July 2022

MHPP Evaluation

Physical Activity Clinical Champions: Final report of findings

Ipsos & National Centre for Sport & Exercise Medicine

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Executive Summary

Introduction

As part of the Moving Healthcare Professionals Programme (MHPP), Public Health England (now the Office for Health Improvement and Disparities, OHID) and Sport England launched a peer-to-peer training programme in 2014, known as Physical Activity Clinical Champion (PACC) training. The training is offered for free to healthcare professionals (HCPs) and is delivered by a national network of trained HCPs, known as PACCs.

The long-term aim of the PACC training programme is to increase 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.

The evaluation

Ipsos and the National Centre for Sport and Exercise Medicine were commissioned to evaluate Phase Two of the MHPP in 2019. The evaluation objectives for the MHPP, and each workstream within it are:

- Understand the processes behind effective delivery.
- 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.
- Enable continuous learning and improvement to inform ongoing delivery and decision-making.

This report concludes the evaluation activities for the PACC workstream. It is based on the following evaluation activities:

- A baseline survey completed immediately before PACC training by 2,250 attendees.
- A follow-up survey completed by 263 individuals 4-6 weeks after their PACC training session.
- In-depth interviews with 10 HCPs who attended a training session – recruited via the baseline survey.
- Four focus groups with PACCs (18 attending in total) and two in-depth interviews with Lead PACCs and experienced PACCs.
- Analysis of monitoring data collected by PACCs, including details of the sessions delivered, the number and role of attendees.
- In-depth interviews with MHPP-wide stakeholders who were interviewed as part of other workstreams within the MHPP evaluation but provided insight into the PACC workstream.

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All fieldwork took place between April 2021 and June 2022. This report builds upon the two interim reports delivered in November 2021 and April 2022.

Training sessions delivered

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 2 of the programme. Despite this, 826 training sessions were delivered in the 39 months between the start of Phase 2 (19 April 2019) and the end of June 2022.

The distribution of PACC training sessions across England reflects the number of PACCs in each region. OHID have recently undertaken further recruitment of PACCs in areas that are less well represented. Analysis also suggests that more could be done to increase the number of training sessions taking place in more deprived areas, reflecting OHID's ambition for the programme to help reduce health inequalities.

Since October 2021, PACCs could choose to deliver their training online or in person (as opposed to solely online). Whilst there has been a shift to more face-to-face training, the majority of sessions in 2022 have remained online (84%). The training is thought to be suitable for online delivery though some attendees (and indeed PACCs) expressed a preference for face-to-face and the additional interaction and networking opportunities this offers.

Over Phase 2 of the programme, 15,836 HCPs (and an additional 3,151 non-HCPs) have received PACC training. The training is most commonly delivered to doctors (making up 42% of attendees) and less so with nurses/ midwives (28%), and Allied Health Professionals (25%). This reflects the higher number of PACCs who themselves are doctors, and the history of the programme which initially was piloted with GPs. PACC training therefore attracts (or is targeted at) a different profile of HCP compared to Moving Medicine and the HEE e-learning modules which are predominately used by AHPs and nurses/midwives respectively.

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 30% of attendees at the follow-up survey saying they do this 'nearly always'). This is in contrast to Moving Medicine and the HEE e-learning modules which have users who are more regularly discussing physical activity with their patients (60% and 49% respectively). The success of PACC training in attracting HCPs who engage in relatively low levels of physical activity is likely to reflect that the training is frequently delivered to whole teams at a time. Unlike Moving Medicine and the HEE e-learning modules therefore, it is not reliant on individual HCPs being motivated to seek out information on promoting physical activity to patients.

In many cases, PACCs arrange the majority of sessions by reaching out to existing contacts within their local area. Some felt that, as clinicians, they lacked the skills and admin time that would help them effectively market the training. In recognition of this barrier OHID provide PACCs with a range of marketing tools (including flyers, template emails and template tweets) to support PACCs with marketing activities. However, there remained a suggestion that it would be more efficient and effective for some of this administration to be carried out centrally.

Experiences of receiving the PACC training

The evaluation data suggests that the PACC training is very well received by attendees. A high proportion (42%) rate the training as 10 out of 10, meaning they would 'definitely recommend' it to

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others. This advocacy rating is in line with that for the HEE e-learning modules (37%), though lower than for Moving Medicine which is particularly highly advocated (63%).

The training receives high scores for it being clear, engaging and delivered at an appropriate pace (93%, 91% and 91% agreeing with these statements respectively). Slightly lower (though still high) scores are given for it meeting attendees' expectations (87%) and being relevant to their needs (84%).

HCPs reported a number of valuable lessons for their practice that they had taken from the training. These included a better understanding of the benefits of physical activity for a range of health conditions, an appreciation for how even small increases in physical activity each day can lead to positive outcomes, and how patients with comorbidities and pain can still be recommended suitable activities to encourage movement. Some of the HCPs interviewed expressed an appreciation for the tools and examples the training provided them with including objective data that they could discuss with patients.

Intended short-term outcomes

The evidence suggests that, overall, the training improves attendees' knowledge, skills and confidence relating to physical activity promotion. For example, those who said they felt 'very' or 'somewhat confident' promoting physical activity went from 75% before the training to 94% following the training. Likewise, a positive shift was seen in attendees' self-reported skill in promoting physical activity (shifting from 69% to 90% saying they felt 'somewhat' or 'very skilled').

Whilst positive shifts are observed at an overall level, there is a sizeable proportion of attendees for whom the training appears to have no impact on knowledge (51%), skills (55%), or confidence (48%) to promote physical activity. 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.

This hypothesis is supported by analysis of the baseline survey data that shows a correlation between knowledge of physical activity and promotion behaviour; those with advanced knowledge are more likely (78%) than average (28%) to promote physical activity 'nearly always'. This indicates that these attendees may have less to gain from the training, and that more impact could be achieved by focusing on those with lower levels of knowledge.

Intended medium- and long-term outcomes

Although the evidence shows a slight increase in the frequency with which HCPs promote physical activity to their patients following PACC training, this increase is not statistically significant. However, the in-depth interviews revealed the training helping to improve the *quality* of conversations with patients rather than the frequency with which these conversations took place. It is worth noting that barriers to having physical activity conversations still remain even after the training has been completed. In some cases these barriers were systemic. For example, a perceived lack of community services to refer patients on to. However, in other cases barriers relating to low levels of knowledge, skills and confidence persisted after the training. For example, concerns about what was age-appropriate or condition-appropriate physical activity.

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

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

PACC and the wider MHPP

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; with the PACC training a core offer as part of the latter.

The evaluation evidence suggests a large number of HCPs have engaged with the PACC training and positively benefitted from it. These individuals could also, however, benefit from other workstreams within MHPP, and participants in the evaluation felt there were opportunities for the PACC training to better promote the other workstreams. For example, just under a quarter (23%) of HCPs who attended the PACC training have also viewed the Moving Medicine website. Whilst the website is mentioned on the PACC slides, individuals thought it could be given more prominence to demonstrate its value and how best to navigate it. This feedback was taken onboard by OHID during a recent review of the PACC training slides. Three additional slides relating to Moving Medicine were added, and information relating to other training offers within MHPP has been made more prominent.

Some suggestions (though to a lesser extent) were made by PACCs and HCPs that training attendees could be directed towards e-learning resources, either before or after the training, to consolidate their learning and provide more time in the training for interactive elements. And it was suggested that, for the programme to have a greater impact, PACC training should be embedded within the undergraduate curriculum.

There was a strong desire from those interviewed to see a continuation of PACC training beyond the end of the funding period. Some suggested the need for greater local system buy-in and ownership of the training, for example, one individual suggested that there could be a network of PACCs within each ICS, who are managed and supported by the ICS themselves. An alternative suggestion was for the programme to reduce its scope and take a more targeted (and, in theory, more impactful) approach by focusing on areas with the highest health inequalities, specific disease types, or HCPs working within specific roles and settings.

Conclusions

Despite the workforce pressures of Covid-19, a large number of HCPs have been trained through the PACC workstream. However, it was felt that more could be done to increase the reach of the PACC training, particularly in more deprived areas, perhaps through dedicated marketing support for the programme. Evidence suggests the training is contributing to some positive shifts in HCPs' knowledge, skills and confidence to promote physical activity to their patients and there was anecdotal evidence that these conversations led to patients increasing their physical activity levels. There are 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. There are also opportunities to further enhance the impact of MHPP overall through providing greater

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connectivity between the individual workstreams, most notably by signposting to Moving Medicine and embedding PACC in the undergraduate curriculum.

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1 Introduction

Overview of PACC training programme

As part of the Moving Healthcare Professionals Programme (MHPP), Public Health England (now the Office for Health Improvement and Disparities, OHID) and Sport England launched a peer-to-peer training programme in 2014, known as Physical Activity Clinical Champion (PACC) training.

The training is offered for free to healthcare professionals (HCPs) and is delivered by a national network of trained HCPs, known as PACCs. While the training is primarily targeted at HCPs, a range of other professionals have also received the training, including social prescribing link workers, social workers, and health coaches.

The training is supported by a slide-set developed by OHID in collaboration with the PACCs. The key topics covered in the slide-set (as of November 2020) included: 1) an overview of activity levels in England; 2) definitions and guidelines relating to physical activity; 3) evidence for the benefits of physical activity for the prevention and management of disease; and 4) advice for incorporating brief conversations about physical activity into routine clinical practice. Depending on the HCP audience and the time available for training, additional content, focusing on specific health conditions (e.g. mental health, diabetes) may be included.

The long-term aim of the PACC training programme is to increase 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.

Following the initial launch of the PACC training programme in 2014, Phase 2 of the programme commenced in April 2019 and is due to run until late 2022. All training sessions were paused from March to August 2020 due to the Covid-19 pandemic. Between September 2020 to September 2021 the programme recommenced with all sessions delivered via video conferencing platform. 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.

Evaluation objectives

Ipsos and the National Centre for Sport and Exercise Medicine (NCSEM) were commissioned to undertake an evaluation of Phase Two of the MHPP in 2019. The PACC training programme is one of several workstreams within the MHPP. The objectives for the evaluation (which also apply to this workstream) are to:

- **Understand the processes** behind effective delivery. This includes 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, measure the effectiveness in increasing patient physical activity levels, reducing sedentary behaviour, and improving health and well-being outcomes.

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- **Enable continuous learning and improvement** to inform ongoing delivery and decision-making, including implementing the programme and workstreams effectively at scale.

Purpose of this report

This report presents the final findings from the Phase 2 evaluation of the PACC training programme, thereby concluding the evaluation activities for this workstream. It provides findings relating to the delivery of the programme, PACCs' experiences of implementing the training, attendees' response to the training, evidence of short-term outcomes, and evidence of outcomes and impacts according to the evaluation logic model (presented in chapter 4).

This report extends the findings reported in the two interim reports (delivered in November 2021 and April 2022) by utilising data from all evaluation activities conducted between April 2021 and June 2022. Since the April interim report, the evidence-base has grown to include findings from: one additional focus group with PACCs; five additional interviews with training attendees; two interviews with Lead/ experienced PACCs; 244 additional baseline survey completions; and 78 additional follow-up survey completions. In a number of places (primarily Chapter 6) the report also draws on findings from interviews conducted with MHPP-wide stakeholders, who were interviewed as part of the wider MHPP evaluation.

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

Evaluation methods

A mixed methods approach was taken to the evaluation and the following evaluation activities were completed. The evaluation received ethical approval from Loughborough University’s ethics board.

Baseline survey

The baseline survey was intended to provide an understanding of attendees' capability, opportunity, motivation, and behaviour relating to physical activity immediately prior to their participation in the PACC training. HCPs who attended training between 19 April 2021 and 28 April 2022 were invited to complete the online survey at the start of the training session. A slide at the start of the training presentation directed attendees to navigate to the survey via either a URL or a QR code. Alternatively, some PACCs chose to share the link to the online survey with attendees prior to the training session, to save time within the session itself.

Over the period that the survey was live, 2,250 attendees (including HCPs and other roles) participated. Across the same time period, audit data provided by OHID indicates that 288 PACC training sessions were conducted, and 6,135 professionals (HCPs and other) were trained. This suggests a baseline survey response rate of 37% which is in line with average response rates reported in survey literature. This is a reasonable response rate given the survey was voluntary and no incentives were offered.

Follow-up survey

At the end of the baseline survey, attendees were asked for permission to be re-contacted for a follow-up survey. The purpose of the follow-up survey was to assess whether attendees' capability, opportunity, motivation, and behaviour had been affected by the PACC training. The survey also collected some process data relating to the training, and demographic information relating to the participant.

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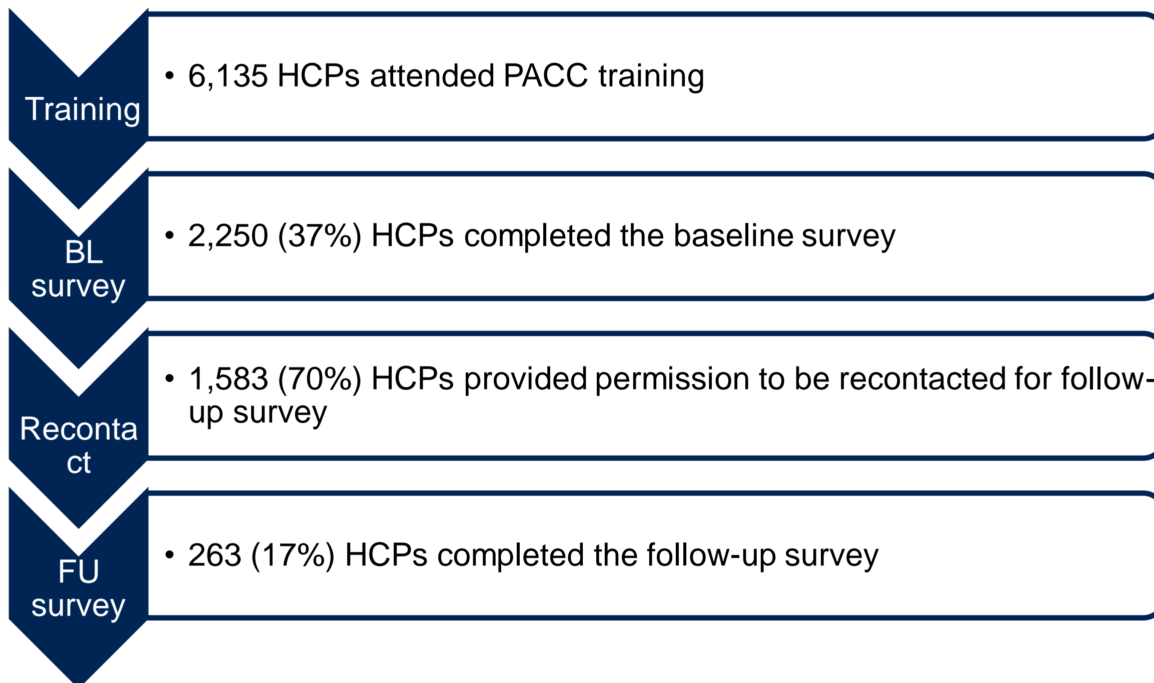
Those who agreed to be re-contacted in the baseline survey were asked to provide a name and email address to which the follow-up survey invitation should be sent. Of the 2,250 attendees who completed the baseline survey, 1,583 provided permission to be re-contacted for the follow-up survey: a re-contact rate of 70%. This proportion remains higher than would usually be anticipated, although it fell slightly over the period that the baseline survey was live (for example, it fell five percentage points, from 75%, since October 2021).

Participants were invited via email to complete the follow-up survey online 4-6 weeks after their PACC training session. Prior to late September 2021, HCPs were sent the invitation email 6-8 weeks following their training session. This interval was shortened in an effort to increase response rates. If attendees had not responded to the follow-up survey invitation within three weeks, a reminder email was sent.

Of the 1,583 invited to complete in the follow up survey, 263 participated (see Figure 1.1). This gives a response rate of 17% which is consistent with that reported in both October 2021, and April 2022. While it is possible to report on the findings from the follow-up survey at a headline level, there are very few statistically significant differences identified between sub-groups. While this may be because there are no differences, it is possible that the low sub-group base sizes mean that real differences between the groups are not being detected.

Figure 1.1: Number of HCPs who attended the training and number of survey completes (BL – baseline; FU – follow-up)



Interviews with HCPs

At the end of the baseline survey, HCPs were asked permission to be re-contacted to take part in an in-depth telephone interview (separately to consent for the follow-up survey). The purpose of the interviews was to explore attendees' responses to the online survey in more depth.

In total, 388 HCPs agreed to be re-contacted (17% of those who completed the baseline survey). Ten in-depth interviews were conducted across two waves. The first five interviews were completed in August 2021 and the final five interviews were conducted in May 2022.

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Recruitment was guided by quotas on HCP's region (North, Midlands, East, South and London), role (nurses and midwives, AHPs and doctors), and confidence levels (with at least five who had low confidence promoting physical activity to patients). The purpose of these quotas was not to achieve a representative sample of HCPs, but rather to ensure that a broad range of experiences were reflected across the interviews.

Focus groups and interviews with PACCs

Four online focus groups were conducted with the PACCs who deliver the training sessions. The aim of these groups was to understand, from PACCs' perspectives, the relationship between the programme and HCP's capability, opportunity, motivation and behaviour in relation to the promotion of physical activity, and to understand their experience of delivering the training.

OHID sent an invitation to all PACCs, encouraging them to sign up to one of the four groups via Eventbrite with the aim of six to eight PACCs (of mixed professions) joining each group. As detailed in The other groups were better attended.

.1, turnout has varied, and was particularly low for the January group (despite eight PACCs having signed up to participate). This is likely due to the high levels of Covid-19 related sickness among NHS staff, and the associated workforce pressures, during this period. Nonetheless, a useful and in-depth conversation was had with the two PACCs who attended this group. The other groups were better attended.

Table 1.1: Breakdown of PACC focus group attendees

Date of focus group	Doctors	Nurses	AHPs	Total
25 Oct 2021	2	2	2	**6**
18 Jan 2022	1	1	-	**2**
10 Mar 2022	2	1	2	**5**
22 June 2022	4	1	-	**5**
Total	**9**	**5**	**4**	**18**

In addition to the focus groups, two in-depth interviews were conducted with Lead/ experienced PACCs covering similar topics to the PACC focus groups. These individuals were interviewed separately to allow more in-depth discussions about the evolution of the PACC programme throughout their involvement, and how they envisaged the PACC programme developing in the future. These individuals are referred to as 'Lead PACCs' in the report.

Analysis of monitoring information

OHID collects a range of monitoring information from PACCs, including details of the sessions delivered, the number and role of attendees. This information was shared with the evaluation team on a regular basis throughout the evaluation period. It has been analysed and presented within this report to provide

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insight into the number and geographic spread of training sessions, the number and roles of HCPs trained, and the baseline survey response rate.

Insight from wider stakeholders

In a number of places throughout the report (primarily Chapter 6), findings are drawn from the evaluation of other workstreams within the programme. For example, a number of interviews were conducted with MHPP-wide stakeholders, who were not aligned with a specific workstream. Where these interviews touched on topics relevant to PACC, this insight is included within the report. These stakeholders are referred to as 'MHPP stakeholders' in the report.

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2 Training sessions delivered

The evaluation sought to understand the processes underlying the delivery of the PACC training programme. This chapter describes the number and geographic spread of PACC training sessions, the number and roles of HCPs who attend the training sessions and explores the suitability of the online delivery model. Specifically, the evaluation aims to answer the following process-related questions:

- How many sessions have been delivered?
- What is the geographic spread of sessions?
- Is the programme adopted within areas with high health inequalities?
- How many HCPs have attended PACC sessions?
- What are the characteristics of HCPs attending the training?
- Is the programme effectively targeting HCPs beyond early adopters?
- Does the training attract those who are not current advocates of physical activity?
- Is the online delivery model seen as fit for purpose?

It should be noted that while the PACC training can be accessed by professionals other than HCPs, OHID wishes – where possible – for the evaluation to focus on HCPs given they are the target audience for the training.

Number of PACC training sessions delivered

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 2 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. Despite these challenges, PACC training sessions have been delivered in most months since the start of the pandemic period.

Analysis of OHID monitoring information reveals that 826 training sessions were delivered in the 39 months between the start of Phase 2 (19 April 2019) and the end of June 2022. As shown in Figure 2.1, the number of sessions per month peaked in January to February 2020, prior to the Covid-19 pandemic, and then fell to close to zero from April to August 2020 (during which time the programme was officially paused) before starting to recover in September 2020.

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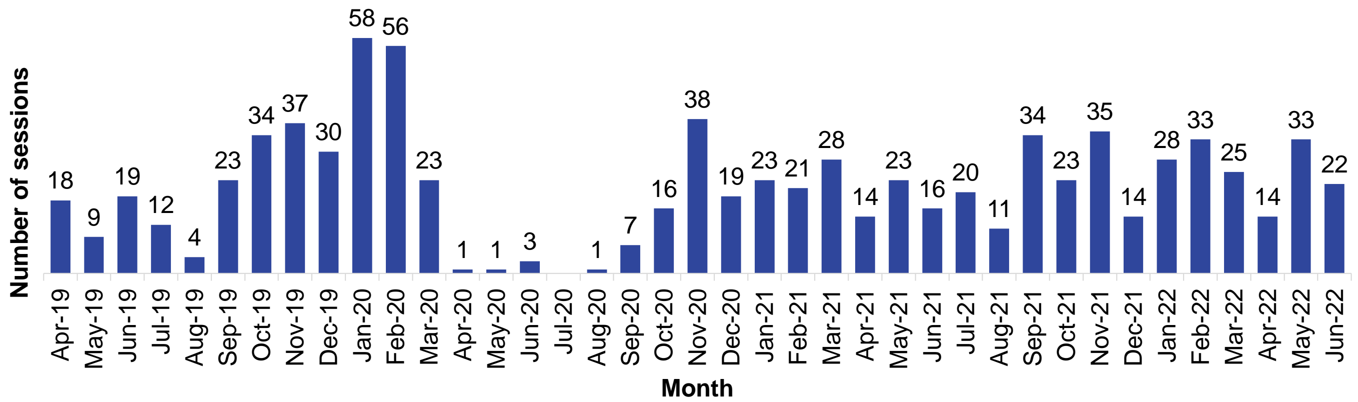
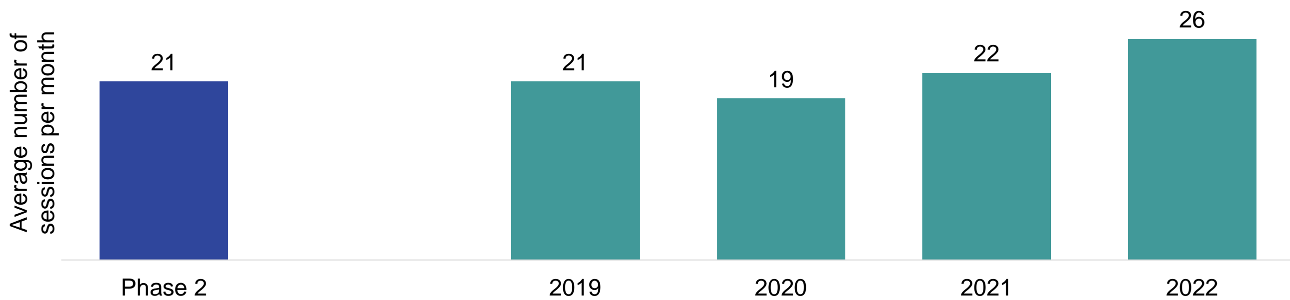
Figure 2.1: Number of Phase 2 PACC training sessions by month



Source: Ipsos analysis of OHID monitoring information relating to 826 training sessions conducted between April 2019 and June 2022.

Across Phase 2, an average of 21 training sessions were conducted per month. The number of training sessions per month in 2020 (19) was only slightly lower than in 2019 (21). This slight difference, despite the pandemic, was due to the high number of training sessions conducted in January and February 2020. However, for the majority of 2020 (particularly between April to September while the programme was paused), the number of sessions conducted each month was low (as seen in Figure 2.1.). Throughout 2021 (22) and the first half of 2022 (26), the average number of sessions per month has increased, and is now higher than the pre-pandemic levels seen in 2019 (see Figure 2.2).

Figure 2.2: Mean number of Phase 2 PACC training sessions per month for Phase 2 and by year



Source: Ipsos analysis of OHID monitoring information relating to 826 training sessions conducted between April 2019 and June 2022.

In the in-depth interviews, PACCs emphasised the extent to which the continuation of the programme throughout the pandemic – with at least 1 session being delivered almost every month – constituted a significant and important achievement.

> **It's not necessarily the perfect model, but it's been through a huge period of change and challenge, just because of we've been delivering within the pandemic. The fact that we've been able to keep it going, and we've had the level of sessions we've had has been quite amazing, really.**
> PACC, Doctor

PACC's experiences of organising sessions

In the focus groups, PACCs reflected on their different approaches to arranging training sessions and the relative strengths and weaknesses of each. In many cases, PACCs arranged the majority of sessions by reaching out to their existing contacts within their local area. PACCs felt that these contacts were most likely to successfully result in a session being booked. However, it was suggested that by using these contacts – some of whom are already working in public health – PACCs may not be

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reaching the HCPs who are the *most* disengaged from physical activity. PACCs were concerned that they did not have a systematic way of ensuring they were reaching out to these disengaged HCPs.

> **It's because the ones that have followed through and booked in is where I've got personal contacts and they know me, and they know what I can do, and I've got connections with people with a similar interest. It's leveraging the networks that you've already got. But I think the flip side of that is it is people who are already interested in this stuff. It's not reaching the people who aren't interested, and I don't have a systematic way of following those up.**
> PACC, GP

PACCs who were new to the role took a similar approach; utilising their existing networks to promote the training sessions. However, many reported that they had made slow progress in getting sessions booked in. Some had found this disheartening, and welcomed the opportunity to discuss these challenges, and reflect on shared experiences, in the focus groups.

> **The challenge definitely for me at the moment is getting going because I don't really feel like I know where to start. So, I have sent out a few emails and I'm talking to people in my own trust and things, but I just don't really feel like I'm getting anything back as of yet.**
> PACC, Mental health nurse

> **It has been very disheartening just to send hundreds of emails into the ether with literally tumbleweed in return.**
> PACC, GP

Both new and well-established PACCs felt that it would have been helpful to receive details (either from OHID or previous PACCs) of organisations and individuals in their local area who had previously expressed interest in, or received the training. This would allow existing PACCs to ensure they were making the most of the work of previous PACCs in their area, and help to ensure that the programme was able to build momentum over time.

> **I think it'd be helpful to have a spreadsheet of contacts because if it's been going on for that long, there should be a spreadsheet of contacts per region. And I don't think that would be that hard to put together from the PACCs that we've already had, and that would be a really good starting point for the new PACCs.**
> PACC, Nurse

More broadly, many PACCs reflected on the amount of admin time required in order to arrange sessions. PACCs sometimes felt that this was not a good use of their time as clinicians, and that they did not have the required skillsets to market the training effectively. In recognition of this barrier OHID provide PACCs with a range of marketing tools (including flyers, template emails and template tweets) to support PACCs with marketing activities. However, there remained a suggestion that it would be more efficient and effective for some of this administration – particularly that which is not reliant on personal contacts – to be carried out centrally.

> **Everyone's touched on the difficulty of getting sessions booked and the admin that goes alongside it. Although we do get some admin time funded, I just don't feel it's a very good use of my time as a clinician. And you really need somebody who's got that skill in marketing to advertise it because it's just really difficult.**
> PACC, GP

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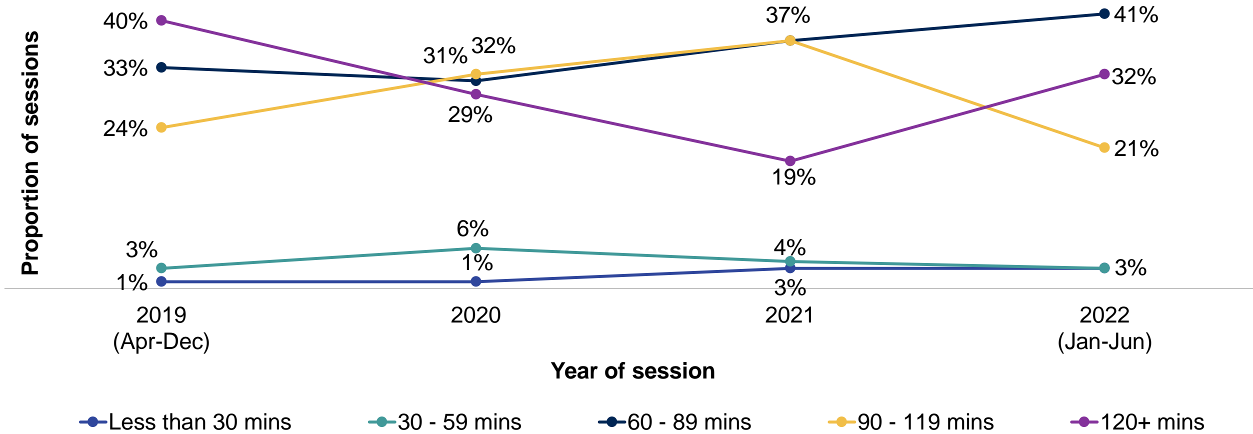
Length of PACC training sessions delivered

The reduction in capacity resulting from the Covid-19 pandemic is reflected in the length of training sessions that were delivered throughout Phase 2. As shown in Figure 2.3, prior to the pandemic in 2019, 40% of training sessions lasted 120 minutes or more. However, this proportion fell to 29% in 2020 and to 19% in 2021. Over the same period, there were corresponding increases in shorter sessions, lasting 60-89 minutes, and 19-119 minutes.

Figure 2.3: Length of Phase 2 PACC training sessions by year



Source: Ipsos analysis of OHID monitoring information relating to 826 training sessions conducted between April 2019 and June 2022.

In focus groups, PACCs reflected on the challenges associated with securing longer training sessions with HCPs. They also explained that delivering the training content within shorter sessions could be challenging. Often PACCs found it necessary to limit the amount of time spent on topics that are covered later in the presentation, such as the motivational interviewing content. PACCs suggested that this could be detrimental to the impact of the training, as the motivational interviewing content was seen as a key component.

> **It's really difficult to get people to commit to the amount of time we need to give the presentation. So, there is a limited amount of time to get through the presentation, and the slides that are around brief intervention and motivational interviewing don't always get the level of interaction that I personally feel is needed.**
> PACC. General Practitioner

Positively, data from the first six months of 2022 indicates that the trend towards shorter training sessions has begun to reverse. Since 2021, the proportion of training sessions lasting 120 minutes or more has increased from 19% to 32%.

Geographic spread of sessions

The PACC training programme aims to serve all regions of England. Table 2.1 presents the breakdown of Phase 1 and Phase 2 training sessions by NHS England region. In Phase 2, the proportion of sessions is highest in the Midlands, and lowest in the South West and East of England.

Table 2.1: Proportion of PACC training sessions by NHS England region

Region	Phase 1	Phase 2
East of England	15%	6%

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London	14%	12%
Midlands	15%	23%
North East and Yorkshire	15%	19%
North West	21%	19%
South East	12%	12%
South West	9%	9%
Total	**100%**	**100%**

The distribution of sessions across regions broadly corresponds to the distribution of PACCs across the regions. Table 2.2 presents the number of PACCs in each region of England. This shows that the North East and Yorkshire, London, and the Midlands have the highest PACC coverage, while the East of England, the South West, and the South East have the lowest. OHID has recently recruited additional PACCs in these areas to create a greater balance across the regions.

Where there seem to be inconsistencies between the number of PACCs in a region and the number of sessions, this may be related to a particularly high level of Covid-19 related hospitalisations in the region. For example, the North East and Yorkshire saw extremely high levels of hospitalisation in the first wave of the pandemic, which is likely to have particularly suppressed the number of sessions the 10 PACCs in the region were able to deliver.

Table 2.2: Distribution of PACCs by NHS England region

Region	Doctor	Nurse/Midwife	AHP	Total
East of England	2	0	0	2
London	3	0	4	7
Midlands	2	3	1	6
North East and Yorkshire	6	2	2	10
North West	2	2	1	5
South East	0	0	1	1
South West	0	2	0	2
Total	**15**	**9**	**9**	**33**

For the PACC training programme to meet OHID's aims to reduce health inequalities, the geographic distribution of sessions should be weighted towards regions with the highest levels of deprivation. To explore this, analysis of deprivation associated with the postcodes of training venues has been conducted.

Figure 2.4 presents the breakdown of Phase 2 training sessions by the Index of Multiple Deprivation (IMD) quintiles. Although the locations of training session venues are slightly skewed towards areas of higher deprivation, these areas are still underrepresented (16% compared with 20% of small areas in England). This may indicate that the programme could be more effective at reaching HCPs working in areas of high deprivation. However, it should be noted that the level of deprivation associated with a training venue is an imperfect proxy for the level of deprivation of patients that HCPs serve.

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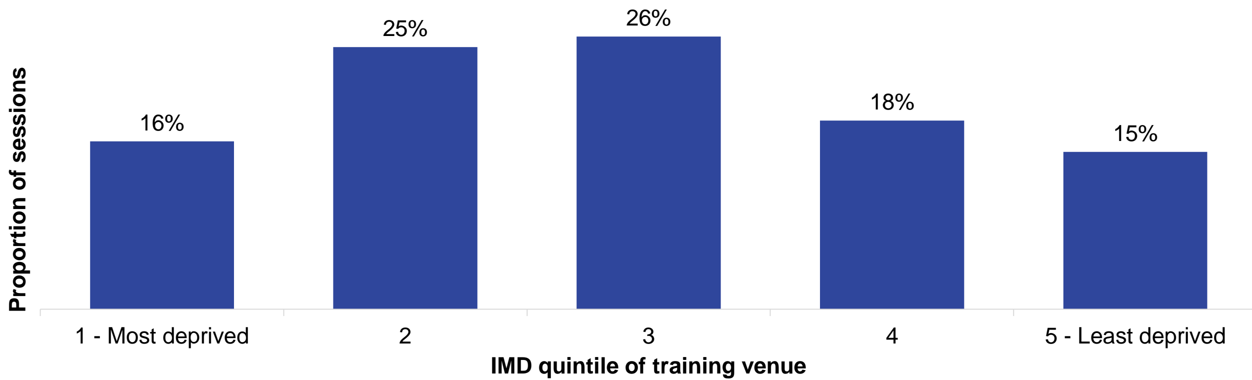
Figure 2.4: Proportion of training sessions delivered in each IMD decile according to the location of the training venue



Source: Ipsos analysis of OHID monitoring information relating to the 681 training sessions conducted between April 2019 and June 2022, for which IMD data was available.

Number of HCPs who received PACC training

During Phase 2 of the PACC training programme, between April 2019 and June 2022, OHID monitoring data indicates that 15,836 HCPs[1] received PACC training. A mean of 406 HCPs were trained per month during Phase 2. As shown in Figure 2.5, the number of HCPs trained per month peaked from January to February 2020, prior to the pandemic, before falling dramatically as the programme was paused.

As mentioned, the workforce pressures resulting from the Covid-19 pandemic led to drastically reduced capacity among HCPs to attend training for a large part of Phase 2. Throughout the qualitative research with HCPs and PACCs, participants reflected on effect of the workforce pressures on reducing the number of HCPs who attended sessions.

> **Quite a few people said they were interested. But on the day itself, with the time pressures, I would say not a lot of people could attend. But there were still maybe a good ten people who attended the session.**
> HCP, Dietician

[1] Including both registered and trainee HCPs.

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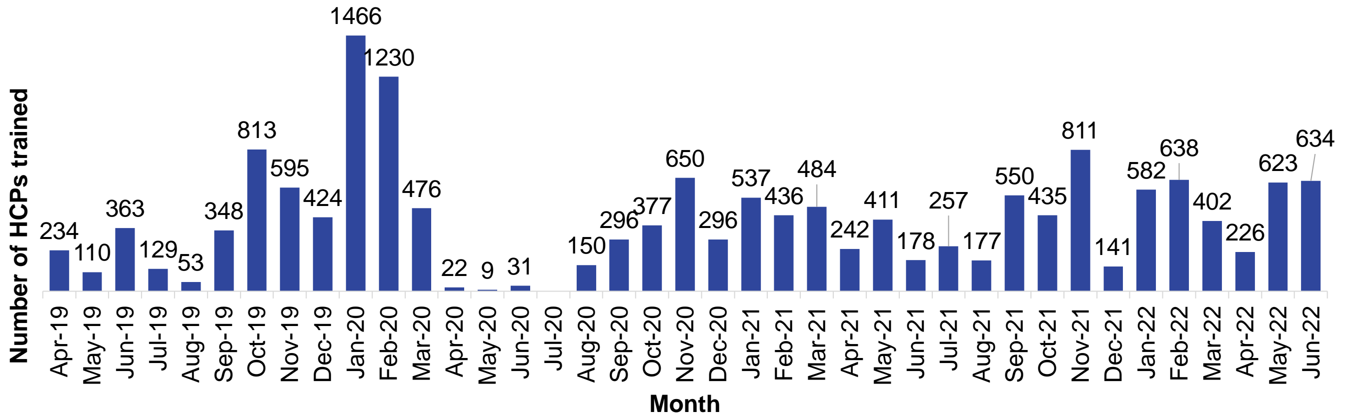
Figure 2.5: Number of HCPs who received PACC training per month



Source: Ipsos analysis of OHID monitoring information relating to 826 training sessions conducted between April 2019 and June 2022.

In addition to the 15,836 HCPs trained during Phase 2, 3,151 non-HCPs were also trained. These include, for example, social prescribing link workers, assistant practitioners, and mental health practitioners. Although non-HCPs fall outside of the objectives of the programme, and are therefore outside the scope of this evaluation, this demonstrates the breadth of professionals that the training is reaching.

In the focus groups, PACCs reported that they felt the opportunity for non-HCPs to attend the sessions was valuable. Not only did PACCs feel that these individuals had a lot to gain from the training, but they also felt that having attendees with diverse professional experiences enriched the sessions, making them more valuable for all attendees.

> **She'd also invited some social prescribers, which was actually really good because they brought something else to the session as well. While they weren't knowledgeable about the whole physiology bit, that didn't bring down the session in any way. I think the mix of people really helped.**
> PACC, Nurse

Characteristics of HCPs who received PACC training

HCP role

Table 2.3 shows the number of HCPs trained by role. Registered and trainee doctors accounted for 42% of the attendees, while registered and trainee nurses and midwives accounted for 28%, and AHPs (here taken to include physiotherapists, psychologists, dieticians and occupational therapists) accounted for 25% of HCPs trained.

In comparison to NHS Digital Workforce data, these figures indicated that doctors are over-represented among attendees (42% compared with approximately 19% of the workforce), nurses and midwives are under-represented among attendees (28% compared with 53% of the workforce), while AHPs are about proportionally represented (25% compared with approximately 24% of the workforce)[2].

[2] Workforce comparisons are taken from NHS Workforce Statistics (March 2022). The statistics include NHS Hospital and Community Health Services staff working in NHS Trusts and CCGs in England but exclude primary care staff.

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This imbalance may reflect the distribution of PACCs across the roles. For example, almost half of the PACCs (15 of 33) are doctors, which could potentially increase the relative number of doctors being targeted to attend the training. Recruiting more PACCs from nursing backgrounds may be the most effective way of increasing the representativeness of the HCPs that receive PACC training. OHID have undertaken a recent round of PACC recruitment (June/July 2022) and offered positions to 18-20 new PACCs. Fewer nurses applied for the role though four have been offered positions.

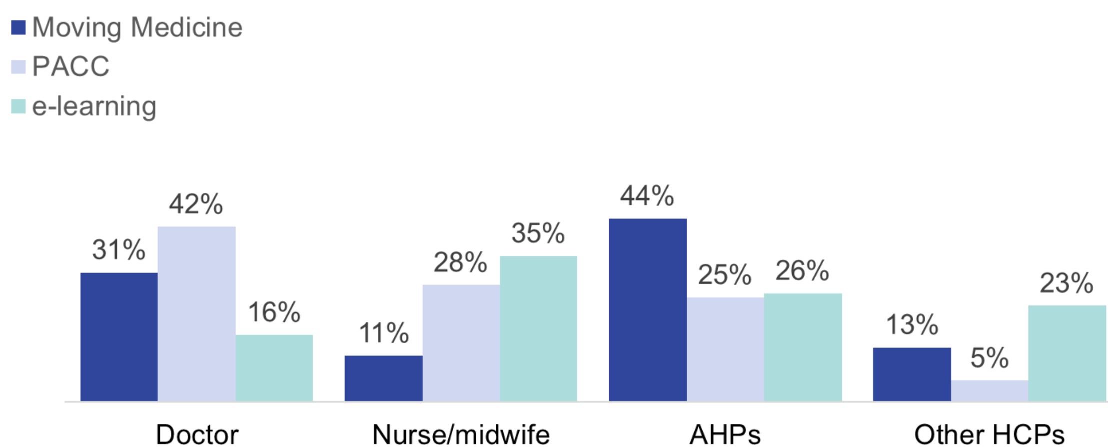
Table 2.3: Number of HCPs trained by role

Role	Registered	In training	Total
Doctors	21%	21%	42%
Nurses and midwives	16%	11%	28%
AHPs	15%	10%	25%
Pharmacists	1%	*%	1%
Healthcare assistant	3%	1%	4%
Total	56%	44%	100%

Source: Ipsos analysis of OHID monitoring information relating to 826 training sessions conducted between April 2019 and June 2022.

PACC training appears to target a different profile of HCPs compared to Moving Medicine and the HEE e-learning modules (see Figure 2.6). PACC is used predominantly by doctors, whilst Moving Medicine most commonly attracts AHPs, and the HEE e-learning modules attract nurses/midwives. Note, a high proportion of users of the HEE e-learning modules are non-HCPs which are not shown in the chart below. 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 e-learning profile data are more reliable as they are based on audit/monitoring data of attendees and users.

Figure 2.6: 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

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Focus groups with PACCs provided additional insight into the representation of different groups of HCPs within the sessions. For example, a number of PACCs reported that they had struggled to engage HCPs who work exclusively with children and young people either because these HCPs did not think the training was sufficiently tailored to their needs, or because the HCPs did not feel that physical activity was a priority for their patients.

> **I've had some feedback from various people that they think the training isn't so relevant to people who work with children and young people. And I've really tried to say, 'No, it's a life course approach. It's totally relevant'.**
> PACC, Nurse

PACCs also highlighted that they felt HCPs in training were a particularly important group to engage, and that they were particularly receptive to the training (as reflected in the numbers of HCPs in training who have participated).

> **I think having a focus on unqualified or students can be really important and a bit of a missing link really and bridging that gap and helping bring training into practice from the ground upwards.**
> PACC, Nurse

HCP's physical activity levels

Figure 2.7 details the number of days in the previous week that PACC attendees reported in the baseline survey having done at least 30 minutes physical activity of at least moderate intensity[3]. Just under one in three attendees (31%) performed moderate intensity physical activity on five or more days. However, over two thirds (69%) of attendees, were physically active on fewer than five days.

The low level of physical activity among attendees has a number of implications for the workstream. Firstly, it is a further indication that the training is not just attracting those who are already advocates of physical activity, but a broader pool of professionals. This is likely to reflect that the training is frequently delivered to whole teams at a time. Unlike Moving Medicine and the HEE e-learning modules therefore, it is not reliant on individual HCPs being motivated to seek out information on promoting physical activity to patients.

Secondly, it indicates that the programme has the potential to indirectly increase professionals' own levels of physical activity, as well as increasing their patients' levels of physical activity.

[3] Note, these figures include professionals other than HCPs who completed the baseline survey

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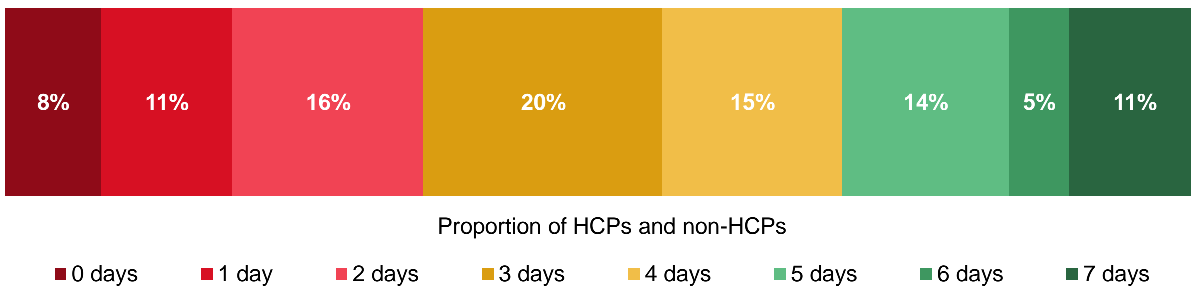
Figure 2.7: In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate?



Source: Ipsos analysis of 2,250 baseline survey responses from PACC training attendees between April 2021 and April 2022.

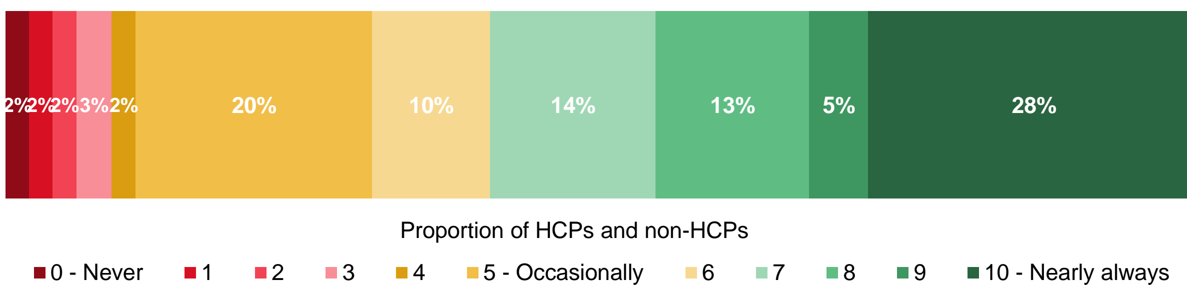
HCP's physical activity promotion practices

In the baseline survey, attendees were asked on a scale of 0 to 10 how often they promote physical activity to their patients who have, or are at risk of developing, long-term conditions (with 0 being 'never' and 10 being 'nearly always').

As shown in Figure 2.8, more than one in four (28%) said they 'nearly always' do this, rating the maximum of 10 out of 10[4]. Additionally, nearly one in five (18%) attendees rated themselves as 8 or 9. This suggests that around two in five (46%) PACC training attendees are already promoting physical activity to their patients on a regular basis.

However, more than half (54%) of attendees rate themselves as 7 or lower for how often they promote physical activity to their patients, which suggests that a large proportion of attendees who attend the PACC training could promote physical activity to their patients more often. This is a positive finding as it suggests that the workstream is accessing those attendees for whom the training will have the greatest impact.

Figure 2.8: On a scale of 0 to 10, how often, if at all, would you say you promote physical activity to your patients who have, or are at risk of, long-term conditions?



Source: Ipsos analysis of 2,250 baseline survey responses from PACC training attendees between April 2021 and April 2022

In contrast to the above, users of Moving Medicine and the HEE e-learning modules are more regularly promoting physical activity to their patients. Of those using Moving Medicine, 60% rate themselves 10

[4] Note, these figures include professionals other than HCPs who completed the baseline survey

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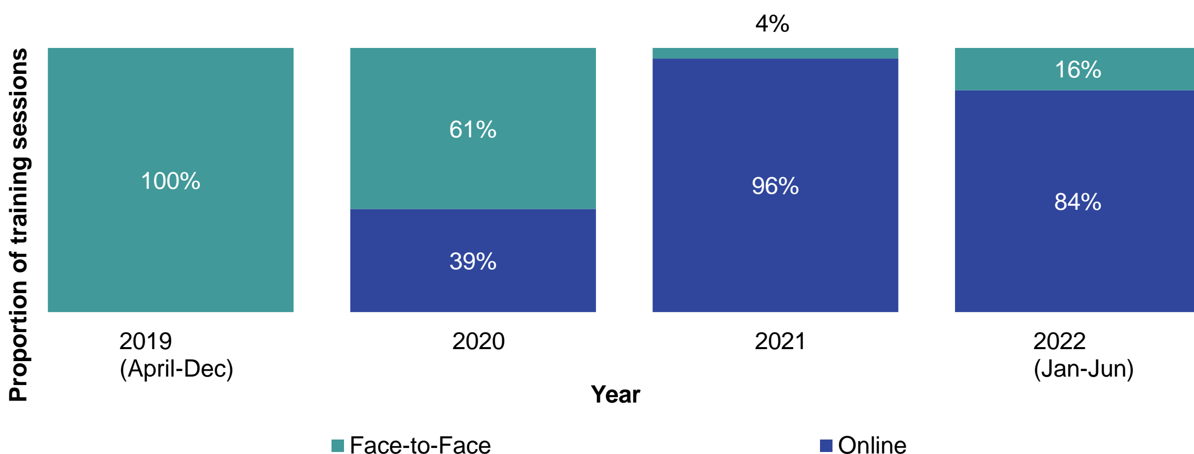
out of 10 to mean they 'nearly always' promote physical activity to their patients, with 49% of HEE e-learning module users saying the same. To provide a more direct comparison to these resources, data from the follow-up PACC survey has been analysed. This shows that 30% of PACC attendees say they 'nearly always' promote physical activity to their patients – much lower than for Moving Medicine and the HEE e-learning modules.

Among attendees who completed the survey, there is a significant positive correlation ($r(2{,}074) = .41$, $p < .001$) between attendees' frequency of promoting physical activity, and attendees' knowledge of physical activity. Among those with advanced knowledge, 78% rate themselves as 10, indicating that they nearly always promote physical activity to their patients. This may indicate that the focus of the training should be to target those with lower knowledge levels, who are less likely to promote physical activity frequently. For example, among those who 'know the basics', just 14% rated themselves as a 10.

Suitability of the online delivery model

Delivery of PACC training sessions transitioned to an online model in September 2020 as a result of the Covid-19 pandemic. More recently, in October 2021, delivery has moved to a hybrid model, in which both online and face-to-face training are available. However, although there has been a slight return to face-to-face delivery since the hybrid approach was introduced, the vast majority (84%) of training sessions delivered in 2022 have been delivered online (see Figure 2.9).

Figure 2.9: Delivery mode of PACC training sessions by year



Source: Ipsos analysis of OHID monitoring information relating to 826 training sessions conducted between April 2019 and June 2022.

Attendees' experiences of online PACC training

Feedback from attendees who completed the follow-up survey, indicates that online delivery of the training has been well received. Well over half (57%) of the attendees strongly agreed that the course content was suited to online delivery, while almost a further third (32%) tended to agree. Only four per cent of attendees disagreed.

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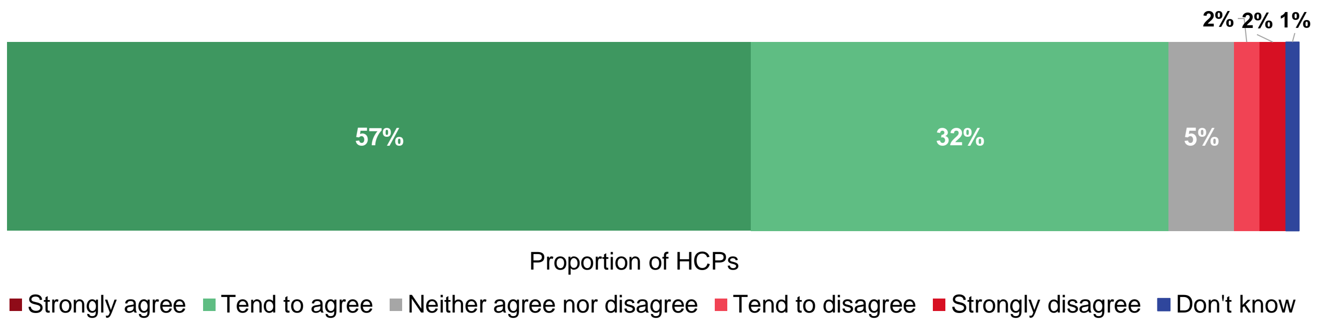
Figure 2.10: To what extent, if at all, do you agree or disagree with the following statements about the PACC training session you attended? The course content was suited to online delivery?



Source: Ipsos analysis of 263 follow-up survey responses from PACC training attendees between May 2021 and June 2022.

The qualitative in-depth interviews with PACC attendees reflected these findings. Attendees reported that online delivery of the training worked well because it was supported by a strong slide deck, and skilled PACCs who delivered the training in an engaging manner.

There were also practical benefits of online delivery for HCPs. This was particularly the case where members of the team worked in the community, or where there were limited physical spaces suitable for training.

> **We've not got much space in the office, so it can be difficult to get a group of people together. And we've got dietitians in another location as well, so they're not all based in Sunderland. It's just a bit easier to get people together, so I think online is good.**
> HCP, Dietician

Some attendees suggested that encouraging attendee interaction with online training is more challenging than with face-to-face training. Again, however, the skill of the PACCs delivering the training was praised in this respect. There were also concerns that some attendees may have found it more challenging to ask questions online than they would have face-to-face. It was suggested that informal mechanisms to allow questions, whether through the chat function or email after the session would be beneficial.

Despite positive feedback about the online delivery of the training, in the ten in-depth interviews conducted with HCPs, the majority expressed that if they had a choice, they would prefer face-to-face delivery. This was because it was seen to encourage greater levels of engagement, as well as interaction, both between the trainer and attendees and amongst attendees.

> **I thought it was perfectly good enough over Zoom. I think in person it would have been better as it would have been easier to engage and ask questions.**
> Obstetrician

Furthermore, when asked for suggestions for how the training could be improved, several follow-up survey participants commented that they felt the training would have benefited from being face-to-face, particularly because this would have allowed some more in-depth discussion among colleagues and with the trainer.

PACCs' experiences of delivering PACC training online

Focus groups with PACCs revealed a range of implications of online delivery; some of which were positive and some of which were more challenging. Positively, some PACCs mentioned that, due to the

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reduced need to travel and the ability to convene groups of professionals working in different locations, virtual training has enabled PACCs to reach a wider group of HCPs.

> **The fact that it's online is brilliant because you can reach teams that are mixed. It doesn't necessarily have to be one team, based in one place. You can reach a range of people, which can mean that the way you deliver it and who you advertise to is much more flexible.**
> PACC, AHP

However, reflecting points raised by HCPs, many PACCs reported that it was more challenging to facilitate engagement and interaction with attendees during online delivery. This was particularly where attendees did not have video cameras enabled throughout the training session. As a result, some PACCs reported that they preferred delivering sessions face-to-face.

> **I have found it really hard. We've always been told to encourage them to have their videos on, otherwise it's a little bit like talking to yourself. Sometimes, if they're a quiet group, you can't really gauge how it's landing.**
> PACC, Doctor

> **I've enjoyed doing the face-to-face sessions. I've not done that many, but when I have, it's probably more enjoyable because you can get better interaction and more eye contact and speak to people afterwards. So, I think I probably enjoy the face-to-face sessions a bit more.**
> PACC, Doctor

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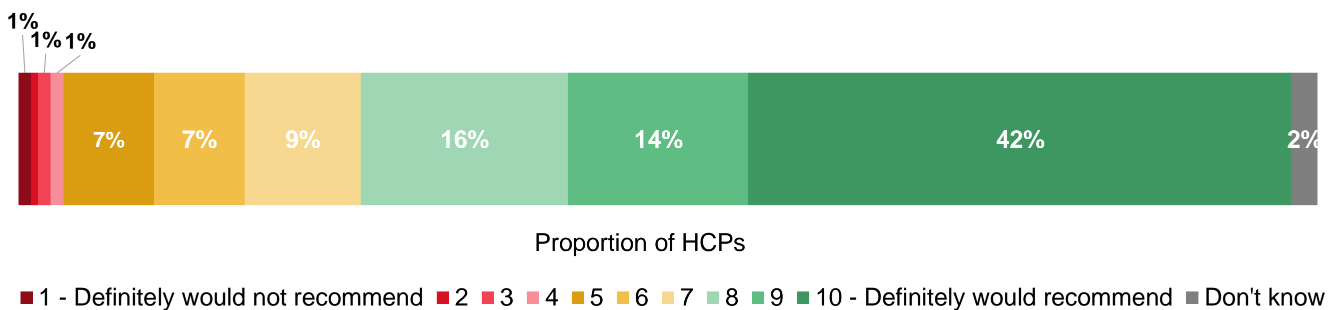
3 HCPs' experiences of receiving the PACC training

The evaluation assumes that, in order for the PACC training to have its intended short-, medium- and long-term outcomes, the training must provide attendees with clear, relevant content that is delivered in an engaging manner. In the follow-up survey, attendees were asked a range of questions about their experience of participating in the training session. Findings from this survey, along with the in-depth interviews, demonstrate that the content and delivery of the training is very positively received.

Reflecting this positivity, as shown in Figure 3.1, most attendees are likely to recommend the training to other HCPs. When asked to rate their likelihood of recommending the training on a scale of 0 to 10, the average advocacy rating was 8.43, with 56% giving an advocacy rating of 9 or 10. On average, nurses gave slightly higher advocacy ratings (8.51), than doctors (8.42), and AHPs (8.31)[5].

Figure 3.1: On a scale of 0 to 10, how likely or unlikely are you to recommend the PACC training to other healthcare professionals?



Source: Ipsos analysis of 263 follow-up survey responses from PACC training attendees between May 2021 and June 2022.

In the in-depth interviews, a number of attendees reported that they had recommended the training to colleagues or other connections. There was, however, lack of clarity about who the training was available for, and how it could be arranged. More readily available information about the training – for example through a webpage – may help ensure that where the training is recommended to HCPs, it is easy for these HCPs to arrange a session.

> **"I have actually mentioned it to a couple of GPs, just saying how useful it was. I didn't know that they could arrange it for themselves because the only time I've had it has been as part of a bigger group."**
> GP trainee

Comparing across the MHPP workstreams, the proportion of HCPs who demonstrate high levels of advocacy regarding PACC training (42% rating ten out of ten) is comparable advocacy towards e-learning resources (for which 37% give an advocacy rating of ten). However, while high, this level of

[5] It should be noted that this sub-group analysis is based on low sample sizes; 38 doctors, 42 nurses and 83 AHPs, and so is indicative only.

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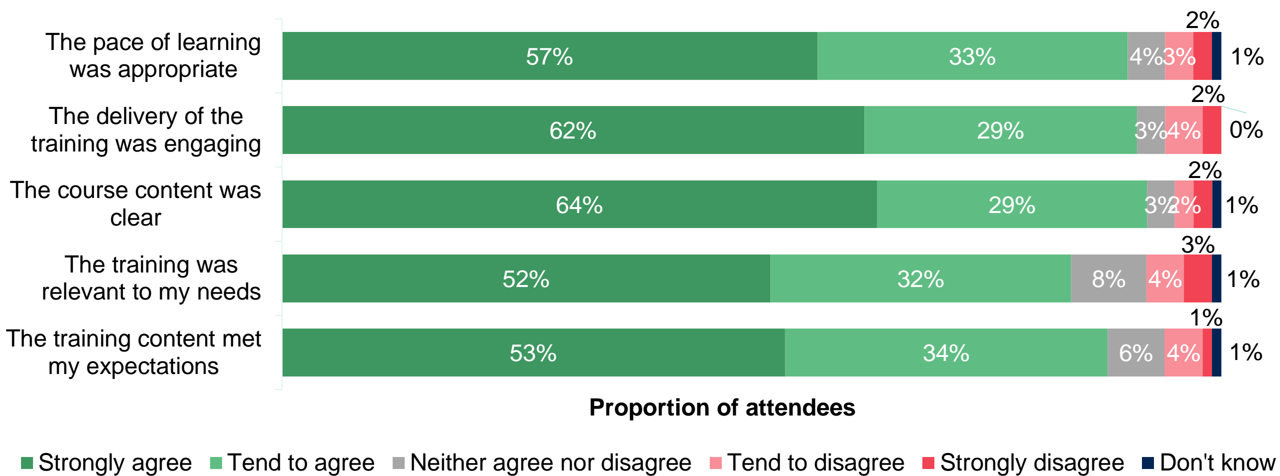
advocacy does not approach the level of advocacy seen in relation to the Moving Medicine website, which almost two in three (63%) gave an advocacy rating of ten[6].

PACC training content

The vast majority of attendees were positive about the content of the training; 87% agreed that it met their expectations, and 93% agreed it was clear (see Figure 3.2).

Figure 3.2: To what extent, if at all, do you agree or disagree with the following statements about the PACC training session you attended…?



Source: Ipsos analysis of 263 follow-up survey responses from PACC training attendees between May 2021 and June 2022.

The in-depth interviews with HCPs revealed that attendees found the evidence-based approach used within the training particularly useful. Specifically, the quality and recency of the evidence that was presented gave it additional impact. The extent to which the evidence resonated with attendees was reflected in anecdotes about how they had used the evidence in conversations with patients. For example, a number of attendees reported that they had found evidence relating to the positive impact of short periods of physical activity, or "movement", particularly useful when speaking to very in-active patients.

> **The trainer said there was new evidence that even one-minute increments of physical activity have benefits. So, I've been using that the whole time since. And people are like, "really?" So, anybody can do one minute and you can build on that.**
> Diabetes dietician

> **I thought it was really comprehensive. I thought the most useful thing was there were loads of statistics like, 'it reduces X percentage of hypertension'. Stuff like that is really useful for patients because they need to conceptualise how beneficial this is for them.**
> Obstetrician

The success of the evidence-based approach was also recognised in the focus groups with PACCs, who noted that attendees found the evidence enjoyable and interesting. These findings emphasise the importance of ensuring the evidence presented in the training slides is as up-to-date and as impactful as

[6] It should be noted that these findings are based on relatively small base sizes of 104 survey completions for the e-learning resources and 70 survey completions for the Moving Medicine resources.

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possible. OHID is currently undertaking a thorough review of the evidence presented within the slides, as part of a wider review of the training slides, to ensure that this is the case.

> **Generally, feedback from people who've attended the sessions has always been that they've enjoyed the data and the statistics.**
> Lead PACC

In the follow-up survey, attendees were asked for suggestions of how the training could be improved. In contrast to views expressed in the interviews, a minority of attendees mentioned that they felt there was too much focus on evidence in the training session.

> **Too much time spent on "preaching to the converted" with interminable slides of research studies and statistics. I didn't need all that.**
> Follow-up survey participant, Social prescriber

Instead, attendees mentioned that they would have welcomed additional tailoring to specific patient groups (to be tailored to the audience), more focus on resources available within the local area, and more case studies and practical advice on how to engage patients in conversations about physical activity. In response to this feedback, as part of a recent review of the PACC training slides, OHID has placed an additional focus on how to have conversations with patients.

> **The training was generic. Perhaps further training for specific patient groups would be more useful, and some focus on what is available in the local area.**
> **I recall a lot of statistics at the beginning - interesting but not vital for a short training session**
> Follow-up survey participant, Nurse

> **I would have liked more in-depth training, for example more skills or techniques training for complex cases- this could be via discussion of case studies or from presenter's experience.**
> Follow-up survey participant, Psychologist

Relevance and usefulness of PACC training

A high proportion of HCPs agree that the training was relevant to their needs (84%), with seven per cent disagreeing with this statement (see Figure 3.1). This may be linked to a finding from the in-depth interviews with attendees that some of the content of the training was familiar to many attendees. As discussed later in this report, the survey data also suggests that those with existing knowledge, skills and confidence relating to the promotion of physical activity gained less from the training than those with no existing knowledge, skills and confidence. This suggests that the training may currently be too basic for those with existing knowledge of the benefits of physical activity. As mentioned above, the follow-up survey responses suggested a demand for the slides to be more tailored to specific patient groups. Furthermore, some attendees mentioned that they would like to have heard more about the biological mechanisms underlying the importance of exercise.

> **I thought it was a little bit too basic. I know it was aimed at medical professionals to try and promote the health of and exercise of individuals so I would have liked to hear more of the science behind it and more evidence perhaps, just to really support it.**
> Diabetes nurse

Despite these concerns, the majority of attendees found the training to be useful. When asked to rate how useful they found the training for their own practice on a scale of 0 ('not at all useful') to 10 ('extremely useful'), attendees gave an average rating of 7.9, with 41% scoring it 9 or 10. However, 12%

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gave a score of 5 or lower, and analysis of score by role indicates that nurses (average score of 8.0) and AHPs (average score of 7.5) found the training less useful than doctors (average score of 8.3)[7].

In the in-depth interviews, HCPs reported a number of valuable lessons for their practice that they had taken from the training. These included a better understanding of the benefits of physical activity for a range of health conditions, an appreciation for how even small increases in physical activity each day can lead to positive outcomes, and how patients with comorbidities and pain can still be recommended suitable activities to encourage movement. Some of the HCPs interviewed expressed an appreciation for the tools and examples the training provided them with including objective data that they could discuss with patients.

> **It's given me more tools to talk to patients and given me more examples to use. And it's made me more confident too… It is an awkward topic to broach but when you see the statistics it makes you think 'yes, this is a really important thing for me to talk about'.**
> Obstetrician

Several attendees also reflected that they had found the advice to refer to 'movement' rather than 'physical activity' when speaking with patients particularly useful. Those who had incorporated this advice into their practice reported that it had both made them more confident when raising the subject with patients, and improved patients' receptivity.

> **I think what really helped me, is the advice to just call it movement rather than exercise, because that can be really off-putting for people. Now I really put the emphasis on making people aware that any kind of movement is good, any kind of movement can have a beneficial effect on mental health and wellbeing.**
> Mental health nurse

PACC training delivery

Attendees' views about how the training was delivered were positive. The vast majority agree that the delivery of the training was engaging (91%) and that the pace of learning was appropriate (91%), see Figure 3.1. These findings were reflected in the interviews with attendees, who consistently commented on the skills of the PACCs who delivered the training.

> **I think the main strength is how easy it is to absorb. It was very well presented and engaging, and it was inspiring as well.**
> Trainee GP

The fact that all PACCs are HCPs was seen to contribute to the credibility of the training, and thereby increase its impact. However, in the focus groups, PACCs reported that the desire for a match between the attendees' profession and the PACC's profession – both from the host and from the PACCs themselves - had occasionally caused barriers to booking sessions. However, they emphasised the value that is brought to the training by having it delivered by a range of professions to their peers.

> **The presenter being an HCP definitely made a difference. The issue of credibility in training is a crucial one. To understand and influence behaviour, you need credibility.**
> Consultant adult psychiatrist

[7] It should be noted that this sub-group analysis is based on low sample sizes; 38 doctors, 51 nurses and 83 AHPs, and so is indicative only.

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It's also worth reinforcing that actually, it's quite helpful having a mixture of health professionals. Sometimes people are quite indignant, and they really don't want someone who's not a medic to run the sessions.
PACC, Nurse

In the follow-up survey, there were several comments from participants that the training had felt rushed. As mentioned earlier in the report, the length of time allocated to training sessions has decreased throughout Phase 2 of the programme. These findings indicate that, where possible, PACCs are supported in encouraging session organisers to arrange longer sessions.

We attended a 1 hour session but there was still lots to cover, and this felt a little rushed. Perhaps either set 90 minutes as a minimum duration or slightly refine what topics to cover in a 60 minutes session.
Follow-up survey participant, Allied health professional

Follow-up training and community of practice

OHID has been considering ways in which to build on the current model of PACC training. These options were discussed as part of the interviews to assess appetite for such changes.

All interviewees felt that some sort of follow-up to the training would be beneficial. For some, a simple repeat of the training would be sufficient as they recognise the benefit of being reminded of best practice. Others welcomed a modified version of the training – such as one which looks more broadly at other lifestyle issues alongside physical activity (such as smoking or obesity), or one which included more scenario-based examples (such as how to respond to patients that are unwilling to be more physically active as a result of their pain). One participant was not supportive of a follow-up training session as such but felt they could have been set targets or encouraged to commit to working with a number of patients to put into practice what they had learnt at the training.

Maybe once a year to remind people and act as a top up. Because otherwise you might forget it. If I had the same talk in a year's time, I think I could still benefit from it.
Obstetrician

It would have been quite nice to set us some targets, or some sort of plan to implement and see how we got on with it and follow up on it.
Diabetes dietician

Stakeholders of the MHPP programme explained that when the training was initially developed there was an aspiration to build a community of practice; with PACCs encouraging training attendees to join the community of practice.

The original vision is that the PACCs would, as they trained people, would sign them up to a kind of virtual group and they would meet that virtual group on a kind of monthly basis or have some form of newsletter or way of engaging them. But the original idea was that the PACCs weren't just about training they were also about keeping a network of people that were trained.
MHPP stakeholder

When tested with HCPs, the idea of a community of practice was less well supported, principally due to the limitations of time available to HCPs to actively participate in such a community. That said, some of the attendees could see the value of having something (whether it be a community or not) to act as a reminder and prompt of what they had learnt at the training, such as a mailing list.

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I don’t know, maybe an email list where you’re sent updates. With the way doctors are with little time, so many logins to sign into… I think it’s too much. I think just people being sent follow-up information and leaflets, things like that [would be helpful].
Obstetrician

If I've got maybe specific questions, it might be good to have a community to ask. Or if people share resources and things, it would be good to keep updated with all that is out there.
Diabetes dietician

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4 Evidence of short-term outcomes

This chapter explores whether there is evidence that the PACC training results in the anticipated short-term outcomes for HCPs. These outcomes for HCPs focus on increased capability, opportunity, and motivation to promote physical activity to patients living with or at risk of developing long-term conditions. As such, the relevant questions that the evaluation seeks to answer around short-term outcomes are:

- Does the PACC training increase HCP's capability to promote physical activity to patients?
- Does the PACC training increase HCP's opportunity to promote physical activity to patients?
- Does the PACC training increase HCP's motivation, including confidence, to promote physical activity to their patients?

Primary outcomes

The short-term outcomes for the PACC training, as stated in the evaluation logic model (below), are for HCPs to have **increased capability, opportunity, and motivation** to advocate physical activity to patients. It is theorised that increased capability, opportunity and motivation are required for behaviour change to occur. The concepts of capability, opportunity and motivation in this context are defined below:

- ***Capability*** to advocate physical activity to patients at risk of or living with long-term conditions: this includes elements of psychological capability, such as awareness and understanding of the importance of physical activity among HCPs, and physical capability such as having the skills to advocate physical activity to patients.
- ***Opportunity*** to advocate physical activity to patients at risk of or living with long-term conditions: this includes environmental opportunity to use knowledge and skills in the way intended such as interaction with 'inactive' patients, and social opportunity, such as having a supportive team or colleagues that also see the value in physical activity for inactive patients. The programme also assumes HCPs will have the time and resource to be able to deliver support.
- ***Motivation*** to advocate physical activity to patients at risk of or living with long-term conditions: this includes moving beyond awareness and understanding to believing in the overall value and intended impacts of advocating physical activity to inactive patients. It also includes HCPs having the confidence to engage in conversations with patients about physical activity as confidence affects motivation.

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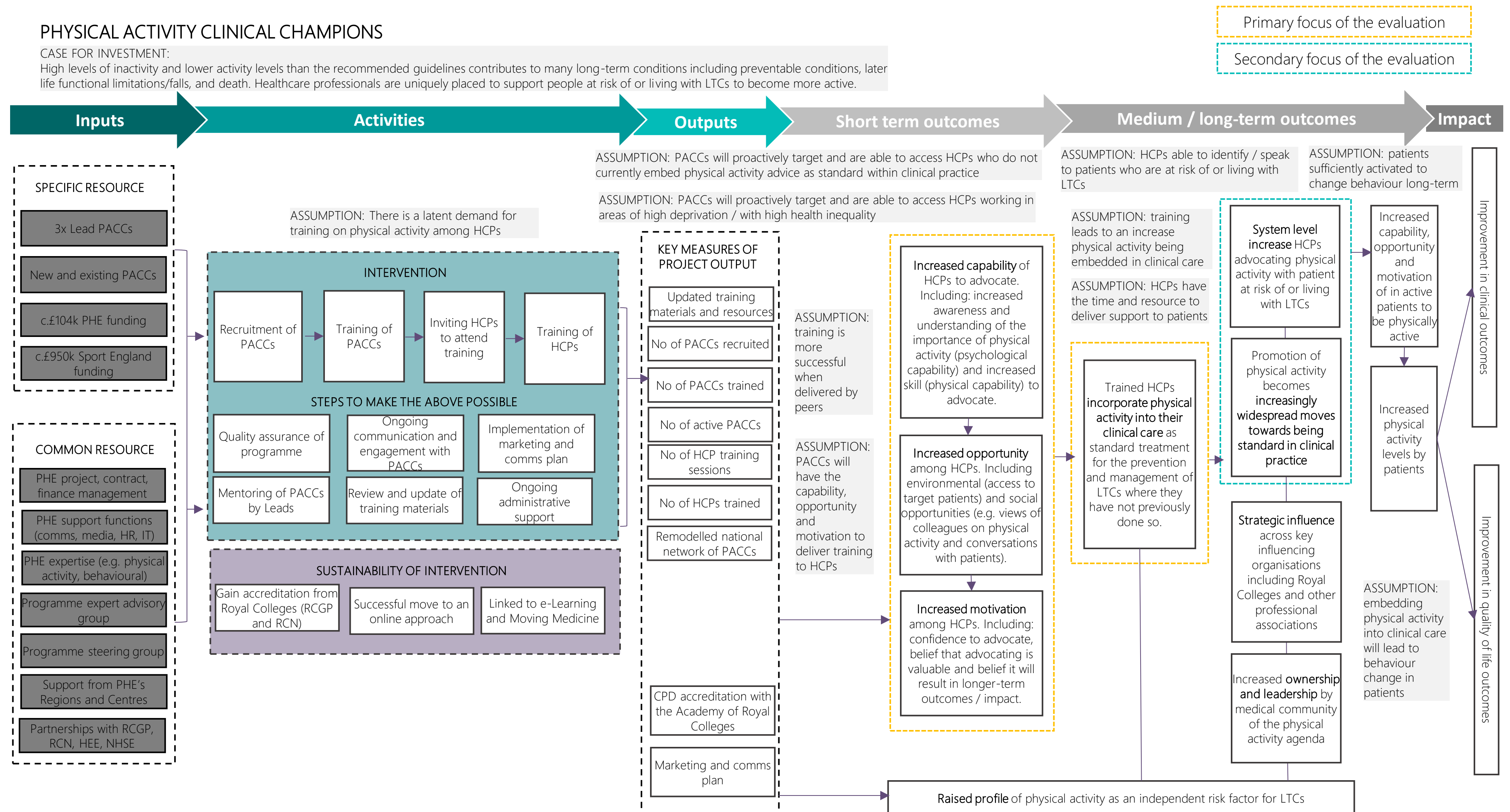
Figure 4.1: PACC evaluation logic model



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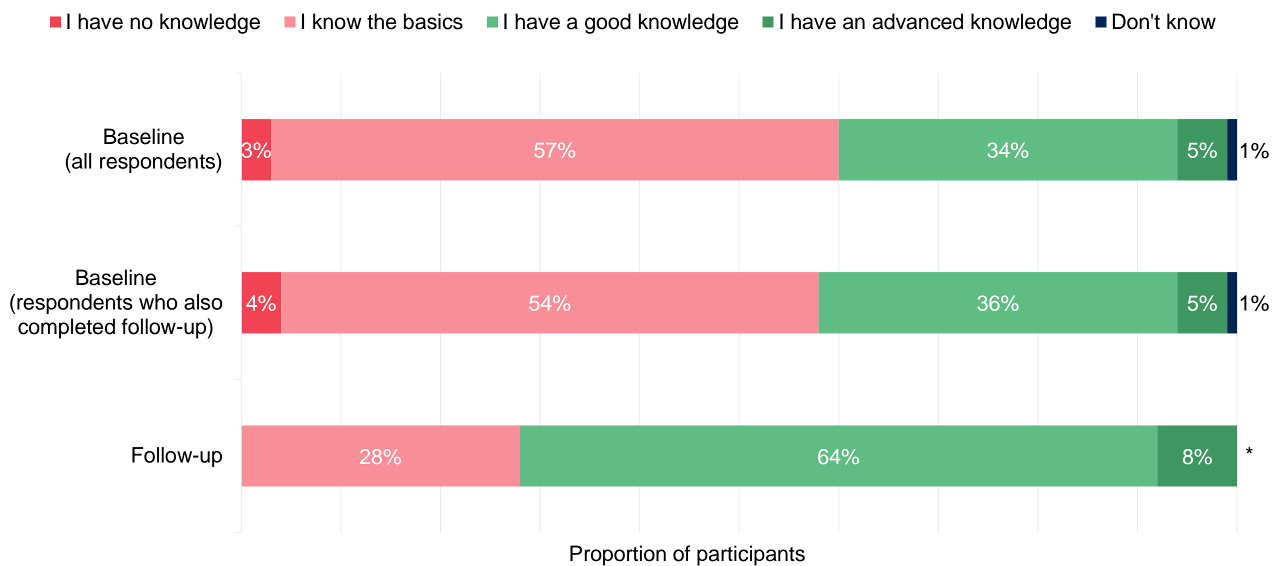
Evidence of increased capability following PACC training

The evidence suggests that, overall, the training improves attendees' knowledge, skills and confidence relating to physical activity promotion (though this is not the case for every participant). Based on the evaluation logic model it is theorised that these increases should support behaviour change to occur. Improvements are particularly notable among attendees who have low baseline levels of knowledge, skills, and confidence prior to the training.

Impact of PACC training on HCP's perceived knowledge

Prior to the training, just over half (54%) of attendees who complete the follow-up survey reported that they knew the basics, and around two in five (41%) reported that they had good or advanced knowledge of how to promote physical activity to patients (Figure 4.2). After the training, these proportions reverse; the majority (72%) who complete the follow-up survey have good or advanced knowledge, and fewer than one in three (28%) report that they know the basics. No attendees report that they have no knowledge of how to promote physical activity to patients after the training (a decrease from 4% prior to the training). These changes are all considered statistically significant.

Figure 4.2: How would you rate your knowledge of how to promote physical activity to patients?



Base: 2,250 (baseline) and 263 (follow-up) PACC attendees who completed the survey (including HCPs and other roles)[8]

An asterisk (*) in the charts throughout represents a value of less than one half or one percent, but not zero.

Comparing responses to the baseline and follow-up surveys at an individual participant-level (263 respondents) shows that fewer than half (43%) of attendees have greater knowledge after the training than they did before the training (Figure 4.3). Attendees who had only a basic level of knowledge ("I know the basics") about promoting physical activity were particularly likely to have experienced an increase in knowledge following the training (79%).

A larger proportion of attendees (51%) reported no change in their perceived knowledge after the training. Again, many of these attendees reported having a basic or good level of knowledge before the training. This may indicate that the content of the training is not sufficiently advanced to make attendees

[8] Note, data is shown here for all participants to the baseline survey (2,250) as a point of comparison, though it is not discussed in the text.

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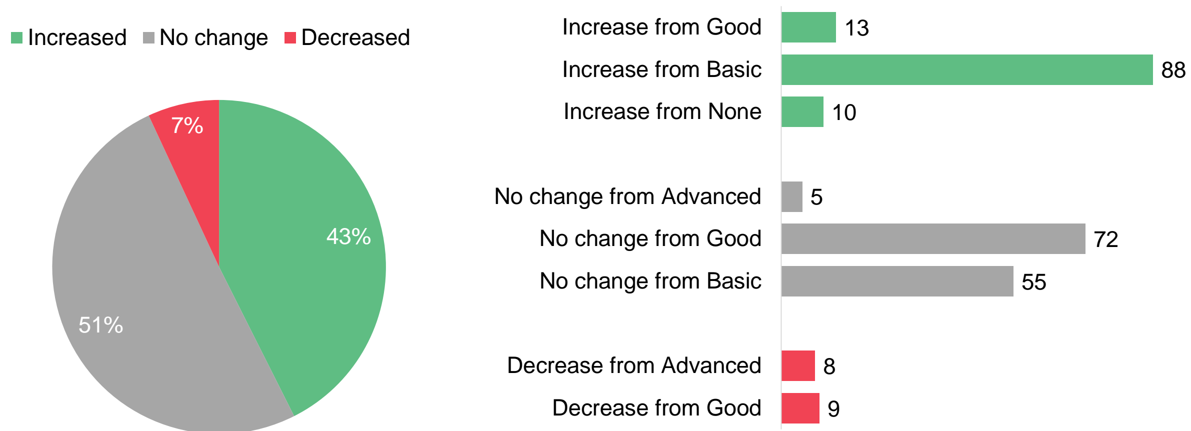
with existing knowledge feel there has been a substantive improvement in their knowledge. As noted earlier in this report, and corroborating this finding, some of the HCPs that were interviewed mentioned that they had felt the content was too basic. Furthermore, when asked about barriers to promoting physical activity in the follow-up survey, a range of attendees expressed concerns that they did not know which types of exercise were appropriate for those with long-term conditions.

> **Sometimes their condition prevents me from knowing what is an appropriate form of exercise for them (e.g., heart condition and bedbound).**
> Follow-up survey participant, Psychologist

A small proportion (7%) of attendees reported a decrease in knowledge following the training. For these attendees, it may be the case that the training highlighted gaps in their understanding which made them re-evaluate their knowledge levels. Within the focus groups, some PACCs recognised this dilemma.

> **I think there's something to do with HCP's expectations when they come to the training. They think they actually know about it, but when we've delivered the training, they probably realise that they didn't.**
> PACC, AHP

Figure 4.3: How would you rate your knowledge of how to promote physical activity to patients? (analysis of change from pre to post-PACC training)



Base: 260 PACC attendees who completed the baseline and follow-up survey (including HCPs and other roles), excluding those who said 'don't know' at either baseline or follow-up.

Impact of PACC training on HCP's perceived skill

Of those who completed both surveys, more than two in three (69%) attendees reported that they were either very or somewhat skilled prior to the training (Figure 4.4). Around one in three (31%) reported that they were not very or not at all skilled.

Following training there was a statistically significant increase in the proportion that reported being very or somewhat skilled (90%) and a statistically significant decrease in the proportion that reported being not very or not at all skilled (10%).

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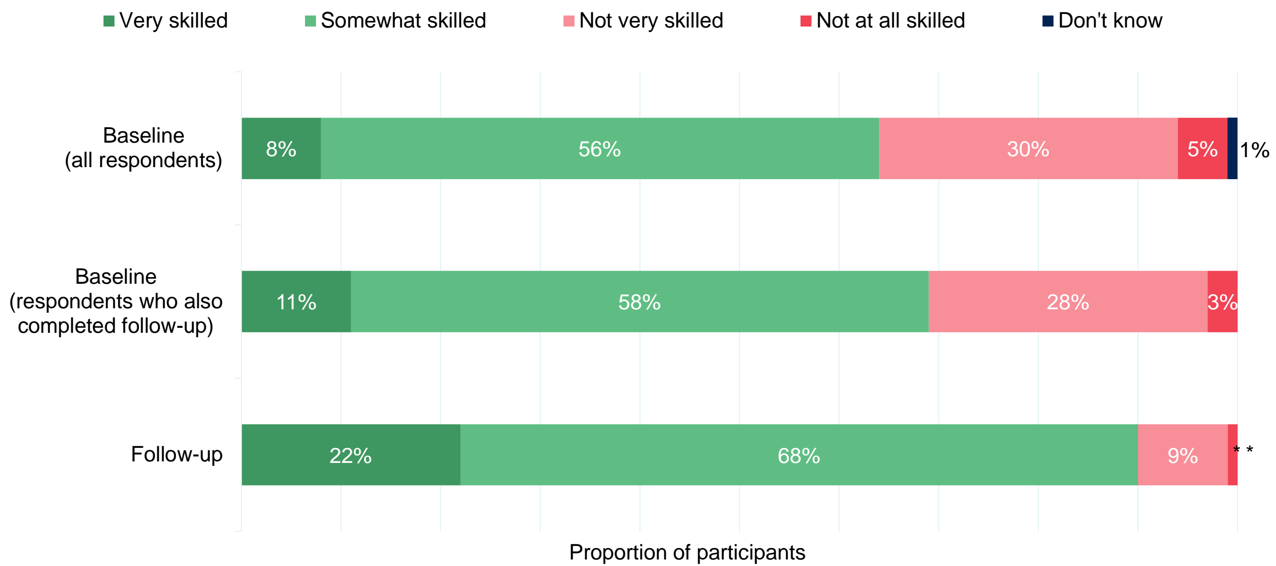
Figure 4.4: How skilled, if at all, do you feel at promoting physical activity to patients?



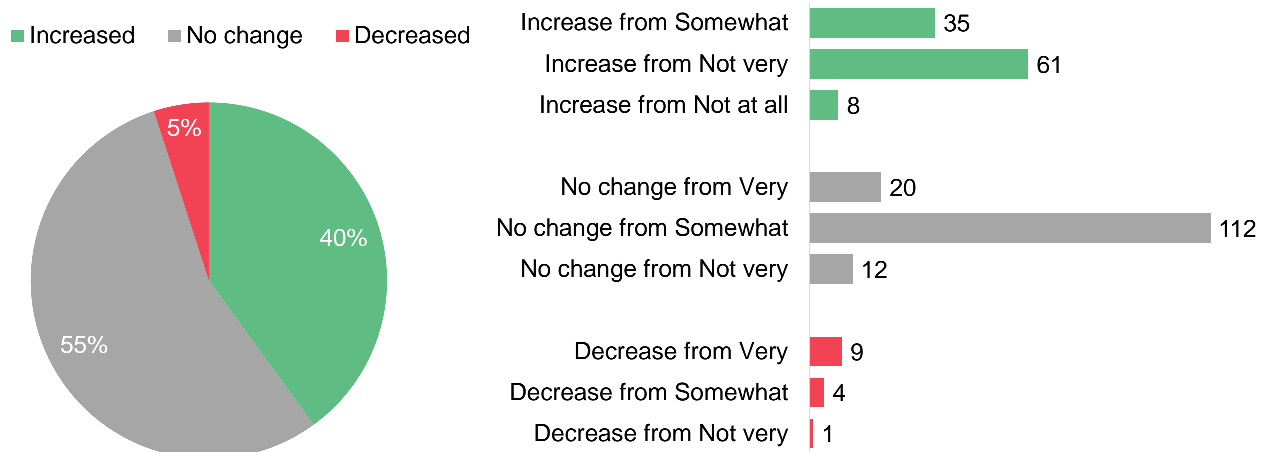
Base: 2,250 (baseline) and 263 (follow-up) PACC attendees who completed the survey (including HCPs and other roles)

Comparing individual participant's responses to the baseline and follow-up surveys (Figure 4.5) shows that two in five (40%) attendees report having higher skills after the training than they did before the training. A large proportion of the attendees who displayed an increase in skills had reported that they were not very skilled prior to the training.

The largest proportion of attendees (55%) however, reported that there was no change in their skills after the training. Of these attendees, the majority had said that they were already somewhat skilled prior to the training. As was the case with knowledge, this may indicate that the content of the training is not focused correctly to make attendees with existing skills feel there has been a substantive improvement in their skills.

A small minority (5%) of attendees report having worse skills after the training than they did before the training. As was the case with knowledge, it is possible that the training highlighted gaps in these attendees' skills which made them re-evaluate their own skill levels.

Figure 4.5: How skilled, if at all, do you feel at promoting physical activity to patients? (analysis of change from pre to post-PACC training)



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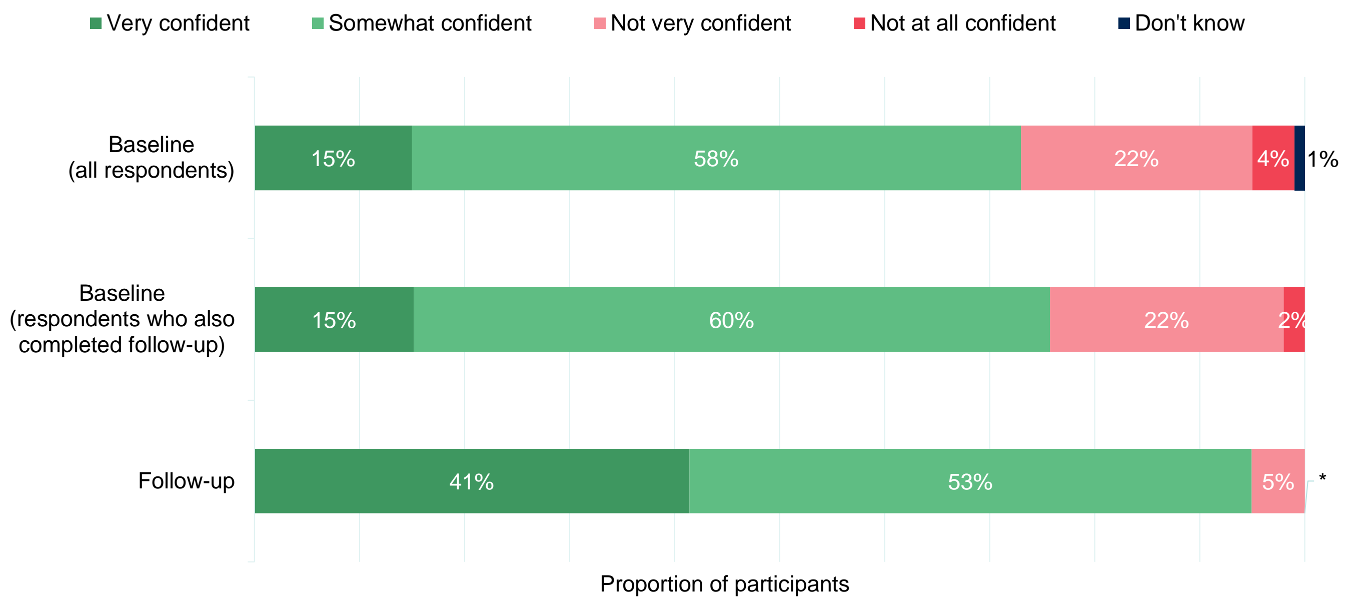
Base: 262 PACC attendees who completed the baseline and follow-up survey (including HCPs and other roles), excluding those who said 'don't know' at either baseline or follow-up

Impact of PACC training on HCP's perceived confidence

A similar story emerges with regards to confidence in promoting physical activity to patients. Prior to the training, around three in four (75%) attendees who completed the follow up survey were very or somewhat confident (Figure 4.6). This increased to 94% of attendees following the training. Conversely, the proportion of patients who were not very or not at all confident decreases from 24% prior to the training to 5% after the training (with no attendees reporting that they are not at all confident after the training). These changes were statistically significant.

Figure 4.6: How confident, if at all, do you feel promoting physical activity to patients?



Base: 2,250 (baseline) and 263 (follow-up) PACC attendees who completed the survey (including HCPs and other roles)

Comparing individual participant's responses to the baseline and follow-up surveys (Figure 4.7) shows that almost half of attendees (47%) reported higher confidence after the training and half (48%) report no change in their confidence after the training. As was the case for both knowledge and skills, the majority of attendees who experienced no change in their confidence reported that they were already at least somewhat confident prior to the training. This again supports the theory that the training content could be better tailored to those who have some existing level of confidence in promoting physical activity.

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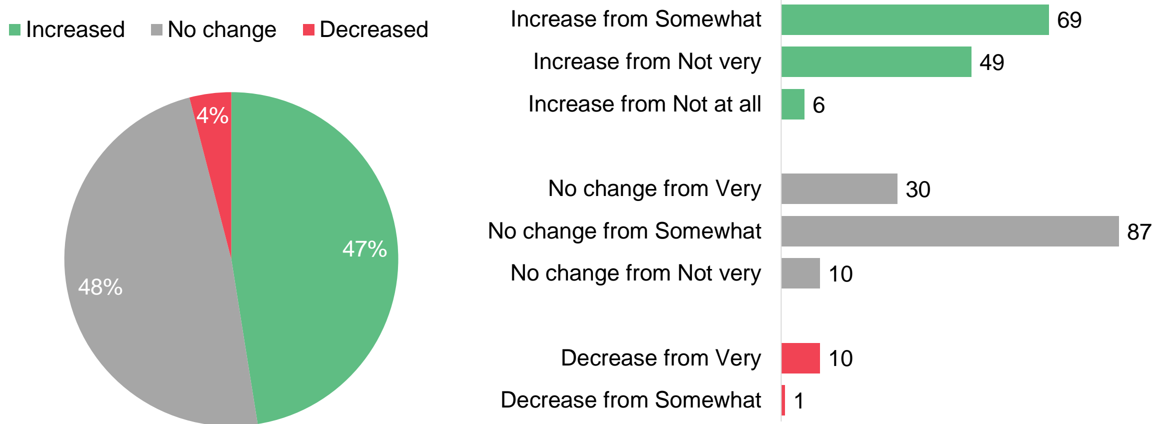
Figure 4.7: How confident, if at all, do you feel promoting physical activity to patients? (analysis of change from pre to post-PACC training)



Base: 262 PACC attendees who completed the baseline and follow-up survey (including HCPs and other roles), excluding those who said 'don't know' at either baseline or follow-up.

Overall, these findings suggest that the training is helping to improve attendees' knowledge, skills, and confidence in promoting physical activity to patients. In most cases, attendees who had low levels of knowledge, skills, or confidence before attending the training experienced a statistically significant increase in these measures following the PACC training.

However, there is a large proportion of attendees for whom the training appears to have no impact on knowledge, skills, or confidence to promote physical activity. 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 substantive pre-existing knowledge, skills, or confidence. This finding was also reflected in the focus groups with PACCs. There was feedback that a greater focus on motivational interviewing would contribute to the impact of the training. In response to this, and other feedback, OHID are currently undertaking a review of the slides, and intend to increase the amount of content with a focus on motivational interviewing. Consideration should be given to whether additional information is included in the existing slide deck or whether this should take the form of a 'part two' PACC training format given the time constraints raised in focus groups and interviews.

> **The motivational interviewing thing can be a bit rushed because it's at the end and it's actually quite a key component.**
> PACC Nurse

> **A lot of people tend to home in on the motivational interviewing skills at the end as what they're really interested in. I think if we were going to do anything differently, then there could be more hints and tips about having motivational conversations with patients. It tends to be an important part but there are actually the least slides on that.**
> Lead PACC

Evidence of increased opportunity following PACC training

Preliminary findings suggest small, though in some cases statistically significant, changes in attendees' opportunity to promote physical activity after the PACC training. These changes are apparent across attendees' abilities to identify patients who would benefit from physical activity and attendees' abilities to signpost patients to appropriate resources.

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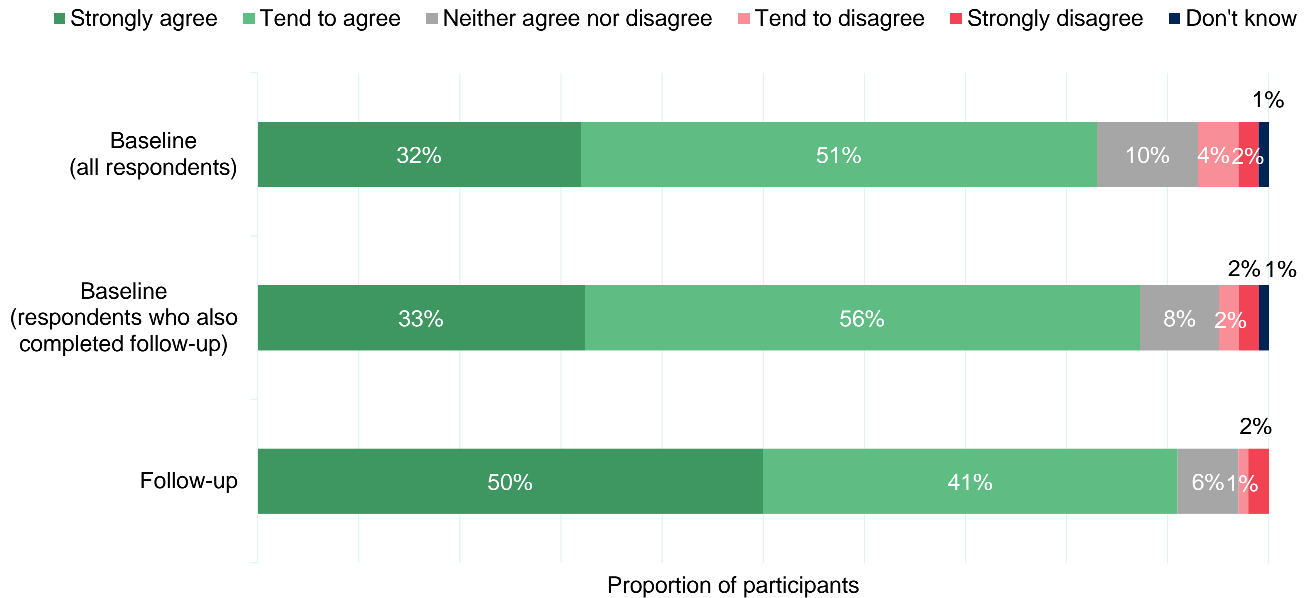
Prior to the training, the vast majority (89%) of attendees who completed the follow-up survey strongly agreed or tended to agree that they were able to identify patients who would benefit from increased physical activity. This increased marginally to 91% after the training, a change which was not statistically significant. Baseline levels of self-reported ability were already high meaning there is less room for change following the training.

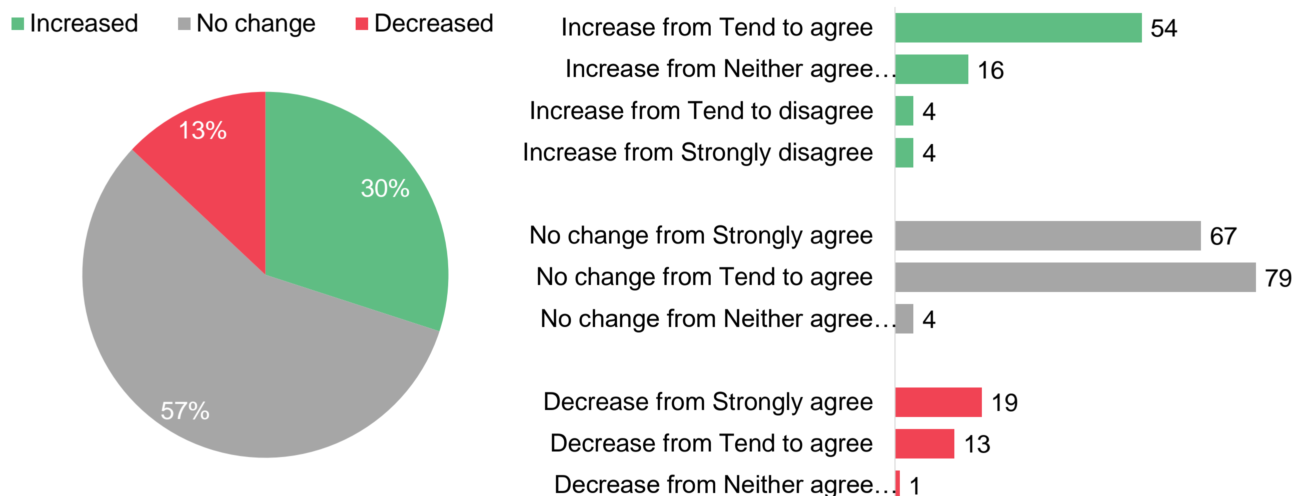
Figure 4.8: I feel able to identify patients who would benefit from increased physical activity.



Base: 2,250 (baseline) and 263 (follow-up) PACC attendees who completed the survey (including HCPs and other roles)

Comparing individual participant's responses to the baseline and follow-up surveys (Figure 4.9) shows that fewer than a third of attendees (30%) felt better able to identify patients who would benefit from increased physical activity after the training. More than half (57%) of attendees report no change in their ability to identify patients after the training. The vast majority of attendees who experienced no change agreed that they were able to identify patients prior to the training.

Figure 4.9: I feel able to identify patients who would benefit from increased physical activity (analysis of change from pre to post-PACC training).



Base: 261 PACC attendees who completed the baseline and follow-up survey (including HCPs and other roles) excluding those who said 'don't know' at either baseline or follow-up.

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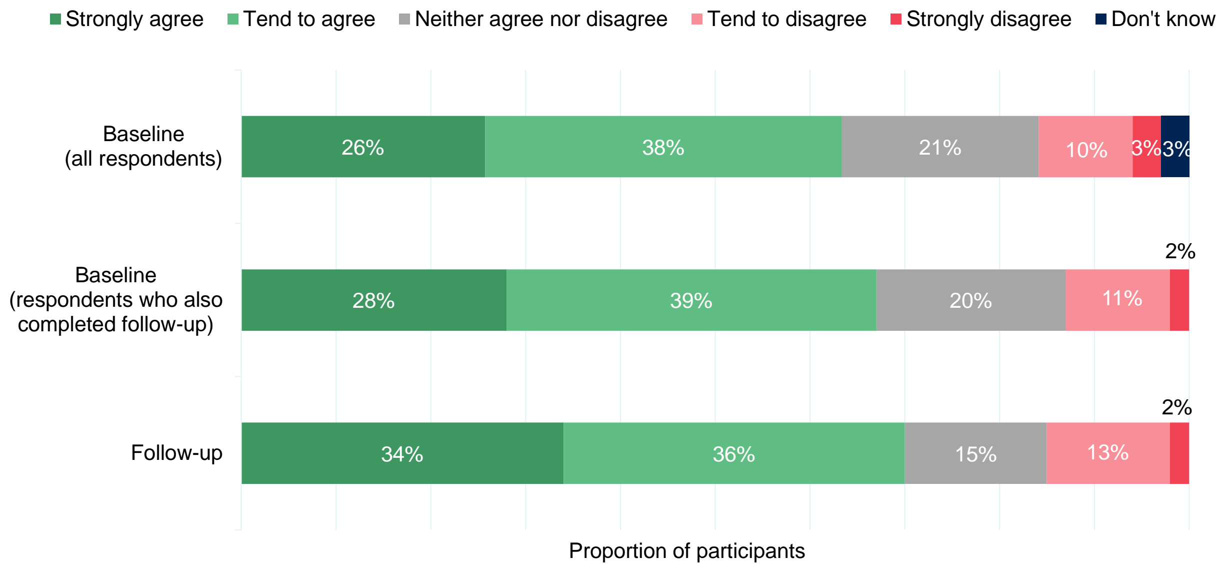
Prior to the training, around two in three (66%) attendees who completed the follow-up survey agreed that they work in a culture that supports healthcare professionals to promote physical activity to patients. Following the training, the proportion that agrees overall (70%) increased slightly, though the change was not statistically significant. It is likely that any meaningful changes to workplace culture will happen over the medium- to -longer-term. As such, it is not surprising that changes were not notable in the timeframes of the survey. Furthermore, the training does not specifically focus on cultural change within an organisation.

Figure 4.10: I work in a culture that supports healthcare professionals to have conversations with patients.



Base: 2,250 (baseline) and 263 (follow-up) PACC attendees who completed the survey (including HCPs and other roles)

Comparing individual participant's responses to the baseline and follow-up surveys shows, despite the lack of change seen in the aggregate data, at an individual level almost one in three (31%) attendees have seen improvements in physical activity culture since the training. Positively, it is not just those who had existing supportive cultures that have seen an improvement. Around one in four of those who have seen an improvement were negative about their workplace culture prior to the training (either tending to disagree or strongly disagreeing that it was supportive).

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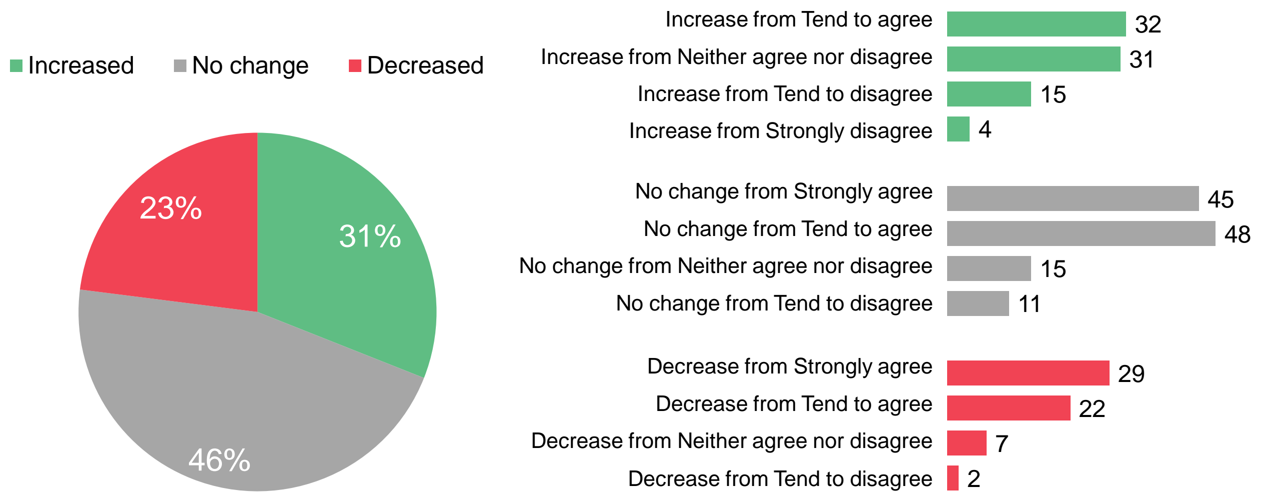
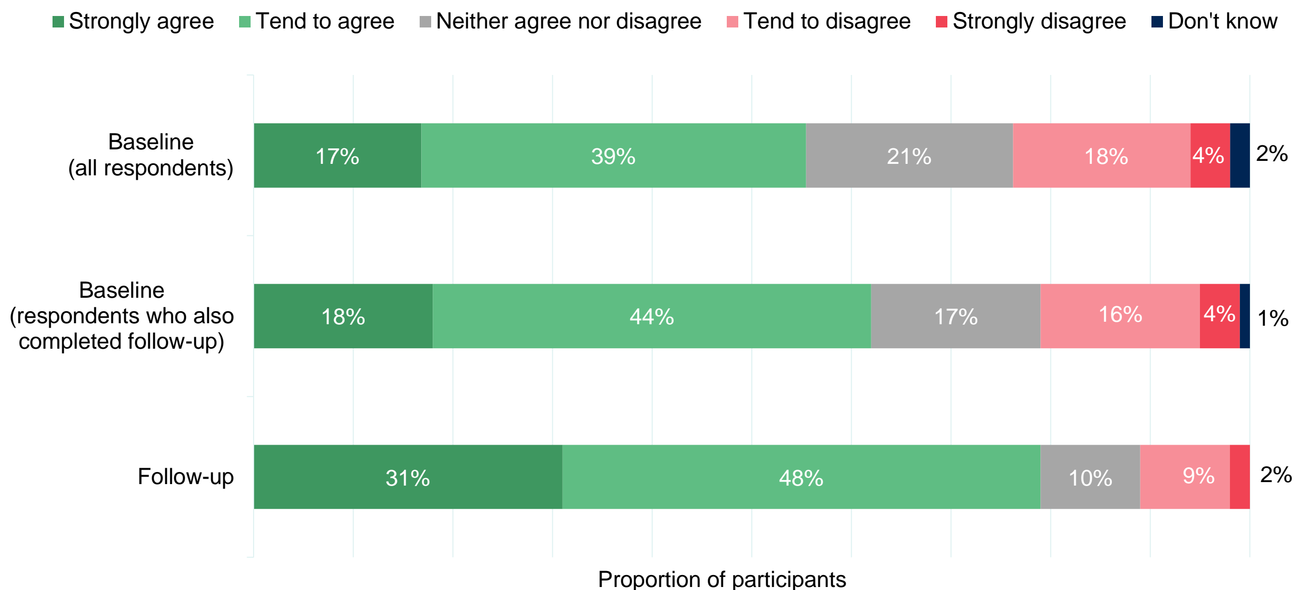
Figure 4.11: I work in a culture that supports healthcare professionals to have conversations with patients (analysis of change from pre to post-PACC training).



Base: 261 PACC attendees who completed the baseline and follow-up survey (including HCPs and other roles) excluding those who said 'don't know' to either baseline or follow-up.

Finally, prior to the training, 62% of attendees who completed the follow-up survey agreed that they feel able to signpost patients to resources that will support them to be more physically active. Following the training there was a statistically significant increase to four in five (79%) attendees.

Figure 4.12: I feel able to signpost patients to resources that will support them to be more active.



Base: 2,250 (baseline) and 263 (follow-up) PACC attendees who completed the survey (including HCPs and other roles)

Comparing individual participant's responses to the baseline and follow-up surveys shows that fewer than two in five attendees (44%) felt better able to signpost patients to resources after the training (see Figure 4.13). Just under half (45%) of attendees report no change in their ability to signpost patients after the training; most of whom agreed that they were able to signpost patients prior to the training.

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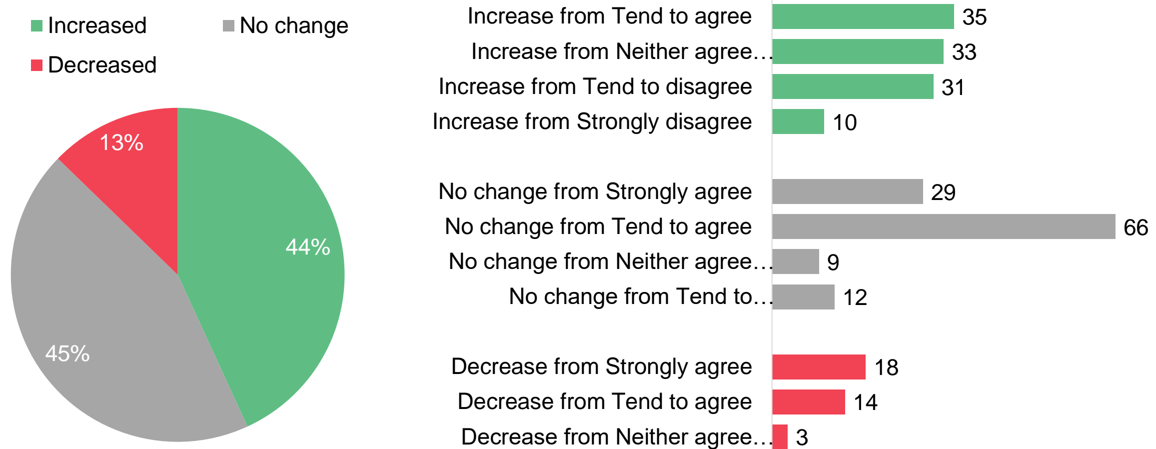
Figure 4.13: I feel able to signpost patients to resources that will support them to be more active (analysis of change from pre to post-PACC training).



Base: 260 PACC attendees who completed the baseline and follow-up survey (including HCPs and other roles) excluding those who said 'don't know' to either baseline or follow-up.

When asked to provide a free-text response on barriers to the promotion of physical activity, around 5% of attendees mentioned either a lack of resources available in the local area, or in some cases a lack of knowledge about the resources available and referral routes. This was exacerbated where patients have specific needs due to a mental or physical condition.

> **I'm unsure of local facilities for patients who require adaptive equipment or similar (I am new to the area where I work currently).**
> Follow-up survey participant, Orthotist

> **Lack of CLEAR referral routes with the various service providers especially patients with complex health problems (mental and physical).**
> Follow-up survey participant, Psychotherapist

Evidence of increased motivation following PACC training

Prior to the training, 85% of attendees who completed the follow-up survey agreed that they were motivated to promote physical activity to patients. There is some evidence that the PACC training increases the strength of motivation among attendees. Although the overall proportion of attendees who agree that they are motivated does not change statistically significantly following the training (87%), the proportion that *strongly* agrees increases from 45% to 57% after the training; a change which is statistically significant.

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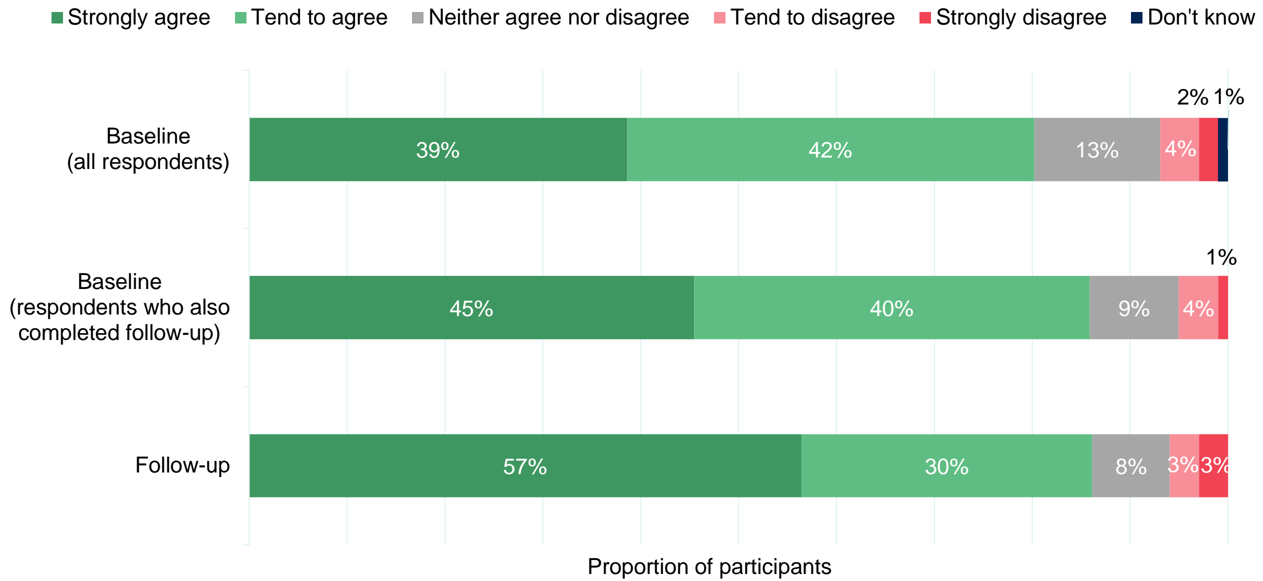
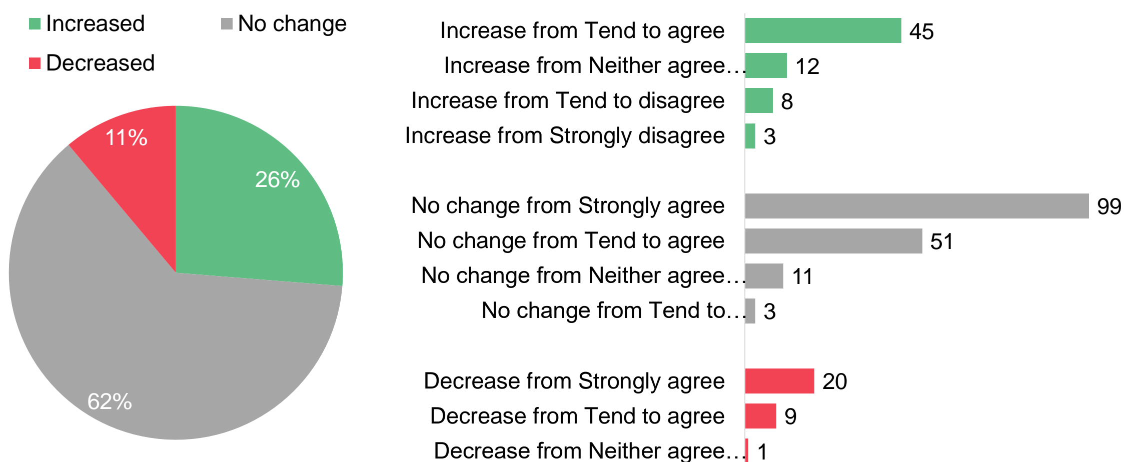
Figure 4.14: I feel motivated to promote physical activity to patients.



Base: 2,250 (baseline) and 263 (follow-up) PACC attendees who completed the survey (including HCPs and other roles)

Comparing individual participant's responses to the baseline and follow-up surveys demonstrates that the majority of attendees (62%) reported no change to their motivation after the training (see Figure 4.15). However, the majority of those for whom there was no change, 'strongly agreed' that they were motivated prior to the training. One in four (26%) attendees report increased motivation following the training; most of whom tended to agree that they were motivated prior to the training.

Figure 4.15: I feel motivated to promote physical activity to patients (analysis of change from pre to post-PACC training).



Base: 262 PACC attendees who completed the baseline and follow-up survey (including HCPs and other roles) excluding those who said 'don't know' to either baseline or follow-up.

For this motivation to translate to behaviour change, NICE evidence statement PA10 suggests that HCPs must perceive that physical activity advice will be effective. Of those who completed both surveys, four in five (82%) of the attendees agreed that promoting physical activity to patients will lead to patients being more active, with more than one in three (36%) *strongly* agreeing with this statement (see figure 4.16). Following the training, the overall proportion that agree with this statement did not change significantly (80%). Given this, it may be helpful if the training placed additional emphasis on the

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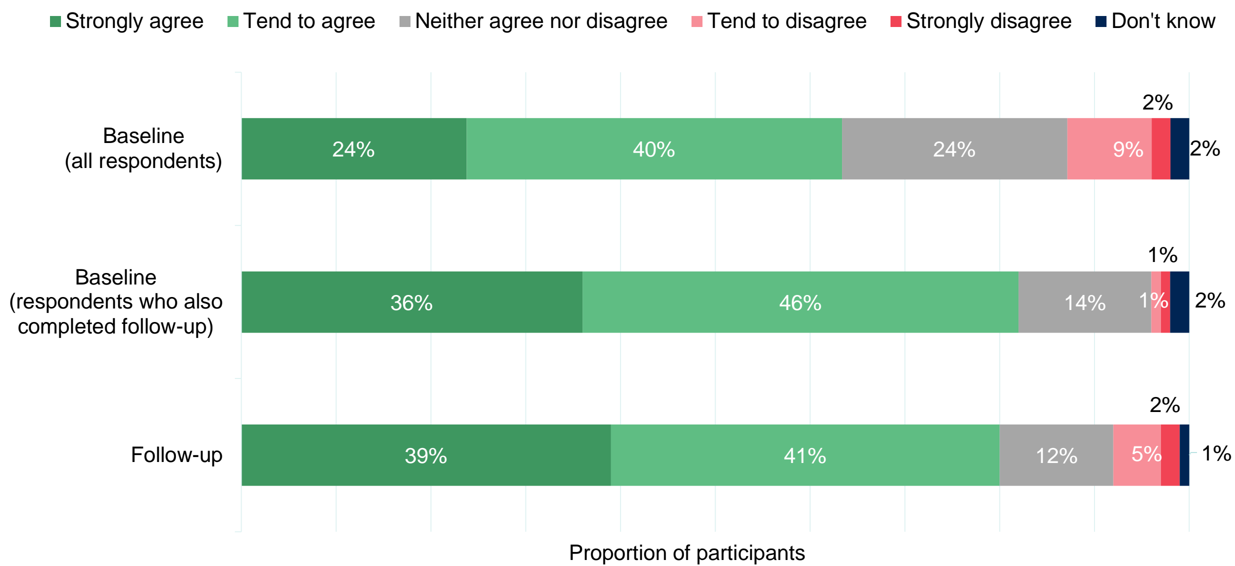
evidence regarding the efficacy of promoting physical activity to patients. Our interviews with PACC attendees revealed a number of examples where attendees' conversations with patients – guided by what they had learned in the training – had led to notable changes in a patient's physical activity levels.

> **I saw a patient with COPD and diabetes about five weeks ago. The only physical activity he was doing was going to the supermarket and cleaning the flat twice a week. I told him that even doing a minute of activity a day would make a big difference. Now he's walking around the block without stopping.**
> Diabetes dietician

Figure 4.16: Having conversations with patients about physical activity will lead to patients being more active



Base: 2,250 (baseline) and 263 (follow-up) PACC attendees who completed the survey (including HCPs and other roles)

Comparing individual participant's responses to the baseline and follow-up surveys reveals that the majority of attendees (52%) did not change their belief that conversations with patients about physical activity will lead to them being more active (see Figure 4.17). However, prior to the training, the majority of those for whom there was no change either 'tended to agree' or 'strongly agreed' that conversations about physical activity would to patients being more active. One in four (24%) attendees report lower levels of agreement following the training; most of whom strongly agreed that conversations were effective prior to the training.

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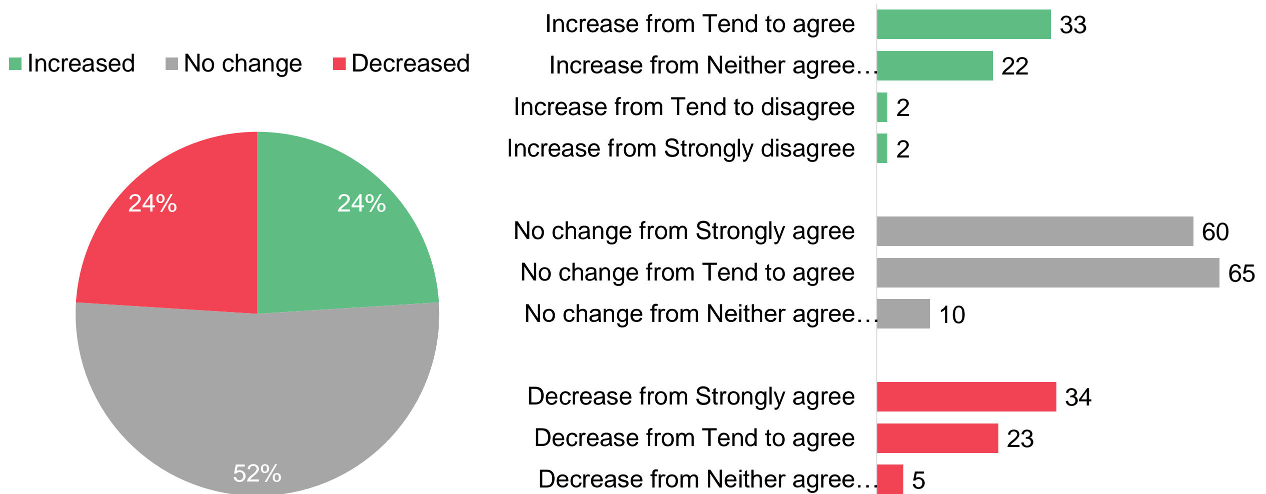
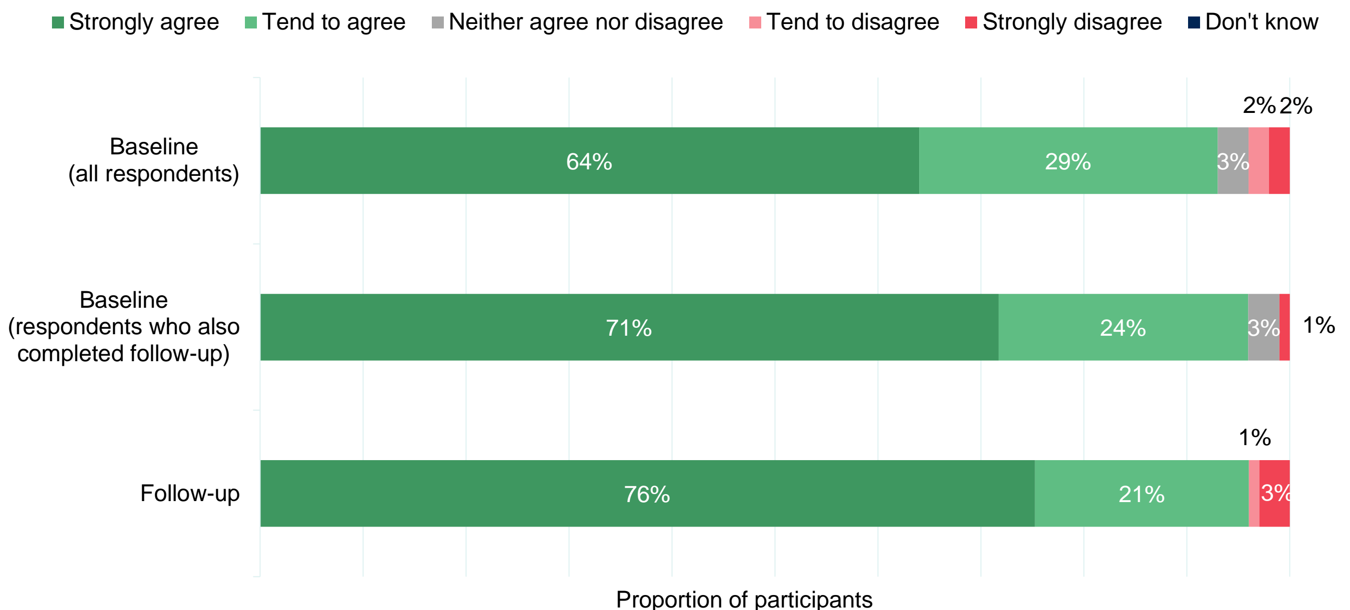
Figure 4.17: Having conversations with patients about physical activity will lead to patients being more active (analysis of change from pre to post-PACC training).



Base: 258 PACC attendees who completed the follow-up survey (including HCPs and other roles) excluding those who said 'don't know' to either baseline or follow-up.

Despite some attendees' doubts about the efficacy of giving brief advice, the majority agreed that HCPs play an important role in promoting physical activity. Of those who completed both surveys, almost all attendees (95%) agreed that HCPs play a role in educating patients around the importance of physical activity. The proportion that *strongly* agree increased from 71% prior to the training to 76% after the training. While this change is not statistically significant (given the relatively small sample size) it is indicative that the training is strengthening perceptions of the relevance of physical activity promotion to healthcare professionals.

Figure 4.18: Healthcare professionals play a role in educating patients on the importance of physical activity



Base: 2,250 (baseline) and 263 (follow-up) PACC attendees who completed the survey (including HCPs and other roles)

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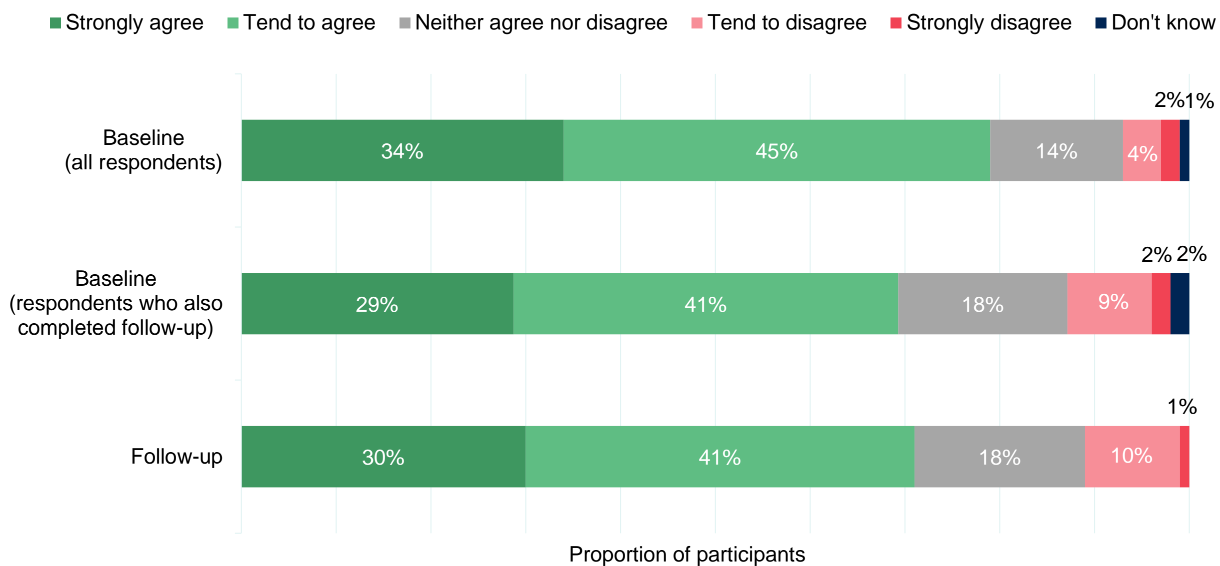
The proportion of participants who agree that having conversations about physical activity is a priority for them did not change following the PACC training (70% compared to 71%). This suggests the training does not have a significant impact on the extent to which attendees feel able to focus on promoting physical activity. Given the high level of motivation reported by attendees, this indicates that other barriers are preventing these conversations being prioritised that the PACC training cannot address.

When asked in the follow-up survey about what prevented them promoting physical activity more often, around one in three attendees (27%) spontaneously mentioned time constraints as a key barrier. This is likely to have been exacerbated by the workforce pressures resulting from the Covid-19 pandemic. This indicates that the PACC training could better highlight the ability to have useful conversations about physical activity in very short timeframes. Currently, only 23% of attendees report that they make use of the Moving Medicine website so, although this is currently promoted as part of the PACC training slides, it is possible that more could be done to promote this to PACC attendees.

> **Time constraints are a barrier. As a Practice Nurse, sometimes we only have 10-20 minutes per long term conditions review.**
> Follow-up survey participant, Nurse

Figure 4.19: Having conversations with patients about physical activity is a priority for me.



Base: 2,250 (baseline) and 263 (follow-up) PACC attendees who completed the survey (including HCPs and other roles)

Comparing individual participant's responses to the baseline and follow-up surveys reveals that, despite the lack of movement in the aggregated data, for 28% of attendees the training did lead to an increase in perceived priority of physical activity conversations. However, these increases are counter-balanced by the 23% of attendees for whom the training resulted in a decrease in perceived priority of physical activity conversations. As seen with other questions, those who saw a decrease following the training, tended to give high ratings prior to the training.

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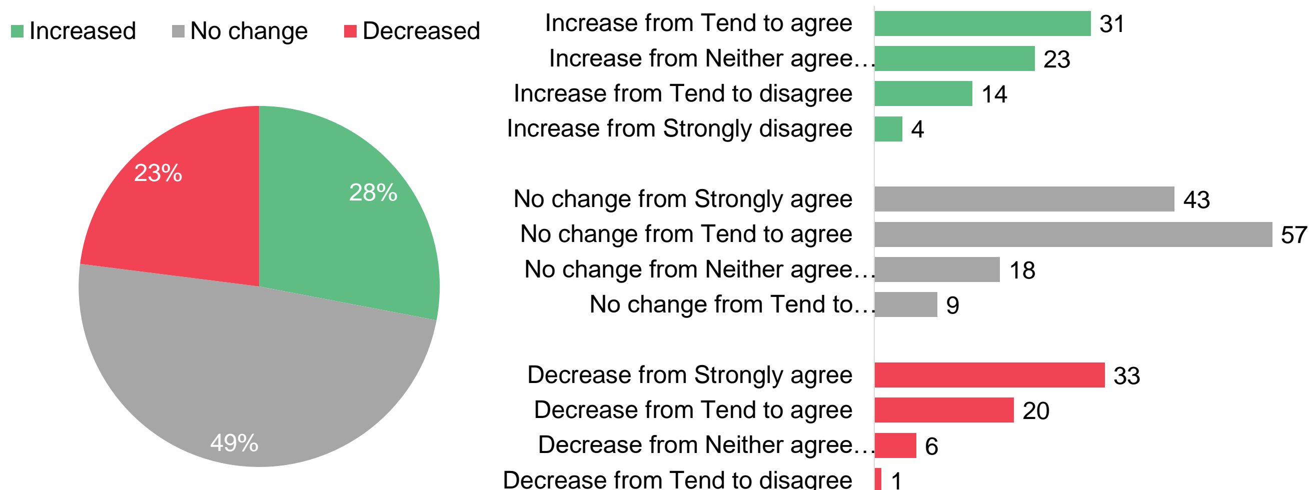
Figure 4.20: Healthcare professionals play a role in educating patients on the importance of physical activity (analysis of change from pre to post-PACC training).



Base: 259 PACC attendees who completed the baseline and follow-up survey (including HCPs and other roles) excluding those who said 'don't know' to either baseline or follow-up.

Alongside time constraints, other barriers to promoting physical activity to patients that were mentioned in the interviews included:

- Working with patients in pain where it was felt to be inappropriate to promote physical activity

  If you've got patients who are suffering with pain, they'll say, 'well how can I exercise if I'm in pain', and that can be challenging because it's a bit of a vicious circle. Because the pain is preventing them from exercising.
  GP trainee

- A perceived lack of services to refer on to, making HCPs more hesitant to raise the topic for discussion

  People don't want to bring it up because they feel they don't have anything to offer to the patient and when services are pulled you can't actually offer them any help really. So, I think people are more reluctant to offer the help if they don't have services available to direct patients to.
  Obstetrician

- A lack of confidence in knowing what physical activity options would be age-appropriate

- Not having been taught in medical school how best to discuss the topic of physical activity with patients

- An increase of telephone consultations making it harder to judge the appropriateness of discussing physical activity

  I think also doing the telephone consultations you can't see your patients, so sometimes you don't necessarily know who it [physical activity] would benefit.
  GP trainee

- A concern that the topic of physical activity was 'touchy' and therefore best left for GPs who have better personal relationships with patients

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- A lack of confidence, and fear of being judged, where HCPs are not physically active themselves, or where HCPs are overweight.

I had one lady. I remember her. She was sat at the back of a session and wasn't really interacting. But as I left, she stopped me and said, thank you, I've really enjoyed that. She said that because she was very big herself, she felt that she didn't have the confidence to talk to people about physical activity because she thought patients would judge her.
PACC Nurse

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5 Evidence of medium- / long-term outcomes

The evaluation logic model proposes that once the short-term outcomes of increasing capability, opportunity, and motivation to promote physical activity to patients have been achieved, attendees will incorporate conversations about physical activity into their clinical care as standard practice. Other medium-term outcomes theorised are a system level increase in HCPs advocating physical activity to patients living with or at risk of long-term conditions, and that promotion of physical activity becomes increasingly widespread and standard in clinical practice.

Theorised longer-term outcomes are then for patients to have increased capability, opportunity, and motivation to become more physically active through these conversations with HCPs, and to then go on and increase their physical activity levels. Ultimately, it is proposed that these increases in patient physical activity levels will result in improvements in clinical outcomes and quality of life outcomes for patients.

This chapter outlines the current evidence from the evaluation as to whether the PACC training is achieving these intended medium and long-term outcomes. The questions the evaluation seeks to answer around these medium and long-term outcomes are:

- Does the training increase the frequency of promotion of physical activity by HCPs?
- Is the PACC training likely to lead to system level increase in the number of HCPs promoting physical activity to patients?
- In what way are patients affected by HCP behaviour change (i.e., promoting physical activity)?
- How likely is PACC training to lead to or contribute to the intended longer-term impacts on patients?

Promotion of physical activity among trained HCPs

Attendees were asked to rate, on a scale of 0 to 10 (where 0 is never and 10 is nearly always), how often they promoted physical activity to patients. Prior to the training, 5% rated themselves in the bottom three categories (0 to 2), while 50% rated themselves in the top three categories (8 to 10). Following the training, the proportion that rated themselves in the bottom three categories remained consistent (four per cent). While the proportion that rated themselves in the top three categories increased slightly, to 56%. This change was not statistically significant.

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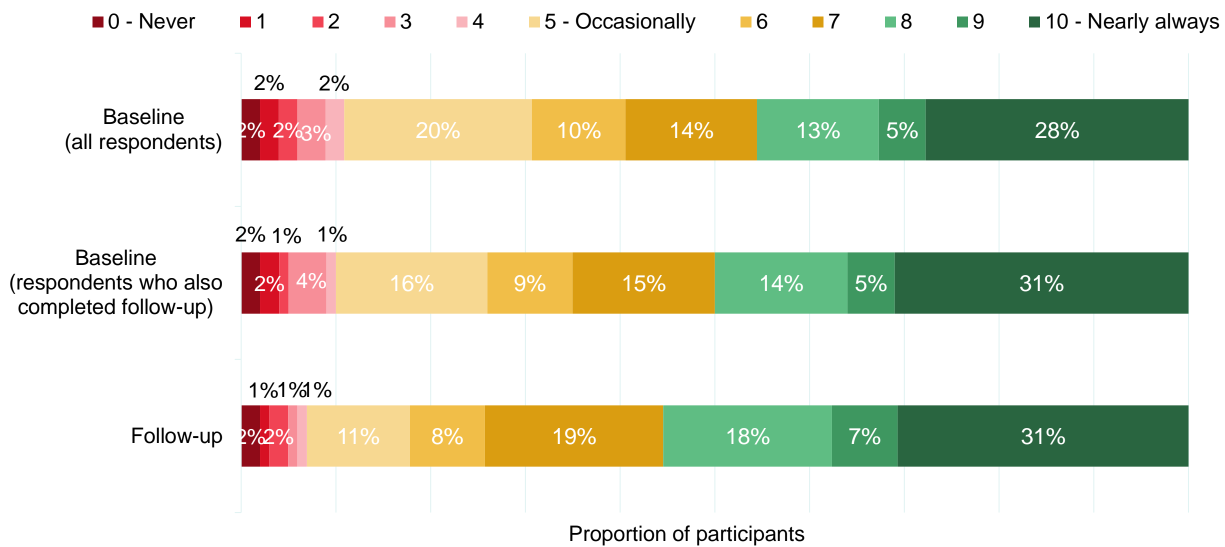
Figure 5.1: On a scale of 0 to 10, how often, if at all, would you say you promote physical activity to your patients who have, or are at risk of, long-term conditions?



Base: 2,250 (baseline) and 263 (follow-up) PACC attendees who completed the survey (including HCPs and other roles)

Change from baseline data reveals that 38% of attendees reported an increase in the frequency with which they promoted physical activity. However, this increase is partially offset by a decrease reported by 26% of attendees. Furthermore, 37% of attendees reported no change in the frequency with which they promoted physical activity to patients. In the interviews, there were some examples of attendees being more willing to discuss physical activity with their patients. Often, the attendees talked about the training helping to improve the quality of their conversations with patients rather than the frequency with which these conversations took place. Furthermore, barriers to having physical activity conversations, such as time constraints, still remain even after the training has been completed. As discussed, this was evidenced in the open-ended responses to the survey question regarding barriers to promoting physical activity.

In the interviews with PACCs, some reflected on these challenges. Specifically, there was acknowledgement that the training model adopted by the PACC programme makes it difficult for PACCs to judge either short- or long-term impact of their training sessions on attendees' attitudes and behaviours.

> **Because we're going out and doing education to teams which we've got no other contact with other than the kind of buzz that you get in the room, and the level of questions and the thanks you get in the chat about how helpful and powerful it's been, there's no way of following-up to get a sense of what it's done.**
> PACC, Doctor

The majority of attendees who completed the follow-up survey (86%) reported that the promotion of physical activity is standard in their care to either a great extent (29%) or to some extent (57%). This compares favourably to attendees' opinions of other healthcare professionals; only 23% of attendees reported that physical activity promotion is standard to a great extent in their colleagues' care, and 13% reported that physical activity promotion is standard to a great extent in wider healthcare professionals' care. It should be noted that a higher proportion of attendees felt unable to comment on promotion of physical activity among colleagues (7% don't know) and healthcare professionals in general (10% don't know), than they did on themselves (1% don't know). However, this finding may indicate that PACC

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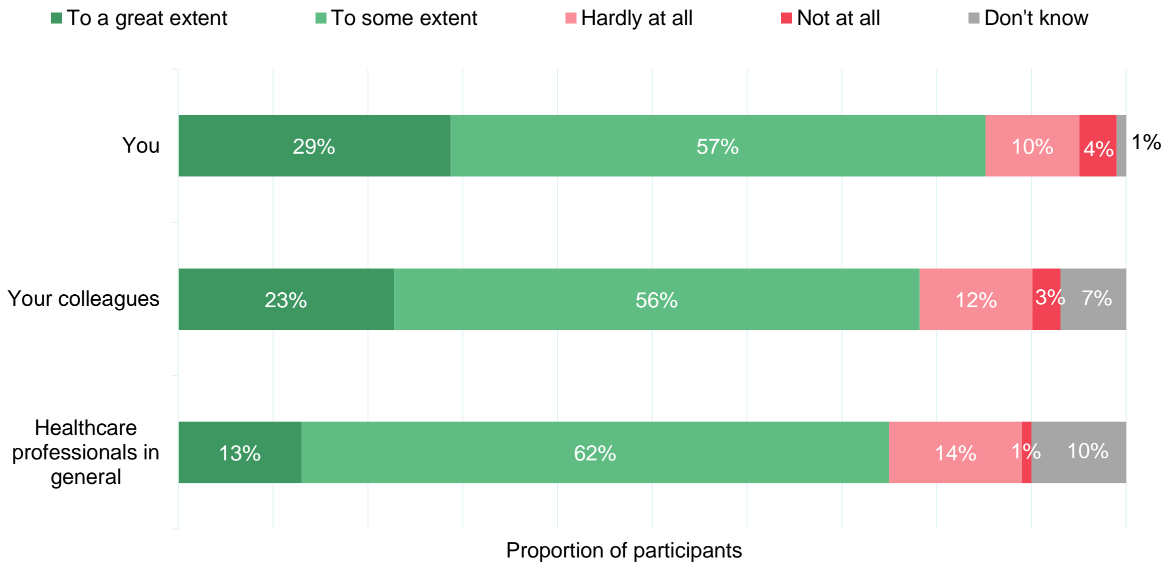
attendees perceive themselves to be promoting physical activity to patients more than is the norm across the healthcare sector.

Figure 5.2: To what extent is the promotion of physical activity standard in clinical care delivered by…?



Base: 263 PACC attendees who completed the follow-up survey (including HCPs and other roles)

System-level change in HCPs promoting physical activity

In the interviews, HCPs were positive about the potential for PACC training to help conversations about physical activity to become standard practice in clinical care. Some mentioned how the form that the training takes, particularly the way that it can bring individuals in different specialties together, can help to challenge the status quo and incite change.

> **I think [system-level change] is an achievable ambition… Encouraging people to look outside a narrow focus and meet peer groups and think about their practice is good. That sort of thing is the way forward.**
> Consultant adult psychiatrist

Others suggested that, even where HCPs hadn't attended the training themselves, it was likely to have an impact on them if others in their team attended. In this way, it is feasible for the PACC programme to have a broader impact than solely on those who attend the training.

> **There hasn't been any follow up to say 'as a team we're going to talk about this training' but you have to hope that sort of training filters through in the way colleagues interact with each other. You have to hope it infuses the approach.**
> Diabetes nurse

Other responses were more cautiously optimistic. For example, one PACC emphasised that the PACC training programme is just one part of a suite of initiatives that will work together to change HCPs' behaviours over time. From this viewpoint, it was not feasible or realistic to expect the PACC programme to have a system-wide impact in isolation.

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> **Our PACC programme is not going to be the one thing that changes everybody's behaviour. It's going to be the whole combination of things that are going to have some impact. But it's really nice to see because I didn't get any physical activity or lifestyle training when I was going through med school, nor through GP training really.**
> PACC, GP

There were also some suggestions that the programme is not established or wide-spread enough to have had a system-wide impact. For example, the need for PACC training to be embedded within undergraduate education and the be repeated at regular intervals was emphasised.

> **We haven't talked to everybody, and we haven't produced a big enough ripple effect for it to be just this is standard practice. It's not accepted like that. Until that gets really embedded in and even if it gets embedded in medical school education or nursing education, I think it still needs the constant reminders and this is a good way of doing it. So, I would, yeah, absolutely dispute that we have done enough.**
> PACC, Doctor

Furthermore, there were some suggestions that in order to make a system-level change, it would be beneficial to engage with a wider variety of professional groups than currently targeted. For example, one clinician warned against a focus on "preaching to the converted", including physiotherapists and occupational therapists. She suggested that healthcare professionals working in mental health, learning disabilities, and forensic services would be good audiences for the training as they often work with young people who have unhealthy lifestyles.

Contribution to longer-term impacts on patients

Intended longer-term outcomes for the PACC training are for patients to have increased capability, opportunity, and motivation to become more physically active through conversations with HCPs, and as a result become more physically active. This in turn is theorised to lead to improved clinical outcomes and quality of life.

> **You would hope that, if more people are starting to have those conversations, and bring it up within their consultations, then that's obviously going to have a positive impact in terms of patients' care. If patients are starting to receive that as more of a consistent and routine message that lots of people are starting to ask them about, and offer support, that would be our intention.**
> PACC, Doctor

The intended audience of PACC training is HCPs rather than patients. Outcomes for patients are further down the causal chain of the theory of change. As such, more extraneous factors (such as patients potentially encountering different services that promote physical activity) mean it is difficult to evaluate with certainty the direct effect that PACC training has had on patient behaviour.

However, in the follow-up survey, attendees were asked their views on the likelihood of the PACC programme contributing to improved outcomes for patients. The majority of attendees think that the PACC training is very likely to contribute to improved physical health (59%) and improved mental health (58%) in patients (Figure 5.3).

In the longer-term, attendees also think it very likely that the PACC programme will contribute to improved clinical outcomes (52%) and improved quality of life (59%) for patients. Only around two per cent of attendees think it unlikely that the PACC programme will contribute to these outcomes.

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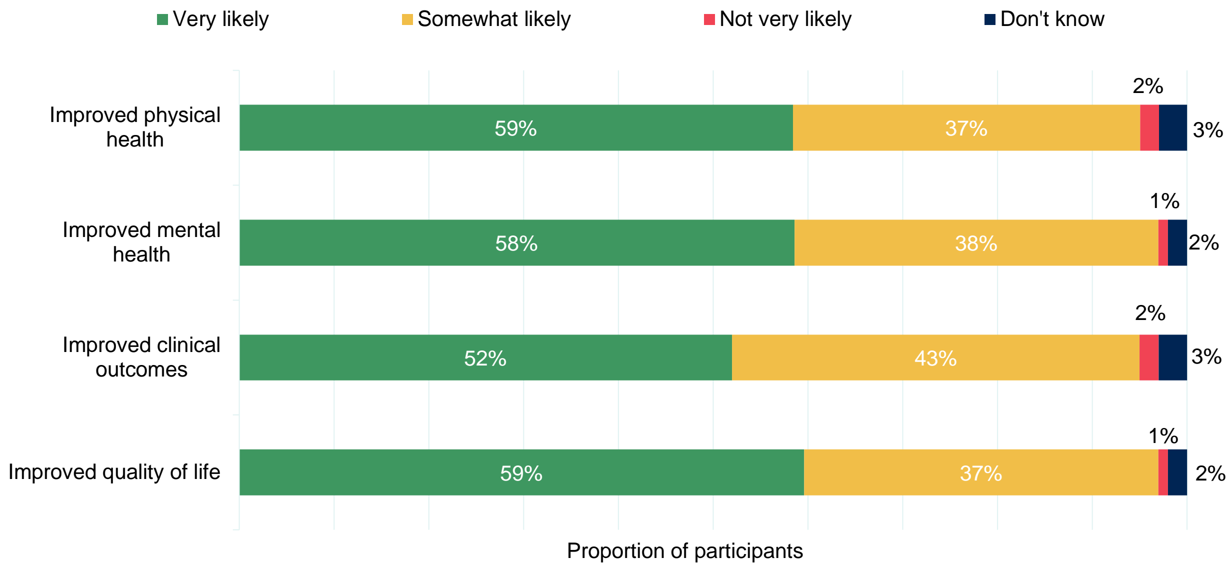
Figure 5.3: How likely is it that the PACC programme will contribute to…?



Base: 263 PACC attendees who completed the follow-up survey (including HCPs and other roles)

In the interviews, around half of the ten attendees gave examples of patients that had become more physically active as a result of recent conversations they had had with them. The other participants either could not be sure their patients had become more physically active or could not be certain that an increase in activity was as a result of their interaction with them.

The quotes below provide examples of patients increasing their physical activity as a result of HCPs engaging them in a meaningful discussion about physical activity.

> **I think it was during lockdown, so obviously everyone was at home quite a lot, and I had a patient, she was struggling with low mood. So, I suggested trying to get out of the house and that she starts off by going for walks, even just five minutes and see how she got on with that. And yeah, then she came back and said that she'd bought herself a bike and she and her husband were biking everywhere, and it did help her mood.**
> Trainee GP

> **I can think of a lady who when I first saw her, she's now lost three stone. She used to walk her dogs and there is a hill nearby. And she said she used to stop five times to walk her dogs to get up to the top, she now does not stop at all.**
> Diabetes dietician

> **I recently had a patient where she'd had a very bad fall and lost confidence completely. She didn't feel able to engage with the rehab suggestion of walking more or doing more, and so we did some seated exercises together and then it's gone from strength to strength and she's now able to move and walk across the room, and so, of course, that's a self-fulfilling prophecy. So, the more stronger she was, and the more she was able to do, the more she did, and she got so much better. So, for her it was absolutely fantastic.**
> Community nurse

In the focus groups with PACCs, it was suggested that, for the training to have maximum impact, it should be supplemented by an understanding of the local health inequalities. This insight – whether

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delivered by PACCs, or at a more local level – would help HCPs to focus on promoting physical activity to those groups where it could have the greatest impact.

> **I really emphasise the whole population data part. I say that if HCPs know that women, or disabled people, or people with long-term conditions in your clinics don't do as much exercise, then those are the people you should really target your physical activity conversations at.**
> PACC, AHP

PACCs also emphasised that an additional focus on the life-course approach and prevention, for example among pregnant people and children, could improve the impact of the PACC training.

> **Unfortunately, just because it's a pregnant woman or a child, it doesn't mean they don't have a long-term condition. I think it's really about making the relevance to the HCPs that you're working with. If you can get across the relevance to their client group, I think they will pick it up a lot more.**
> PACC, Nurse

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6 PACC and the wider MHPP

This chapter considers how well the PACC training programme is integrated into MHPP and sustainability plans for its continuation. In doing so, the relevant questions the evaluation seeks to answer are:

- How does the PACC training programme fit with other workstreams / how is it being integrated?
- What changes might need making to the training, or its fit within the system to increase impact?
- What further resources are required if any to increase the efficacy of the PACC training programme?

Integration of the PACC training programme in MHPP

The MHPP programme was devised as a “whole-system educational approach” (encompassing professional development) 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 healthcare professionals[9].

As set out in the paper by Brannan et al. (2019), 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 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.

Regarding ways in which the different work packages could better support each other, interviewees felt that there were opportunities to better use the PACC training to amplify the impacts of other workstreams within MHPP. One stakeholder described the PACC training as a "marketing tool" which is not currently being utilised to its full effect. For example, although the PACC training content does include reference to the Moving Medicine website, at the time of the follow-up survey, only 23% of PACC attendees said that they had used the Moving Medicine website.

> **I think one arm [of increasing awareness of MHPP] could be the PACC training because essentially, we are a marketing tool. We’re already getting out there raising awareness, so it seems a really easy add on that wouldn’t require a significant resource increase.**
> MHPP stakeholder

Specifically, stakeholders felt there was a natural synergy between the PACC training and the Moving Medicine resources. As mentioned earlier in this report, there was a widespread feeling – among PACCs, HCPs, and stakeholders – that the PACC training should have a greater focus on motivational

[9] Brannan et al. (2019) Moving healthcare professionals – a whole system approach to embed physical activity in clinical practice. *BMC Medical Education*

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interviewing. In addition to adapting the training to include more motivational interviewing content, stakeholders felt there should be more formalised links between the PACC training and the Moving Medicine resources.

PACCs also felt that more time within the training should be dedicated to explaining and demonstrating the Moving Medicine resources. For example, one PACC suggested that a short video tour of the resources could be embedded within the training slides. This was reflected in feedback from the follow-up survey participants; some of whom said they would have valued more guidance on the Moving Medicine resources.

> **I think one of the things that was fed back through the end user review group was that it would be good to have a link to the Moving Medicine website as part of the presentation. So, to click through actually onto the website and show people it. We could just demonstrate one element of it, at least people then can be reassured that actually it's quite easy to use.**
> PACC, Nurse

> **Would have been more helpful to focus less on the statistics/background and more on navigating resources that could be used to sign post I accessed the main site that was being promoted the day after training and found that it wasn't as accessible as had been promoted**
> Follow-up survey participant, AHP

Although not explicitly mentioned by stakeholders, findings from interviews with PACCs and HCPs suggested there may be potential for additional integration between the e-learning modules and the PACC training. For example, in the follow-up survey feedback, some HCPs requested reading materials both prior to and following the session. As mentioned, a large proportion of HCPs reported liking the evidence-based nature of the training, although there was also a call for slightly less focus on this within the slides. There may be benefits in circulating the e-learning modules, before or after the training, to provide detailed information on the benefits of physical activity. By taking this approach, the volume of evidence covered within the training itself could be reduced, and a more HCPs will be encouraged to use the e-learning resources; at the time of the follow-up survey, only 29% of PACC attendees said that they had used e-learning training modules or course[10].

> **I had thought the course would go into a bit more detail about the 'how' to improve someone's skills to engage others to be more active. Motivational Interviewing was mentioned as being one of the important parts of how to do this, however it was very quickly skipped over - I thought maybe less time on the 'why' people should be more active (this information is readily available on posters, etc) and more on the 'how' - the skilled aspect with the lecturer support.**
> Follow-up survey participant, AHP

Finally, as mentioned earlier in the report, it was suggested that for the programme to have a greater impact, PACC training should be embedded within the undergraduate curriculum.

Sustainability of the PACC training programme

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[10] Note, this was not specified as being HEE's elearning for healthcare modules but e-learning modules in general

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The second phase of the MHPP programme will end in late 2022 with funding for the PACC training no longer available through the current route. In the interviews and focus groups, PACCs and other stakeholders were asked for their opinions on the best approach for ensuring the sustainability of the programme in the future. Importantly, there was a strong steer from interviewees that the programme serves a crucial function and that it should continue in some form.

> **I see it as something where all of us involved in it really care deeply about it. And I do think there's a real role for this education. So, it could certainly continue as is and offer an awful lot of value. But there are also ways to enhance its value.**
> MHPP stakeholder

> **I definitely think there is a real role for education around physical activity, we're still playing catch-up with people who were trained without physical activity public health content being part of their curriculum, and there is a huge gap and huge need for the training to continue.**
> MHPP stakeholder

A number of considerations were raised regarding the way in which it is continued. First, a couple of stakeholders suggested that there should be greater local system buy-in and ownership of the training. For example, one stakeholder suggested that there could be a network of PACCs within each ICS, who are managed and supported by the ICS themselves. This approach has the benefit that it would allow the training to be better tailored to the local area in terms of both the local population profile and the local resources. Feedback from HCPs who attended the training, suggested that there was a widespread demand for this tailoring.

> **There should be more emphasis on local system buy-in to the training offer, and I wonder whether the ICSs can have a role in that working with their training leads to say that this is something we believe in, this fits with our strategy around sustainability, around population health, and we're going to put all of our staff through this training.**
> Lead PACC

An alternative suggestion was that the programme should reduce its scope by taking a more targeted approach. For example, it could target the localities with the highest health inequalities, it could target specific disease types, or it could target HCPs within specific roles or settings. It was suggested that this approach might lead to a programme with a smaller scale, but which would potentially have the same or greater impact.

> **The other way of doing it is perhaps looking at particularly where our target areas are, so whether we're looking at our health inequality data and saying, OK, we really want to focus on areas where we know we've got those really areas of high deprivation, or real black and ethnic minority mixes where we know we've got extra challenges.**
> PACC, Doctor

Finally, regardless of how the training is delivered, there was consensus that the consistency and quality of the core training content would need to be maintained. This was seen as crucial to maintaining the efficacy of the training programme. It was suggested that to do this, these elements of the programme would need to be overseen centrally.

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7 Conclusions

Key findings and conclusions from the evaluation are outlined below:

- Despite the workforce pressures resulting from the Covid-19 pandemic, a sizeable number of PACCs have been recruited and retained, and subsequently, they have trained over 15,800 HCPs during Phase 2 of the programme.

- 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. Despite data suggesting a desire for face-to-face delivery to return, this is not reflected in the uptake of face-to-face sessions to date. In the first six-months of 2022, the average number of sessions per month has recovered and is now higher than the pre-pandemic levels seen in 2019.

- There is an uneven distribution of PACCs across the country and further recruitment of PACCs – most notably in the East of England – will help improve the reach of the programme. Likewise, further recruitment of PACCs in areas of high deprivation may help contribute to OHID's ambition for the programme to reduce health inequalities. A recent wave of PACC recruitment has just been completed as of July 2022.

- Doctors make up the greatest proportion of PACC training attendees (42%), with a fairly even split of nurses and midwives (28%) and AHPs (25%). This suggests the training appeals (or is promoted) to a different type of HCP compared to Moving Medicine and the HEE e-learning resources which are predominately used by AHPs and nurses/midwives, respectively and thus is a useful contribution to the suite of educational resources available through the MHPP.

- Relative to the size of the workforce, a small proportion of nurses attend PACC training compared with doctors or AHPs. This may be related to the relatively high numbers of medic PACCs. Recruitment of more nurse PACCs may help improve this balance.

- Prior to the training, a large proportion (54%) of the HCPs that attend the training did not regularly promote physical activity to their patients. This suggests the programme is not just attracting those who already routinely talk to their patients about physical activity and distinguishes the training from Moving Medicine and the HEE e-learning resources which are used by HCPs that more regularly promote physical activity.

- The PACC training was very positively received – with the majority of attendees scoring it highly for its usefulness and praising both its content and delivery. The majority of attendees said they would be very likely to recommend the training to others. There is, however, some lack of clarity about who the training was available for, and how it could be arranged should HCPs recommend others to attend it and thus more information could be made publicly available about how to book sessions.

- The majority of those completing the follow-up survey felt very or somewhat skilled and confident to promote physical activity – which is an improvement upon the baseline survey results. Positive shifts were also seen in HCP's knowledge of how to promote physical activity to patients. However, more than one in four still described their knowledge as 'basic' following the training

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suggesting more advanced content could be included. OHID are currently revising the slide-deck to address this.

- When looking at the change over time for individual HCPs, there is a sizeable proportion for whom self-perceived knowledge, skills and confidence in relation to promoting physical activity are not affected by the training. This appears to be particularly prevalent among HCPs who attend the training with some pre-existing knowledge, skills or confidence. Findings from the interviews with HCPs suggests that this may be due to the content of the training being too basic. Focus groups with PACCs and open-ended responses to the follow-up survey suggested that an additional focus on motivational interviewing techniques would be welcomed by HCPs which could increase the impact of the training.

- Although the evidence shows a slight increase in the frequency with which HCPs promote physical activity to their patients following PACC training, this increase is not statistically significant. However, the qualitative interviews with HCPs suggested that the training positively impacted on the quality of conversations rather than the quantity. HCPs provided anecdotal evidence of a positive impact on patients’ physical activity levels as a result of conversation they had in routine practice.

- Whilst barriers to discussing physical activity with patients remain, there are opportunities for the training to address these, for example, by providing advice on how to discuss the topic in phone consultations, how to raise the topic with patients who they feel might be less receptive due to comorbidities or pain, and how to have brief conversations when time is limited, linking to the Moving Medicine consultation guide resources.

- There are opportunities for greater integration of PACC with other MHPP workstreams, most notably Moving Medicine and the undergraduate curriculum, which would help raise awareness and engagement with the whole suite of educational resources available through the programme. Greater integration could lead to greater impact at a system-level.

- There were also suggestions that a more systematic approach to promoting the PACC training could maximise reach beyond PACCs' existing networks. For example, a central website providing information about the programme, and central admin support to help with booking sessions, could help to make the sessions more accessible to a wider range of HCPs.

- There is strong support for the continuation of PACC training beyond the end of the funding period with some suggestions that a more local delivery model, or focused approach to the training, might be options for the future. Capitalising on the opportunities that ICSs will offer should be explored.

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