs who do not regularly promote physical activity compared to Moving Medicine and the E-Learning modules. Only 28% of PACC trainees at the baseline survey say they 'nearly always' promote physical activity to their patients, compared to 60% and 49% of Moving Medicine and E-Learning users respectively.

As mentioned elsewhere, each of the training assets attracts a different profile of HCP, showing they help to provide a suite of tools to meet the needs of a broad audience.

- **Increased opportunity among HCPs to promote physical activity:** Arguably, the main workstream which focused on creating a more positive culture in support of physical activity was Active Hospitals. Here interviews with staff suggested physical activity had been given greater prominence within their pathways, and changes to pathway infrastructure had helped HCPs consider their patients' physical activity needs, though a deeper shift in culture would take longer to occur. Additionally, knowing where to signpost or refer patients for those who require more intensive support has also helped increase opportunities for HCPs in the pilot sites to broach the topic of physical activity.

  Interviews with HCPs across the workstreams showed that the programme could influence the capability of HCPs to have conversations with patients about physical activity, but barriers still remain to having these conversations (such as limited time) which are outside the bounds of the MHPP assets to address.

- **Increased motivation among HCPs to promote physical activity:** Alongside increased capability, the MHPP workstreams appear to have the greatest impact on HCPs' confidence to discuss physical activity with their patients. Nearly all (96%) of survey participants reported that using the Moving Medicine consultation guides had positively impacted their confidence to have brief conversations with patients about physical activity, with the equivalent figure for E-Learning being 89%. A very high proportion of HCPs (92%) attributed feeling motivated to promote physical activity to patients (at least to some extent) to the HEE E-Learning modules.

  An increase in confidence was also observed across the Active Hospitals pilot sites, with the training HCPs had received being an important contributor to this.

The PACC training appears to increase the confidence of many HCPs'; the proportion feeling 'very' or 'somewhat confident' increased from 75% before the training to 94% after the training. However, this positive impact was not felt by all HCPs. Looking at the sub-set of HCPs who completed both the pre and post-survey reveals that 37% of HCPs saw no change from being 'somewhat' or 'not very' confident, even after attending the training.

Though not explicitly mentioned in the workstream logic models, it is worth noting that the three principal MHPP training tools evaluated (PACC, Moving Medicine and E-Learning) were well received by HCPs. High advocacy scores were given for all three assets – most notably for Moving Medicine as 73% of users rated it 9 or 10 out of 10 meaning they would 'definitely recommend' it to others, with the equivalent figures being 56% for PACC and 47% for the E-Learning modules.

7.2.3 Medium/ long-term outcomes

A number of medium/ long-term intended outcomes for the MHPP workstreams focused on embedding the promotion of physical activity into clinical practice, and positively impacting on patients. These are discussed in turn below:

- **Embedding the promotion of physical activity into clinical practice:** For some HCPs engaged by the programme, qualitative evidence shows they are more routinely discussing physical activity with patients, and that these conversations are higher quality and more effective. Where the MHPP asset had positively impacted HCPs' behaviour, individuals described a greater willingness to enter into conversation about physical activity with patients, and a modified approach to such conversations (such as focusing on exploring patients' motivations for being active).

  The PACC training specifically appears to improve the quality of conversations with patients rather than the frequency with which these conversations take place. It is worth nothing, as aforementioned, that barriers to having physical activity conversations, such as time constraints – which were exacerbated during Phase Two due to pressures associated with the pandemic – still remain even after the training has been completed and that there are wider forces at play in determining how often HCPs discuss physical activity with their patients.

  The training received by HCPs working across the Active Hospitals pilot sites helped physical activity promotion to become more routine alongside changes to IT infrastructure which help prompt HCPs to consider their patients' physical activity needs. There are indications that more work is needed to ensure these conversations are taking place consistently across all HCPs within participating pathway teams.

  In the interviews across the workstream evaluations, some HCPs were positive about the potential for the MHPP assets to help conversations about physical activity become standard practice in clinical care. Others were more cautiously optimistic, recognising that it was not feasible or realistic for the assets to have a system-wide impact in isolation. There was a sense among those interviewed that the training assets needed to be embedded into the undergraduate curriculum, and promoted to a broader set of professionals, to better contribute to the programme's ambition of system-level change.

- **Positively impacting on patients:** HCPs from across the workstream evaluations were able to provide anecdotal evidence of patients becoming more physically active following conversations about increasing their physical activity. Whilst only anecdotal, and not directly attributable to the MHPP workstreams, these examples are indicative that some patients may benefit from the

increased focus on physical activity in their exchanges with HCPs. HCPs provided examples of patients reporting better aerobic fitness, reduced pain, improved mental health/ mood, better management of fatigue, and greater enjoyment of physical activity.

7.3 Stakeholders' perceptions of the MHPP's impact

Stakeholders interviewed as part of the Activating NHS Systems and programme-level evaluation were able to identify a number of impacts of the MHPP, as well as changes in the system that the MHPP may have contributed to. These are discussed in turn below:

- **Good HCP engagement with a number of tools:** A clear product of the MHPP has been the training tools available to support HCPs in their promotion of physical activity. Sizeable numbers of HCPs have made use of the training assets available through the programme. A few of the stakeholders interviewed felt this engagement with the MHPP tools was suggestive of a move towards physical activity being recognised and valued. One stakeholder commented on the uptake of MHPP tools within Active Partnerships as an incremental shift towards more widespread promotion of physical activity. The MHPP has provided champions of the cause with tools to try and engender change around them, without them having to 'reinvent the wheel'.

  "I mean Active Partnerships I think have picked up on stuff and have been able to use elements of the programme to change things at a local level. And I think all of these things incrementally add up."
  (Stakeholder 9)

- **The provision of a platform:** Having a national programme dedicated to supporting HCPs in their promotion of physical activity was seen by some stakeholders as providing a platform to work from. For example, it provided an infrastructure to socialise changes to the CMO's physical activity guidelines. It provided a means through which to engage senior ministers on the importance of physical activity. The involvement of Sport England was also seen by one stakeholder as a permissive means for Active Partnerships to utilise the programme and its assets.

  "I think it provided, well, it provided a platform, I guess, that wasn't there before. So, the fact that there was this national programme, led by Sport England about this agenda, I think it gave people permission to do work in this space."
  (Stakeholder 2)

- **Greater recognition among HCPs and patients of the value of physical activity:** A number of stakeholders talked about how the system 'had moved on' in terms of there now being greater recognition – among both HCPs and patients – of the value of physical activity compared to when the programme started. They talked about indicators of this progression which included greater acceptance from patients about the value of physical activity and almost an expectation that it would be discussed with them. They also referenced physical activity having greater prominence in the strategies of Integrated Care Boards compared to CCGs at the time of the programme's inception as a marker of its heightened importance. These stakeholders acknowledged that the greater value placed on physical activity by HCPs and patients was by no means uniform but that they felt the 'tide is turning'.

  "I think if you interviewed a lot of the healthcare professionals now compared to the ones previously, we'd have a very different narrative about physical activity than we did when it [the MHPP] started."
  (Stakeholder 4)

"I think that the agenda has really moved on over the course of these sort of five years or so. I think from a general public point of view, there's more awareness of the role of physical activity and health, I think there's more noise about it."
(Stakeholder 2)

Stakeholders talked about the, 'huge, unexpected seismic impact' of COVID-19 on healthcare and patients and, by proxy, on physical activity. Whilst evidence suggests that the pandemic and measures to suppress the virus led to reductions in population physical activity levels[35], some of the stakeholders interviewed felt the pandemic raised awareness of the importance of physical activity and the link to health outcomes.

- **Greater recognition among organisations of the value of physical activity:** A number of stakeholders commented on what they observed to be a broadening of the organisations involved in conversations about the importance of physical activity. Many of these stakeholders attributed this development to the Activating NHS Systems workstream which was leading to new conversations between relevant parties in a way that had not been seen before. For example, the roundtable workshop with NHS England as part of this workstream brought together upwards of 30 senior representatives within the organisation to discuss the physical activity agenda. Some stakeholders talked about this workstream enabling a better understanding of the system and the leverage points within it, as well as facilitating improved relationships, though it was acknowledged this was incremental progress and only the start of the process.

"One of the successes of this programme is very much about the power of convening, bringing the right people together to have the right conversations, bringing people in who wouldn't usually have a seat at the table."
(Stakeholder 13)

One stakeholder talked about how the MHPP programme was an effective precursor to the whole systems approach set out in the Activating NHS Systems workstream.

"I mean, there's a part of me that thinks it was exactly what was needed at the time. I don't think we could have jumped to where we want to go now without doing that as a first step if that makes sense. I think if we'd have tried, we'd have failed if we'd gone straight into this idea of Activating NHS Systems at every level."
(Stakeholder 2)

Other stakeholders felt the programme as a whole, rather than Activating NHS Systems specifically, had placed physical activity higher up the agenda of other organisations. They cited recent work by the Richmond Group of Charities on the physical activity agenda as an example of this, or leaders within the Royal Colleges who used to be PACCs helping to embed the agenda further.

- **Shared focus between the health and physical activity sectors:** Some stakeholders talked about the programme facilitating more of a shared focus between the health and physical activity sectors. The Active Partnerships, and their uptake of MHPP assets, has helped in this regard, as has the programme being funded by Sport England – something which was considered a strong signal to the system about the relevance of the two sectors to one another. Continued work is still

[35] Tison G, et al. (2020) Worldwide effect of COVID-19 on physical activity: a descriptive study. Ann Intern Med. https://doi.org/10.7326/M20-2665

required to engender a shared agenda and common language between the two sectors though these stakeholders felt the MHPP had made progress in this regard. Health and wellbeing is now listed as one of Sport England's five key areas of focus for the next ten years in their strategy, Uniting the Movement.

"You can argue about whether Sport England would have such a focus on health and people with long-term conditions if it wasn't for the programme. And that's radical."
(Stakeholder 8)

Stakeholders were quick to caveat that it was not always possible to attribute changes seen at the system level to the MHPP. However, they felt it was plausible that the programme will have contributed in some way to these impacts and to the building momentum of physical activity being better valued.

"How you attribute that to this programme, I don't think you can, but I think what you can argue is that without this strategy, without the individual components of this strategy, targeting different parts of the system, and then collectively giving that part of the system confidence to have a voice and talk about the value of activity, you probably don't get that movement towards where we are now."
(Stakeholder 4)

7.4 Unintended consequences

No evidence of harm to either patients or HCPs was observed, in any of the workstreams through the evaluation.

The evaluation did not produce any clear evidence of unintended consequences resulting from the MHPP activities. However, it did highlight a lack of consideration of potential unintended consequences within the programme. Any health promotion intervention has the potential to widen health inequalities and a mechanism for exploring and monitoring this should be built into programmes at inception.

Within workstreams, any future monitoring systems should be sensitive to the potential of the programme to increase health inequalities; particularly where workstreams interface with end users. For example, any future Active Hospitals should be asked to conduct a Health Impact Assessment at inception and to monitor and report on their impact on health inequalities on an ongoing basis.

Future plans should include the integration of a robust health inequalities framework to ensure that opportunities to reduce inequalities are maximised, particularly given the reach of the MHPP, and that the programme team are alert to potential unintended negative consequences. Specific developments could include greater explicit content within training tools, and greater focus on ensuring underserved communities are engaged in physical activity. For example, by targeting the PACC programme towards HCPs working in areas of high deprivation.

8 Challenges to the programme

The MHPP Phase Two has been delivered through an unprecedented global pandemic. It has faced a number of other challenges which are discussed below to provide further contextual understanding to what the programme has been able to achieve. This chapter draws on evidence from the individual workstream evaluations, alongside the programme-level interviews.

8.1 Challenges to the programme

8.1.1 COVID-19

All aspects of the MHPP Phase Two were paused for six months from April – September 2020 in response to the COVID-19 global pandemic. This decision was made to lessen any unnecessary pressure on frontline NHS workers at that time, and reflects the changed priorities for the national OHID team. Evaluation activities were also paused with immediate effect over the same time period. The full impact of the pandemic on the programme is not immediately discernible and has extended far beyond the time period over which the programme was paused.

It is also worth noting, that some consequences of the pandemic have been beneficial to the programme and its implementation. The following impacts of the pandemic on the programme – both positive and negative – have been observed:

- **A reduced number of PACC training sessions and HCPs trained through PACC:** The workforce pressures resulting from the COVID-19 pandemic led to drastically reduced capacity among both PACCs and HCPs for an extended period during Phase Two of the programme. In addition to this, across many areas of primary, secondary and community care, there was a pause on all non-mandatory training. Although they have evolved since the outbreak of the pandemic, these workforce pressures are still very evident (for example, in the form of waitlists for elective surgery), and are likely to remain for a long time. However, despite these challenges, a large number of HCPs have been trained through this workstream.

- **Transition to online delivery of PACC training:** PACCs rapidly transitioned from face-to-face to online delivery in response to the restrictions enforced to limit the spread of COVID-19. In October 2021 there was a transition to a hybrid delivery model with sessions taking place either online or face-to-face based on PACCs' preferences. There is some suggestion that online delivery of the training means geographically dispersed HCPs can attend the same session which helps ensure the minimum number of attendees are met for each session.

- **Impact on the implementation of Active Hospitals:** The pandemic had a considerable impact on the implementation of Active Hospitals activities. This included pilot sites having to alter their priorities, staff being redeployed, wards being repurposed as COVID-19 wards, physical adaptations to hospital spaces not permitted due to social distancing rules, and promotional activities curtailed as deemed 'non-critical'. The impact of which was delays in implementation and reduced opportunities to promote physical activity to patients. However, the pandemic also facilitated remote working and an ability to convene busy clinicians working across different sites in a way that would have been challenging pre-pandemic.

- **Fewer promotional opportunities for Moving Medicine:** Promotion of Moving Medicine has historically focused on social media and conferences, speaking opportunities and journal

publications. Promotion through conference presentations and speaking opportunities has been limited due to the pandemic.

- **Greater use of E-Learning:** Use of the HEE E-Learning resources peaked during the first national lockdown between April and June 2020. The same trend was observed for the BMJ modules also.

- **Move to more online and telephone appointments:** This has presented both challenges and opportunities to HCPs in terms of promoting physical activity to patients. Some commented that consultations with patients in these mediums allows them to more overtly use the Moving Medicine resource as part of their discussions. Others stated that it added another barrier to the promotion of physical activity as they lacked visual clues as to whether the patient would benefit from such a conversation or not.

- **Impact on population physical activity levels and awareness:** Throughout the pandemic, levels of physical activity reduced overall, but not consistently across the population. Some groups, including older adults and those with health conditions, experienced disproportionate reductions in physical activity, in part due to shielding requirements[36]. This, in turn, led to efforts to provide printed and online physical activity support opportunities for people during the pandemic.

- **A revision of evaluation plans:** Reflecting the delivery changes in the programme as a result of the pandemic, extensive work was undertaken to review and refine the evaluation approach accordingly.

8.1.2 Changes for the programme team

Stakeholders perceived that the achievements of the MHPP Phase Two had been delivered during a period of significant change for the programme team. Two primary factors contributed to this perception of change. First, following the dissolution of PHE in October 2021, management of the programme transitioned to OHID. Second, over the course of the programme, there have been a number of personnel changes across the multiple workstreams within the programme.

Given this context of change, which was further compounded by the pressures of the pandemic (as described earlier in this chapter), stakeholders generally felt that the successes of the programme were all the more notable.

"I think, especially given the context and all the things that they were challenged with, from moving to OHID, the pandemic, changes in management, political changes earlier on as well, I think its procurement challenges. They had it all, and I just think, overall, it's been a very positive and beneficial programme of work."
(Stakeholder 2)

Nonetheless, stakeholders described ways in which they felt these challenges could affect the outcomes or impacts of the programme.

Stakeholders made a range of comments which suggested that, as a 'brand', OHID is less well known, and less closely associated with physical activity, than PHE. One clear impact of this change was

[36] Sport England. Active Lives adult survey mid-March to mid-<ay 2020: coronavirus (COVID-19) report. London: Sport England; 2020. https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/2020-10/Active%20Lives%20Adult%20May%2019-20%20Coronavirus%20Report.pdf?2L6TBVV5UvCGXb_VxZcWHcfFX0_wRaI7

articulated by a Lead PACC, who commented that it was easier to secure engagement when the training was PHE branded and thus perceived to have higher credibility.

"There was something previously about the brand [PHE] – people got it. I think it helped the training to be seen in a higher regard."
(Stakeholder 7)

These concerns about OHID's 'brand' were compounded – and perhaps illustrated – by some stakeholders' opinions that OHID has not taken as strong a leadership stance on physical activity as PHE. This is not to say that leadership was not occurring within OHID, but that it was not fully visible to some external stakeholders. Stakeholders did not feel this had negatively affected the outcomes or impact of the programme at present. However, some were concerned that it could have implications for the programme's future success, which they saw as dependent on visible leadership that is able to create momentum around physical activity.

"Under OHID, that's [the leadership in physical activity] been diluted a little bit around obesity and diet and such like under perhaps the current political narrative."
(Stakeholder 4)

Changes to programme team personnel throughout the programme were felt to have a range of implications.

Some stakeholders suggested that the capacity of the programme team was reduced while staff were recruited and/ or embedded within the team. While this reduction in capacity was not seen to have affected the core delivery of the workstreams, a couple of stakeholders suggested that it resulted in less focus being placed on the integration of the workstreams.

"We had quite a lot of movement, especially at project manager level. So, I think it just meant that that glue wasn't always there. But I think it would be unfair to say that at the beginning we said we needed this all to come together really seamlessly. We never expected that completely. It just sometimes felt a little bit like, because they were separate bits of work, it made it harder for those organisations to come together."
(Stakeholder 2)

Further, some stakeholders felt that the team changes had resulted in what they observed to be a loss of organisational memory; particularly in relation to the original vision and aims of the programme.

"There's been a huge loss of knowledge at repeated stages from the central team. So yeah, I think each team comes in and you try and get to grips with what's going on and in doing that you lose that oversight and joined up thinking a bit."
(Stakeholder 18)

8.1.3 Organisational alignment

As discussed in Chapter 6, OHID commissioned a number of different organisations with the expertise required to lead several of the MHPP workstreams. Stakeholders reflected that this was the appropriate decision for the programme, but that there had been challenges at points where organisational priorities were not aligned. Stakeholders suggested that the time spent trying to bring organisational priorities into closer alignment ultimately presented an opportunity cost to the programme, and weakened synergies across the workstreams.

“I think it’s that problem with partnership – everyone’s got to be committed to the partnership and the whole, rather than some parties wanting to keep in their furrow, if you like.”
(Stakeholder 8)

“I guess what got in the way is human nature because they were all different types of organisations, all trying to achieve slightly different things.”
(Stakeholder 2)

This finding is a reflection of the key challenges organisations involved in system change face.

9 Strengths and limitations of the evaluation

This chapter explores the strengths and limitation associated with the evaluation, providing context to the findings presented in this report.

9.1 Strengths of the evaluation

The following strengths of the evaluation have been identified:

- **Iterative and formative:** Interim workstream reports, programme progress reports, and presentations to the Advisory Board were completed as part of the evaluation (though initially findings were delayed by the COVID-19 pandemic and suspension of activities) so data could be used to inform programme decisions. Indeed, OHID have taken action to enhance the programme and its constituent workstreams as a result of early evaluation findings. The evaluation approach and methods were reviewed regularly as the programme progressed to maximise learning.

- **Flexible:** The direction of the evaluation was shaped by the COVID-19 pandemic and the impact of this on the MHPP overall. This included changes to delivery models and delays to the mobilisation of some workstreams. The use of evaluation resource across the programme was reviewed regularly and shifted accordingly as the workstreams became more (and less) sizeable from the programme's perspective. Likewise, evaluation timeframes were continually revisited to reflect changes in the programme's implementation. The evaluation also needed to remain sensitive to changes in the national context and greater integration across local systems.

- **Theory-driven:** The MHPP as an intervention is complex; it is based on hypothetical causal chains with many interdependencies, feedback loops, and assumptions. For this reason, it lent itself to a theory-driven evaluation with an emphasis on exploring potential mechanisms that explain observed changes. Underpinning the evaluation was a robust framework (articulated in the individual logic models for each workstream).

- **Triangulation of data:** Linked to the theory-driven approach, there has been a triangulation of evaluation data from multiple sources for each workstream (such as survey data, monitoring/ performance data, and qualitative interviews). Triangulating data in this way has strengthened the validity of the evaluation findings.

- **Structured around COM-B:** COM-B behaviour change theory underpinned the development of research materials (such as questionnaires and topic guides) and subsequent data analysis. This has facilitated the identification of behavioural drivers and change among HCPs.

- **Connections made across the programme:** The evaluation has reported on individual workstreams, their interconnectivity, and the interaction between the programme and the wider system. This has facilitated learnings across the different workstreams as well as providing a holistic view of the programme as a whole.

9.2 Limitations of the evaluation

As with all evaluations, there are limitations to the evidence compiled. The principal limitations to the evaluation are judged to be as follows:

- **Limitations to the robustness of the impact evaluation:** Impact evaluations seek to estimate what would have happened in the absence of an intervention, to confirm whether the achieved outcomes are the result of the intervention or can be explained by other reasons. Time series analysis (pre/ post data collection) is the first step towards a robust impact evaluation. This was achieved for both PACC and in some of the Active Hospitals pilot sites. However, time series analysis was not considered feasible for Moving Medicine and E-Learning due to the relatively low samples sizes typically secured through online pop-up surveys (which these two workstreams necessitated). Time series analysis is sufficient to ascertain if certain outcomes have been achieved, but insufficient to attribute impact to the intervention without use of a matched comparator. The design of the MHPP was not suited to such analysis and thus a pragmatic, theory-driven evaluation (as referenced above) was undertaken instead, with a focus on plausible attribution.

- **Evaluation within a complex system:** The aim was to evaluate the MHPP acknowledging that it was delivered within a complex, adaptive system, the aim was not to evaluate the system itself. Illustrative examples of related initiatives are given but this is in no way an exhaustive representation of relevant system activity.

- **MHPP in its entirety not examined:** As mentioned previously, the Undergraduate Curriculum workstream was not in scope for the evaluation. As the evaluation has progressed, the importance of this workstream to achieving the programme's ultimate aim has become apparent, with many stakeholders viewing it one of the most viable means of achieving scale in the promotion of physical activity. Understanding progress made through this workstream and its potential outcome would therefore have benefitted the evaluation. The evaluation was never intended to be a whole-systems evaluation, but rather an evaluation of a set of interconnected interventions being delivered within a dynamic system. However, Activating NHS Systems has gained traction and grown beyond what was anticipated, and thus understanding its impact would have necessitated greater evaluation resource and timeframes than were available. Instead, a small qualitative study has been undertaken to collate information on the opportunities, barriers and facilitators to a whole systems approach to promoting physical activity, and gather the perceived value of activities conducted thus far.

9.3 Considerations for the reader

This has been an ambitious, mixed methods evaluation of several interconnected interventions being delivered within a complex system. It has comprised both a process and impact evaluation, with a focus on enabling continuous learning and development. Given the nature of the programme, and the complexity of the system within which it sits, the means of assessing impact are imperfect but realistic – and thus this should be borne in mind by readers of this report. Furthermore, it should be recognised that the MHPP assets were not designed to be compared, but should rather be viewed as a suite of resources for HCPs.

10 Future opportunities and direction

Funding for the MHPP Phase Two will cease in late 2022. In recent months, OHID and Sport England have been engaging system partners and one another in discussions about the future of the programme. This chapter explores opportunities for the future direction of the programme and whole systems approach to physical activity, drawing on stakeholders' reflections as part of the programme-level interviews, those conducted as part of the Activating NHS Systems workstream evaluation, and the individual workstream evaluation reports.

Central body to convene the system and enable local adaption and delivery

When considering future opportunities for the MHPP, stakeholders most commonly mentioned a centralised model which facilitated local adaption and delivery of tools to aid the promotion of physical activity. Stakeholders recognised the energy currently in local systems as ICSs bed-in, and the collaboration between Active Partnerships, local authorities and the local NHS continues to strengthen. These organisations understand the needs of local citizens and communities and thus stakeholders felt they were well placed to tailor and deliver MHPP assets locally. Stakeholders also recognised the value of a national, centralised body to maintain ownership of the MHPP assets to ensure there was no dilution in the quality of the products.

Multiple stakeholders described a future for PACC training whereby it is curated centrally by a national body, but that the training is commissioned at the ICS level. Central ownership would provide some continuity, oversight of the resource, and the ability to provide a network and peer support for clinical champions. Local commissioning would ensure ICSs were invested in the training programme, and able to adapt content and delivery to suit the needs of their local populations. Stakeholders were also keen to emphasise the importance of Active Partnerships in helping to embed the training at a local level.

"So having someone at a national level who is pushing this forward, having the conversations and then somebody at ICS level who is the font of all knowledge with the data, the knowledge, the experience and the networks and the connections to push this out through local organisations both in and out of the NHS."
(Stakeholder 13)

"There's a likelihood that there needs to be like a smorgasbord of options and opportunities around physical activity, within a framework perhaps, that ICSs and their constituent stakeholders and organisation can pick and curate and simulate into their programmes as they see fit."
(Stakeholder 9)

This model would rely upon individuals within ICSs and local systems championing the PACC training and other aspects of the MHPP. Thus the national body would have a responsibility for setting a strong signal to ICSs around physical activity, whilst working flexibly to influence individuals within the local setting, recognising the diversity of ICSs and their strategies. It is understood that in recent months, OHID, Sport England, NHS Horizons and partners have been working to influence ICSs to ensure that physical activity is taken into account as they embed.

Few stakeholders offered a view on which national organisation should have central responsibility for the MHPP assets, though one stakeholder expressed a definitive view on the continued delivery of PACC training. This stakeholder felt the training needed to sit within a Royal College or multiple colleges to ensure it maintained credibility among GPs. Whilst it was felt Active Partnerships would have the capability of delivering the content, they were concerned the training would be viewed as less credible if

it sat outside the medical system. This was countered by other views that focused on the need to extend across and beyond the medical system. Another stakeholder, involved in the conception of the MHPP, reaffirmed that PHE's original intention was to create momentum in the system about the need for physical activity promotion but not to remain a delivery provider (as it has been for PACC training).

Continue with the momentum of strengthening relationships

Some stakeholders acknowledged the progress made through the MHPP in building relationships and collaboration across the system in support of physical activity promotion. They were keen to see this momentum in collaboration continue. They talked about further strengthening of relationships between the health and sport and physical activity sector (principally, but not exclusively, through the relationship between OHID and Sport England), with NHS England, with the Royal Colleges, and with the social prescribing agenda with the ambition of creating shared goals across organisational boundaries. Some stakeholders felt that furthering the collaboration between the health and sport and physical activity sectors would require work to create a shared vocabulary and language around the physical activity promotion agenda.

"The continued relationships between OHID and Sport England and Royal Colleges is critical, but again, that comes back to leadership. So those relationships we need to build on and strengthen and make sure that we don't lose momentum on that connectivity."
(Stakeholder 4)

Clear leadership

Whilst stakeholders recognised the value and need for national bodies to collaborate on the physical activity agenda (of which MHPP is a part), some stressed the importance of clear – and visible – leadership on the issue. By this, stakeholders meant they wanted to see a central body responsible for: convening organisations across the system to a shared agenda; considering the MHPP assets as a whole; and setting a nationally coordinated training offer (particularly in the context of HEE moving into NHS England). Despite the Activating NHS Systems workstream being consciously not about 'command and control', some stakeholders wanted to see more active co-ordination of activities. Overall, there was a recognition that complex problems like physical inactivity cannot be solved by linear approaches and that, instead, systems approaches are needed. However, within systems approaches, some mechanism for convening and supporting the activities is required.

"I guess what I'm sort of seeing is like a sort of 1,000 flowers bloom model where there's lots of interesting things going on all over the place. I suspect that without kind of really big systemic change at sort of where the power lies, then those models will bloom, but they will always be limited."
(Stakeholder 16)

"Moving Healthcare Professionals in its broadest sense requires someone sitting at the centre thinking how do all of these things join up and, and flexing them in or out depending on what's happening in medical education and medical politics."
(Workstream stakeholder 1)

Embedding physical activity into the undergraduate curriculum

It is the programme's ambition that learning outcomes for physical activity are established on the undergraduate curriculum. This ambition was shared by a number of stakeholders who felt this was of fundamental importance to embedding the promotion of physical activity into clinical care. They felt the benefit would be twofold – undergraduates would finish their training with the unquestioned understanding that they had a role to play in the promotion of physical activity. These individuals would

then have an influence on qualified clinicians by challenging the status quo. Ultimately this was seen as a more effective mechanism to embedding the promotion of physical activity in clinical care than 'playing catch up' with qualified professionals, in part because it targets HCPs at the start of their career, but moreover because it is the best mechanism to ensure that all HCPs are trained. Some viewed this as the only viable means of achieving scale.

"If people come out of training understanding and accepting, and not even challenging, the fact that they have a role to play in supporting their patients to be active, whether they're going to be a medic or a nurse or a midwife or what have you, then I think the rest of it will fall into place and there's less need for the rest of it."
(Stakeholder 7)

Broadening the programme to upskill non-HCPs

A number of stakeholders expressed a hope that non-HCPs could benefit from the MHPP as HCPs have done. This would principally be in relation to widening the inclusion criteria for PACC training, but also promoting Moving Medicine and the E-Learning resources to non-HCPs as well as HCPs. The types of professionals stakeholders thought would benefit from the MHPP assets included social prescribing link workers and those working in the voluntary and community sector. Arguably these roles are well placed to have longer and repeat conversations with people and tend to have a good understanding of local communities, culture and available assets to help support physical activity promotion and some stakeholders had observed an appetite to be trained in physical activity promotion among these groups. It was acknowledged that the PACC training in its present form would need adapting to suit the knowledge level of these professionals and reflect the length of time they might be able to spend discussing physical activity with people.

One stakeholder suggested that PACC training could be delivered to 'micro-communities' such that GPs, practice nurses, and social prescribing link workers working with the same set of individuals were trained together. The benefit of delivering the training in this way would be the ability to explore how the different professionals could connect and interact to maximise the effectiveness of physical activity promotion for individuals.

"The core group who we deliver to, I think, has to change. It can't just be healthcare professionals anymore. I think we've done that. Working with those people who work at grassroots level in communities where we know we're going to get some really great impact data, I think that's where it will prove its point."
(Stakeholder 3)

More comprehensive promotional strategies

Phase Two of the MHPP has shown a number of the programme's assets to be effective at contributing to the physical activity agenda. The workstream evaluations have however shown reasonably low awareness of the MHPP assets, leading many of the HCPs interviewed (and some stakeholders) to conclude that more comprehensive promotional strategies would benefit the programme's impact. This does, however, depend on the future model of delivery for the programme and its assets. Not just having the assets endorsed by the Royal Colleges, but having the Royal Colleges more actively promote them was considered important. Likewise, strengthening the connections between the workstreams so there was greater promotion between them was a common suggestion. Other HCPs and stakeholders conveyed the importance of promotional strategies that marketed the assets to professionals who were less engaged on the topic of physical activity to ensure the programme continued to 'preach beyond the converted'.

Co-production with communities

A small number of stakeholders felt the future progression of the MHPP needed to involve co-production with communities, members of the public and specific population groups. These stakeholders felt co-production of this manner would help connect different parts of the system so that individuals – having had physical activity promoted to them – were then better supported in the community to get (and remain) active. This could help establish processes and capacity for social prescribing, including renumeration of community groups that provide physical activity opportunities. These stakeholders pointed to Easier to be Active, and We Are Undefeatable as good examples of how to engage communities meaningfully, while playing a role in reducing health inequalities.

"Meaningfully engaging people at all levels you know is to me is, is essential and the work that we do in community, like looking at community development and how that supports people to have better lives is that kind of model that I think the NHS should really try to adopt."
(Stakeholder 16)

Progressing the Activating NHS Systems agenda

A number of themes have emerged through the Activating NHS Systems workstream as important areas of focus to progress the physical activity agenda. It is noteworthy that these refer to the wider system and are not directly focussed on the MHPP. These are briefly summarised below for completeness:

- **Relationship building:** As discussed elsewhere, engaging ICS leaders to ensure physical activity is a key priority throughout their development, and continuing to strengthen relationships between the health and sport and physical activity sectors.
- **Health inequalities:** It is thought that building a physical activity narrative with health inequalities as a focus will help bring organisations together on this shared goal.
- **Data:** Making sure the right data is available at the right level to make the case for physical activity promotion.
- **NHS staff health and wellbeing:** This theme reflects the size of the NHS workforce and the benefits they would glean from being more physically active (30% of the NHS workforce are classified as inactive[37]), but also reflects the evidence which shows HCPs are more likely to promote physical activity to patients if they are active themselves[38].

[37] Roberts, M. (2022) Unlocking the 'miracle cure', HSJ https://www.hsj.co.uk/service-design/unlocking-the-miracle-cure/7032324.article
[38] Lobelo F, de Quevedo IG. The Evidence in Support of Physicians and Health Care Providers as Physical Activity Role Models. American Journal of Lifestyle Medicine. 2016;10(1):36-52. doi:10.1177/1559827613520120

11 Conclusions and implications

The following are conclusions and implications for OHID and Sport England following completion of the evaluation of the MHPP Phase Two.

- The MHPP is an ambitious programme, involving multiple partners, delivered in a complex and dynamic system. Phase Two has reached significant numbers of HCPs and has been delivered through the unprecedented circumstances of a global pandemic.

- Workstreams within the programme have achieved their aim of increasing the capability and motivation of HCPs to promote physical activity. Principally this is seen through improvements in HCPs' knowledge, skills and confidence to promote physical activity. The training tools have been very well received and are highly recommended by HCPs.

Implications for the specific workstreams from the evaluation findings are as follows:

- **PACC:** The evaluation has shown the value of this workstream in reaching less frequent promoters of physical activity and its ability to scale successfully. Future delivery of this workstream may involve curation by a central body with local commissioning of the training and management of PACCs (most likely at the level of ICSs), and adaptation of the content to suit local population needs. Moving forwards, the following should be given consideration: establishing centralised ownership and support, ensuring regular updates to the training content, enabling local tailoring, and providing an increased focus on health inequalities.

- **Moving Medicine:** Evaluation evidence shows Moving Medicine to be very well received and highly recommended by users. In order to reach an audience who are less likely to advocate physical activity, and broaden engagement with the resource, a more comprehensive promotional strategy is required.

- **Active Hospitals:** The four pilot sites have taken diverse approaches to becoming Active Hospitals and have effectively shared their learning through the Community of Practice of 24 trusts. Aspects of their work have become embedded as business as usual, and they are seeking funding for the continuation and/ or expansion of activities. To continue the momentum built through the Community of Practice, a single organisation is required to take responsibility for its curation and development going forwards to support further adoption and spread of the Active Hospitals initiative.

- **E-Learning:** Compared to PACC (as the other MHPP training asset), the HEE E-Learning modules attract a more modest number of HCPs but they ensure the MHPP provides a remote learning option as part of its suite of training tools. A greater understanding is required of the modules' place – and HCPs' access to them – in a nationally coordinated training offer as HEE moves into NHS England.

- **E-Advice:** Whilst this workstream's evidence review affirmed the value of a digital intervention, the challenges associated with standardising a digital product for the diversity of GP software systems used within and between localities across England might prove a limiting factor in any future ambitions to scale the intervention. A larger pilot of the E-Advice tool is required to make an informed decision about its progression.

The following are implications for the programme more broadly:

- Each of the training assets attracts a different profile of HCP, showing they help to provide a suite of tools to meet the needs of a broad audience. More comprehensive promotional activities, including cross-promotion between the assets, would enable the programme to have greater reach. Any such promotional activity should consider how the programme can 'preach beyond the converted', reflecting on how this is achieved through the PACC workstream. This may include widening the target audience of the programme to non-HCPs such as social prescribing link workers.

- Securing the programme's ambition of embedding physical activity promotion into the undergraduate curriculum would be an effective means of achieving scale to meet the programme's aims in the long-term. It would have the potential to reach every HCP in training and provide a critical first point of education on physical activity that could then be consolidated by accessing other assets post-registration.

- The MHPP has evolved such that the Activating NHS Systems workstream has become a central focus for progressing beyond the end of the funded programme. In recent months, greater traction has been seen in the conversations and connections being realised across the system in support of the whole systems approach. There is a risk that this momentum is lost as the programme concludes without a single body having specific responsibility for continuing to drive these conversations forward. Stakeholders felt there is a clear role for a single organisation to convene and support a coalition of leaders within the context of whole systems approach to reducing inactivity.

- Whilst stakeholders recognised the value and need for national bodies to collaborate on the physical activity agenda (of which MHPP is a part), some stressed the importance of clear – and visible – leadership on the issue. By this, stakeholders meant they wanted to see a central body responsible for: convening organisations across the system to a shared agenda; considering the MHPP assets as a whole; and setting a nationally coordinated training offer. If this direction is taken, consideration should therefore be given to which body, or bodies, has this future responsibility, recognising the need for them to be credible, connected, with a historic understanding of work to date, and with the reach, capacity and knowledge of driving system change.

- The development of ICSs offers the programme opportunities to respond to local need, connect at the local level and embed physical activity in local strategies. The challenge to this is the diversity of ICSs which requires the tailoring of assets and communications, and the recency of their statutory footing meaning local systems are still in flux. Active Partnerships, and OHID regions and places, have much to offer in terms of embedding the promotion of physical activity and promoting the MHPP assets.

- The programme has signalled, and facilitated, greater collaboration between the health and physical activity sectors. Continuation of such collaboration would be welcomed. Efforts to better align the language used around physical activity promotion between the two sectors should facilitate such collaboration.

- A concerted effort to review the actual and potential impact of the MHPP on health inequalities, and identify opportunities to lessen such inequalities, is needed. Future plans should include the

integration of a robust health inequalities framework to ensure that opportunities to reduce inequalities are maximised, particularly given the reach of the MHPP, and that the programme team are alert to potential unintended negative consequences. Within workstreams, any future monitoring systems should be sensitive to the potential of the programme to increase health inequalities; particularly where workstreams interface with end users. For example, any future Active Hospitals should be asked to conduct a Health Impact Assessment at inception and to monitor and report on their impact on health inequalities on an ongoing basis.

- Increasing the capability, opportunity and motivation of HCPs has been identified as a viable intervention point that could drive greater system change and there is evidence that this has been achieved. However, reducing inactivity at the population level clearly goes beyond targeting the behaviour of HCPs. Whilst there is some evidence that the MHPP has had broader impacts that contribute to reshaping the system, it is an approach that relies on individuals engaging on the issue of physical activity (both HCPs and patients). Future MHPP developments would be complemented by other strategic interventions at policy level across known areas of influence as described in global guidance[39]. Interventions that create structural change, focus on reducing inequalities and enable a greater focus on the wider determinants of health will collectively contribute to long-term system change.

[39] International Society for Physical Activity and Health (ISPAH). ISPAH's Eight Investments That Work for Physical Activity. November 2020. https://ispah.org/wp-content/uploads/2020/11/English-Eight-Investments-That-Work-FINAL.pdf

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