

Let's Get Moving

Commissioning Guidance

A physical activity care pathway



DH INFORMATION READER BOX

Policy HR/Workforce Management Planning/Performance	Clinical Commissioner Development Provider Development Improvement and Efficiency	Estates IM & T Finance Social Care/Partnership Working
Document purpose	Best Practice Guidance	
Gateway reference	17189	
Title	<i>Let's Get Moving – A physical activity care pathway. Commissioning Guidance</i>	
Author	Department of Health/Physical Activity Policy	
Publication date	16 March 2012	
Target audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Directors of PH, Directors of Nursing, Local Authority CEs, PCT Cluster Chairs, NHS Trust Board Chairs, Directors of Finance, GPs	
Circulation list	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult Ss, PCT PEC Chairs, PCT Cluster Chairs, NHS Trust Board Chairs, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Voluntary Organisations/NDPBs, Physical Activity leads, Obesity leads, Vascular Risk leads, Older People leads, Long Term and Chronic Condition leads	
Description	The commissioning guidance sets out an evidence-based behaviour charter model – Let's Get Moving – encouraging local commissioning of physical activity interventions in primary care.	
Cross reference	<i>Start Active, Stay Active: A report on physical activity for health from the four home countries</i>	
Superseded documents	<i>Let's Get Moving – A new physical care pathway for the NHS. Commissioning Guidance</i>	
Action required	N/A	
Timing	N/A	
Contact details	Physical Activity Policy Team Room 703, Wellington House 133–155 Waterloo Road London SE1 8UG	
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408803 1p 7.5k February 12 (ESP)
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Let's Get Moving

Commissioning Guidance

A physical activity care pathway

First published September 2009

Reviewed January 2012

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Executive Summary



Over the next few years, as budgets in health become much tighter, it would be easy to see spending on physical activity as a luxury which could be foregone. That would be a big mistake. It should be seen by all commissioners as a necessity to secure health improvements in our population and in so doing reduce the need for many people to have to use our health services in a much more costly way.

**Richard Sumray, Chair,
NHS Haringey**

Introducing a physical activity care pathway – Let's Get Moving

Promoting active lifestyles is a simple answer to many of the big health challenges facing our country today. With significant potential to improve the health of the nation, reducing all-cause mortality and improving life expectancy, promoting physical activity can save the NHS money and significantly ease the burden of chronic disease on the acute sector and public services.

Supporting financial balance and transforming the provision of care, the **Let's Get Moving** (LGM) programme provides a vehicle for commissioners to move towards lower-cost, more efficient and effective services.

The benefits of regular physical activity have been clearly articulated: for adults, achieving 150 minutes of moderate intensity physical activity a week helps prevent and manage over 20 chronic conditions including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions.

Key health fact

On average, an inactive person spends 38% more days in hospital than an active person, and has 5.5% more family physician visits, 13% more specialist services and 12% more nurse visits than an active individual.¹

However, despite the multiple health gains associated with a physically active lifestyle, only 40% of adult men and 28% of adult women meet the previous CMO's recommendations for health.² **That is 27 million adults in England alone who are not active enough to benefit their health.**

There are clear and significant health inequalities in relation to the prevalence of physical inactivity according to income, gender, age, ethnicity and disability. For example, physical activity:

- is higher in men at all ages and then **declines significantly with increasing age** for both genders;
- is lower for black and minority ethnic groups, with the exception of African-Caribbean and Irish populations; and
- is lower in low-income household groups than in high-income household groups.

The cost of inactivity to the NHS and to the health of our nation as a whole is irrefutable. Physical inactivity places a significant economic burden on the NHS for the treatment of long-term conditions and associated acute events (such as heart attacks, strokes, falls and fractures), as well as the costs of social care arising from the loss of functional capacity.



Being active is so associated with health, it's hard to deliver any clinical care without the involvement of physical activity promotion. As a GP running a diabetic clinic without any access to physical activity options for the patients I felt I was failing them, which is why I started the Walking for Health and Green Gym schemes to provide a local, low-cost, fun, social method of becoming active that other GPs can also benefit from signposting their patients to.

**Dr William Bird, GP,
Berkshire West PCT;
strategic health adviser,
Natural England**

In terms of return on investment, for certain measures such as $VO_{2\max}$ (a measure of aerobic fitness) blood pressure and cholesterol, the benefits can accrue in a matter of weeks or months. The same is true for specific conditions such as mild to moderate depression, low back pain and chronic obstructive pulmonary disease (COPD).

For just five conditions – post-menopausal breast cancer, lower gastrointestinal cancer, cerebrovascular disease, cardiovascular disease and type 2 diabetes – a study demonstrated an annual estimated cost to the NHS of £1.06 billion.³ Adding the indirect costs to the wider economy, such as working days lost to sickness absence and premature mortality, results in a total bill for physical inactivity that may be as high as £8.3 billion every year.

LGM, a physical activity care pathway, will help bring the vision of a more active nation alive.

Key health fact

One in four people in England said they would become more active if they were advised to do so by a doctor or nurse.²

The average patient will visit their GP about four times a year, with 78% of people consulting their GP at least once during each year.⁴

Let's Get Moving – a solution

LGM is a behaviour change intervention that has been designed to provide a systematic approach to identifying and supporting adults, who are not meeting the CMO's recommendation for physical activity, to become more active, for the purpose of both prevention and management of inactivity-related chronic disease. The programme can be integrated as a solution with other public health initiatives such as NHS Health Checks.

The LGM approach is based on the recommendations of the National Institute for Health and Clinical Excellence (NICE) public health guidance *Four commonly used methods to increase physical activity*, which endorses the delivery of brief interventions for physical activity in primary care as being both clinically effective and cost-effective in the long term.⁵

There is compelling economic and clinical evidence for investment in the promotion of physical activity in primary care through brief interventions. In terms of return on investment, NICE established that a brief intervention for physical activity in primary care costs **between £20 and £440 per quality-adjusted life year (QALY)** (when compared with no intervention) with **net costs saved per QALY gained of between £750 and £3,150**.

LGM works on the key principles of:

- raising standards of care;
- enabling patient choice; and
- addressing prevention issues and supporting people with long-term conditions.

LGM has been designed so that it can be flexibly commissioned to meet your local health needs.



As a GP and commissioner of local health services I am charged with reducing morbidity and mortality, reducing health inequalities, promoting behavioural change, and using available resources to gain the best health outcomes. Much has been done to reduce the prevalence of smoking and alcohol use, to combat obesity and to educate patients with chronic diseases, such as type 2 diabetes, in self-care. However, little emphasis has been placed on the value of exercise to promote and maintain both physical and mental health. As healthcare professionals we should take every available opportunity to promote this undervalued means of maintaining and improving health and social outcomes.

**Dr Charlotte Asquith,
Fusehill Medical Centre,
Carlisle**

LGM provides a physical activity care pathway which can be used by service providers systematically to recruit patients and screen for inactivity using a validated questionnaire. Patients identified as not meeting the CMO's recommendations for physical activity will be offered a brief intervention, drawing upon motivational interviewing techniques, which:

- takes a patient-centred approach to highlighting the health benefits of physical activity;
- works through key behaviour change stages; and
- concludes with a clear physical activity goal set by the patient, identifying local opportunities to be active, including exercise on referral schemes where appropriate.

Participating patients are then followed up over 3, 6 and 12 months after the brief intervention to check progress, encourage and reset goals.

LGM has been tested in a feasibility trial in 14 surgeries by the British Heart Foundation National Centre for Physical Activity and Health, Loughborough University. The results of the trial demonstrated that LGM is feasible for delivery in primary care and is suitable for wider implementation.

The LGM programme provides a suite of resources to assist commissioners and service deliverers to implement and deliver the intervention. These include:

- LGM commissioning guidance (this document);
- a training package for service providers; and
- an LGM patient support pack.

Commissioning Let's Get Moving

This guidance is intended to equip commissioners with the necessary knowledge to commission LGM.

It should be noted that this guidance was reviewed in January 2012 and cannot fully reflect the proposed changes to the health and care system. Subject to Parliamentary approval, local authorities will be given the duty from April 2013 to take steps to improve the health of their local populations, which could include commissioning physical activity programmes.

The LGM commissioning guidance supports local areas to meet the health needs priorities in their Joint Strategic Needs Assessment and demonstrates the value of working with local partners to commission an effective and high-quality LGM service. The guidance creates flexibility for the commissioner to establish the best model locally and identify the most appropriate service providers to deliver LGM and local health outcomes.

Commissioning Let's Get Moving explained

LGM can be commissioned using the agreed systems and procedure to secure budget approval.

Local commissioners can decide whether they wish to commission LGM as part of their strategy to improve the health of their local population, meet local priorities and support the achievement of financial balance. The service can be tailored to meet their local needs:

- by targeting specific population groups or geographic areas. LGM might be commissioned across the whole area, or used selectively, for example in specific wards, to tackle areas with high levels of health inequality; and
- as a solution to meet the needs of other initiatives such as NHS Health Checks.

The delivery method for LGM is flexible and can be adapted to the needs of your locality. The recommendations set out in this commissioning guidance are based on the NICE public health guidance,⁵ and are supported by key learnings from the LGM feasibility study. As such, LGM is primarily aimed at delivery by health practitioners in primary care.

In line with best practice and procurement principles, you may also wish to draw on wider evidence (for example, from the Local Exercise Action Pilots) to commission other service providers such as exercise professionals delivering LGM in the surgery or pharmacists in the community – for further details, see annex 9.

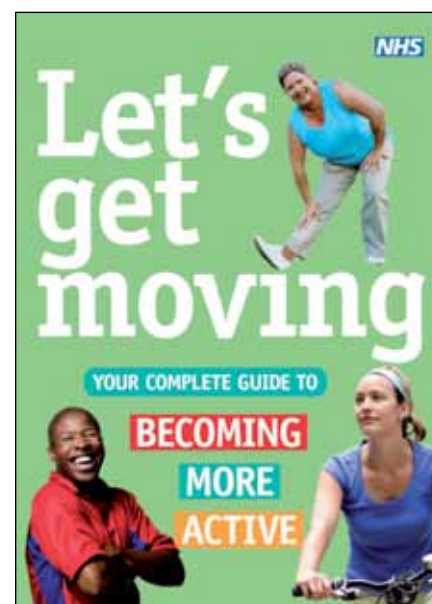
Conclusion

Let's Get Moving provides a unique opportunity to instil and embed the promotion of physical activity at the very core of the NHS, offering a major opportunity for health professionals to make a real difference to the future health of our nation.



In our collective quest to improve the health of ourselves and our patients we have a rediscovered tool. The challenge is not to prove the wide-ranging benefits of regular exercise but to apply it as part of routine evidence-based practice. The potential benefits, in both health and financial terms, of this lo-tech intervention are likely to significantly exceed established treatments already promoted in primary and secondary care.

Dr Jerry Hill, Ship Street Surgery, West Sussex



chapter 1

The Case for Let's Get Moving

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Introduction

This chapter sets out the evidence base and case for embedding the promotion of physical activity in the NHS by:

- establishing the strong link between a sedentary lifestyle and a wide range of chronic diseases;
- highlighting current population activity levels, health inequalities and costs to the NHS;
- proposing an evidence-based solution: **Let's Get Moving (LGM)**; and
- discussing the National Institute for Health and Clinical Excellence (NICE) guidance for brief interventions in primary care and how the intervention sits with local commissioning processes.

1. Physical inactivity and ill health

Physical inactivity is a significant, independent risk factor for a range of long-term health conditions affecting society today. There is a compelling case for embedding the promotion of physical activity in the NHS to secure the future health of our nation.

An active lifestyle:

- has a substantial impact on the risk of major non-communicable disease, including coronary heart disease (CHD), hypertension, type 2 diabetes, chronic kidney disease and some cancers;⁶
- can reduce the risk of stroke, and be used to treat peripheral vascular disease and to modify cardiovascular disease (CVD) risk factors such as high blood pressure and adverse lipid profiles;⁶
- protects against cancers of the colon, breast (post-menopause) and endometrium;⁷
- reduces the risk of and helps manage musculoskeletal health conditions, including osteoporosis, back pain and osteoarthritis;⁶
- reduces the risk of depression and promotes many other positive mental health benefits, including reducing state and trait anxiety; improves physical self-perceptions and self-esteem; and can help reduce physiological reactions to stress;⁶
- has been found to be just as effective in the treatment of mental ill health as anti-depressant drugs and psychotherapy;^{8,9} and
- supports weight management – physical activity by itself can result in modest weight loss of around 0.5–1kg per month.⁶

Key health fact

Inactive lifestyles in England are twice as prevalent as smoking, hypertension or high cholesterol. Evidence shows that the health impact of inactivity in terms of coronary heart disease, for example, is comparable to that of smoking, and almost as great as that of high cholesterol levels.⁶

Table 1. The relationship between physical activity and health outcomes

Health outcome	Nature of association with physical activity	Effect size	Strength of evidence
All-cause mortality	Clear inverse relationship between physical activity and all-cause mortality.	There is an approximately 30% risk reduction across all studies, when comparing the most active with the least active.	Strong
Cardiorespiratory health	Clear inverse relationship between physical activity and cardiorespiratory risk.	There is a 20% to 35% lower risk of cardiovascular disease, coronary heart disease and stroke.	Strong
Metabolic health	Clear inverse relationship between physical activity and risk of type 2 diabetes and metabolic syndrome.	There is a 30% to 40% lower risk of metabolic syndrome and type 2 diabetes in at least moderately active people compared with those who are sedentary.	Strong
Energy balance	There is a favourable and consistent effect of aerobic physical activity on achieving weight maintenance.	Aerobic physical activity has a consistent effect on achieving weight maintenance (less than 3% change in weight).	Strong
		Physical activity alone has no effect on achieving 5% weight loss, except for exceptionally large volumes of physical activity, or when an isocaloric diet is maintained throughout the physical activity intervention.	Strong
		Following weight loss, aerobic physical activity has a reasonably consistent effect on weight maintenance.	Moderate
Musculoskeletal health	<p>Bone: There is an inverse association of physical activity with relative risk of hip fracture and vertebral fracture.</p> <p>Increases in exercise and training can increase spine and hip bone marrow density (and can also minimise reduction in spine and hip bone density).</p>	<p>Bone: Risk reduction of hip fracture is 36% to 68% at the highest level of physical activity. The magnitude of the effect of physical activity on bone mineral density is 1% to 2%.</p>	Moderate (weak for vertebral fracture)

Health outcome	Nature of association with physical activity	Effect size	Strength of evidence
Musculoskeletal health (continued)	<p>Joint: In the absence of a major joint injury, there is no evidence that regular moderate physical activity promotes the development of osteoarthritis.</p> <p>Participation in moderate intensity, low-impact physical activity has disease-specific benefits in terms of pain, function, quality of life and mental health for people with osteoarthritis, rheumatoid arthritis and fibromyalgia.</p>	<p>Joint: Risk reduction of incident osteoarthritis for various measures of walking ranges from 22% to 83%.</p> <p>Among adults with osteoarthritis, pooled effect sizes (ES) for pain relief are small to moderate, i.e. 0.25 to 0.52. Function and disability ES are small: function ES = 0.14 to 0.49 and disability ES = 0.32 to 0.46.</p>	<p>Weak</p> <p>Strong</p>
	<p>Muscular: Increases in exercise training enhance skeletal muscle mass, strength, power and intrinsic neuromuscular activation.</p>	<p>Muscular: The effect of resistance types of physical activity on muscle mass and function is highly variable and dose-dependent.</p>	<p>Strong</p>
Functional health	<p>There is observational evidence that mid-life and older adults who participate in regular physical activity have reduced risk of moderate/severe functional limitations and role limitations.</p> <p>There is evidence that regular physical activity is safe and reduces the risk of falls.</p>	<p>There is an approximately 30% risk reduction in terms of the prevention or delay in function and/or role limitations with physical activity.</p> <p>Older adults who participate in regular physical activity have an approximately 30% lower risk of falls.</p>	<p>Moderate to strong</p> <p>Strong</p>
	<p>Cancer</p> <p>There is an inverse association between physical activity and risk of breast and colon cancer.</p>	<p>There is an approximately 30% lower risk of colon cancer and approximately 20% lower risk of breast cancer for adults participating in daily physical activity.</p>	<p>Strong</p>
Mental health	<p>There is clear evidence that physical activity reduces the risk of depression and cognitive decline in adults and older adults.</p>	<p>There is an approximately 20% to 30% lower risk for depression and dementia, for adults participating in daily physical activity.</p>	<p>Strong</p>
	<p>There is some evidence that physical activity improves sleep.</p>		<p>Moderate</p>
	<p>There is limited evidence that physical activity reduces distress and anxiety.</p>	<p>There is an approximately 20% to 30% lower risk for distress for adults participating in daily physical activity.</p>	<p>Limited</p>

Source: Adapted from Department of Health and Human Services (2008) *Physical Activity Guidelines Advisory Committee Report*, Washington, DC: US Department of Health and Human Services.

The clear link between physical activity and chronic disease is set out in table 1 (on pages 12 and 13). The strength of the relationship between physical activity and health outcomes persists across the life course, and highlights the potential health gains that could be achieved if individuals can be supported to become more active.

In terms of return on investment, for certain measures such as $VO_{2\max}$ (a measure of aerobic fitness), blood pressure and cholesterol, the benefits can accrue in a matter of weeks or months. The same is true for specific conditions, such as mild to moderate depression, low back pain and chronic obstructive pulmonary disease (COPD). However, a reduction in risk of overall mortality requires a longer time period and depends on new activity levels being sustained.

Key health fact

The risks associated with taking part in physical activity are low, and continuing with an inactive or sedentary lifestyle presents greater health risks than gradually increasing physical activity levels. Helping people to move from inactivity to low or moderate activity will produce the greatest benefits.

Key health fact

For an average practice of 20,000 patients (made up equally of men and women), each year there are:

- 68 new cases of CHD;¹⁰ and
- 32 new cases of stroke¹¹

that could be mitigated by promoting physical activity effectively in primary care (using QOF data; statistics are relevant for the year of the study).

Key health fact

On average, an inactive person spends 38% more days in hospital than an active person, and has 5.5% more family physician visits, 13% more specialist services and 12% more nurse visits than an active individual.¹

Inactivity also has far-reaching implications for the wider public sector, such as social care. For example:

- of adults aged over 65, 12% are not able to walk outside on their own, and 9% cannot manage stairs unaided;⁶ and
- by the age of 70, 25% of women and 7% of men do not have sufficient leg strength to get out of a chair without using their arms.⁶

Key health fact

Falls are a leading cause of accidental death of older people in England, and fractured hips cost the NHS and social services £1.8 billion a year in England.¹²

Physical activity is part of the solution to supporting the promotion of independent living in older adults, and thereby reducing the cost of social care.

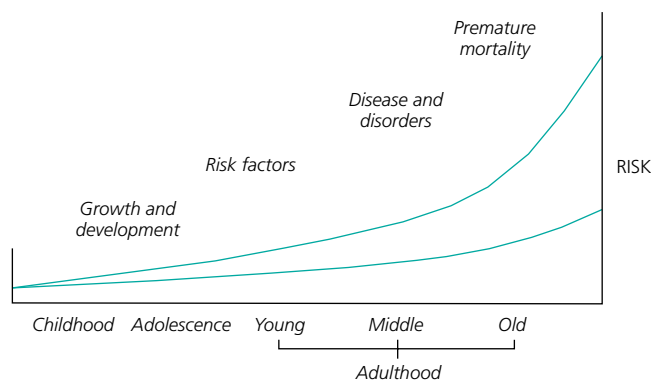
Physical activity protects against cognitive decline in later life and against the onset of depressive symptoms and anxiety.¹³ In mid-life and older adults, physical activity can slow or prevent age-related cognitive decline, and is associated with a lower risk of developing dementia.¹⁴

Physical activity, particularly training to improve strength, balance and coordination, can be highly effective in reducing the incidence of falls.

Key health fact

Long-term regular physical activity, including walking, is associated with significantly better cognitive function and less cognitive decline. In one study, for every mile walked per day, over a sustained period of time, there is a 13% reduction in risk of cognitive decline.¹⁵

Figure 1. A lifecourse perspective on the effect of activity on disease risk



The upper line represents risk for individuals with an inactive lifestyle.
The lower line represents risk for those with an active lifestyle.

Source: Chief Medical Officer (2004) *At least five a week*, p22

2. Inactive England: the scale of the problem

Physical activity comprises a range of behaviours involving movement, expenditure of calories and raised heart rate. Physical activity can take the form of sport, recreational and occupational activity, active travel (e.g. walking and cycling as a means of transport), and heavy domestic activity (e.g. gardening and housework).

The UK Chief Medical Officer's (CMO's) report *Start Active, Stay Active*¹⁶ provides recommendations for the amount of physical activity required for general health benefits. For the first time this includes a lifecourse approach incorporating guidelines for early years and older adults. Specifically, adults should achieve at least 150 minutes of moderate intensity physical activity across the week in no less than 10-minute sessions. Adults should aim to be active daily.

Despite the multiple health gains associated with a physically active lifestyle, only 40% of adult men and 28% of adult women meet the previous recommendations for health.² That equates to 27 million adults in England alone not sufficiently active to benefit their health.

Key health fact

For a practice population of 10,000 (made up equally of men and women) 7,100 believe that they are active enough, and yet a total of 6,600 men and women are not doing enough physical activity to benefit their health. The real challenge is that 75% of men and 67% of women believe that they are active enough.¹⁷

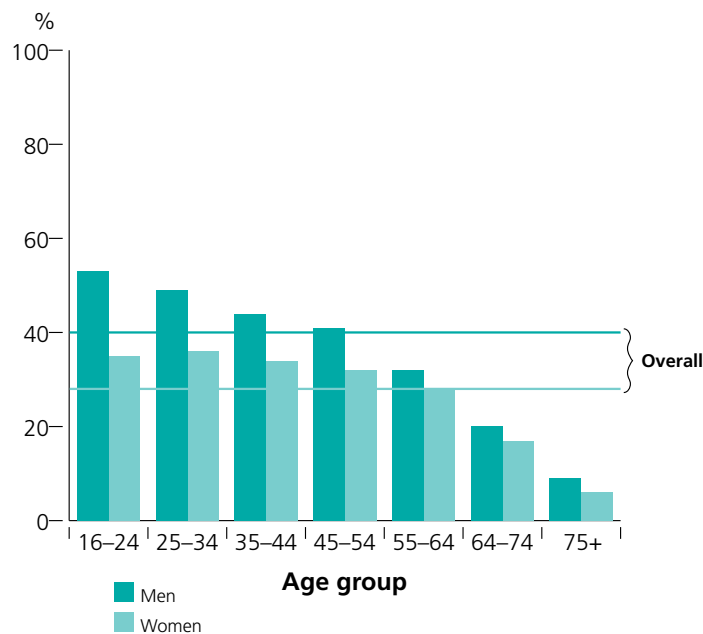
Health inequalities

There are also clear and significant health inequalities in relation to the prevalence of physical inactivity according to income, gender, age, ethnicity and disability. These are demonstrated in figures 2 and 3. For example:

- physical activity is higher in men at all ages;
- physical activity declines significantly with increasing age for both men and women;
- physical activity is lower for black and minority ethnic groups, with the exception of African-Caribbean and Irish populations; and
- physical activity is lower in low-income household groups than in high-income household groups.

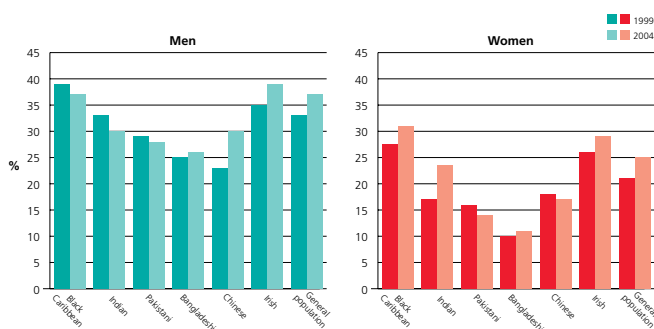
The burden of ill health from inactivity is clear and the statistics further highlight the potential for significant reductions in morbidity and mortality, which could be achieved if we systematically and actively encouraged the participation in physical activity of sedentary adults throughout the NHS.

Figure 2. Rates of physical activity at recommended levels in England, 2008, by sex and age



Source: *The Health Survey for England 2008*

Figure 3. Adults achieving the physical activity guidelines, by ethnic group and gender, England, 2004



Source: *The Health Survey for England 2004: Health of Ethnic Minorities, Summary booklet, p12*

This data refers to the previous Chief Medical Officer's physical activity guidelines.

Physical activity statistics: the main sources

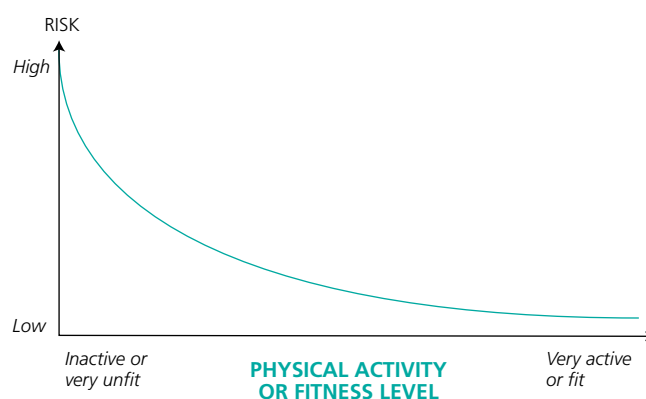
The two main sources of data relating to rates of physical activity in England are the Health Survey for England (HSE) and Sport England's *Active People Survey* (www.sportengland.org):

1. The HSE collects data on sport, recreational and occupational physical activity, and walking and cycling for any purpose, and includes heavy housework and gardening.
2. The Active People Survey measures participation in sport and active recreation, and provides details of how participation varies from place to place and between different groups in the population.

Further information about walking and cycling for transport is available from the National Travel Survey (NTS).

There is a clear causal relationship between the amount of physical activity and all-cause mortality. Figure 4 demonstrates the relationship between physical activity levels associated with the risk of CHD and type 2 diabetes. Increasing the physical activity levels of all adults who are not meeting the CMO's recommendations is important. However, targeting those adults who are significantly inactive, i.e. engage in less than 30 minutes' activity per week, will produce the greatest reduction in the risk of chronic disease.

Figure 4. Schematic representation of the dose-response relationship between physical activity level and risk of disease



This curvilinear dose-response curve generally holds for coronary heart disease and type 2 diabetes: the higher the level of physical activity or fitness the lower the risk of disease. Curves for other diseases will become more apparent as the volume of evidence increases.

Source: CMO (2004) *At least five a week*, p17

3. Counting the cost of inactivity

Investing in the prevention agenda by embedding the promotion of physical activity in NHS services has the ability to significantly reduce the financial burden of inactivity on the economy.

A report estimated that for just five conditions,* in one year alone, the burden of physical inactivity:

- caused over 35,000 deaths;
- caused 3.1% of morbidity and mortality in the UK; and
- added over £1.06 billion to the direct health cost burden on the NHS.³

* Post-menopausal breast cancer, lower gastrointestinal cancer, cerebrovascular disease, cardiovascular disease and type 2 diabetes

Key health fact

For a practice population of 10,000 the cost of these five conditions attributable to physical inactivity averages £50,000 per year.¹⁸

Adding the indirect costs to the wider economy, such as working days lost due to sickness absence and premature mortality, produces a total bill relating to physical inactivity that may be as high as £8.3 billion every year.

The cost of inactivity to the NHS and to the health of our nation as a whole is irrefutable. However, the ability to effect behaviour change is within our reach.

Key health fact

The return on investment to promote physical activity at population level can be significant. Cycling England has estimated that a 20% increase in cycling by 2015 would save £107 million by reducing premature deaths, £52 million from lower NHS costs and £87 million due to fewer absences from work.¹⁹ When targeting those adults most at risk of inactivity, we would anticipate even greater cost savings.

4. Let's Get Moving – a physical activity care pathway

There is strong evidence to demonstrate the importance and the potential of using health professionals to promote physical activity. In 2006 NICE endorsed brief interventions in physical activity as being both clinically and cost-effective for delivery by the NHS in primary care.⁵

Key health fact

One in four people in England say they would be more active if they were so advised by a doctor or nurse (cited by 28% of men and 23% women).²

Based on the recommendations of the 2006 NICE guidance, LGM is a behaviour change programme, which incorporates a physical activity care pathway (PACP) designed to help inactive adults aged 16–74 to become more active.

The physical activity care pathway can be utilised by service deliverers to systematically recruit patients and screen for inactivity using a validated questionnaire. Patients identified as not meeting the CMO's recommendations for physical activity are offered a brief intervention drawing on motivational interviewing techniques, which **takes a patient-centred approach**. The brief intervention:

- highlights the health benefits of physical activity;
- works through key behaviour change stages; and
- concludes with a clear physical activity goal set by the patient, identifying local activity-based opportunities, including exercise on referral schemes where appropriate.

Following the brief intervention, participating patients should be followed up over 3, 6 and 12 months to check patient progress, encourage and reset activity goals.

Let's Get Moving – a practical option

LGM has been tested in a feasibility trial in 14 surgeries, by the British Heart Foundation National Centre for Physical Activity and Health, Loughborough University. The results of the trial demonstrated that LGM is feasible for delivery in primary care and (subject to a number of specific refinements, which have been implemented) is suitable for wider implementation.

NHS Haringey, Let's Get Moving pilot

NHS Haringey took part in the Let's Get Moving physical activity care pathway pilot. As a result of this involvement, staff at Pandya Practice recognised the importance and value of physical activity, and realised the potential of the pathway for improving the health of their patients.

Both Dr Sejal Pandya and Nurse Practitioner Sharon Seber were involved in delivering LGM. They found the pathway to be particularly useful in opening up a dialogue about physical activity with patients and for supporting patients in making these important health behaviour changes. To support the care pathway, a health walk from the practice was also established which continues to be well attended by patients.

5. Physical activity brief interventions in primary care: evidence of effectiveness

NICE public health guidance: brief interventions in physical activity

The NICE public health guidance *Four commonly used methods to increase physical activity*⁵ concludes that brief interventions are effective at increasing physical activity levels:

- in the short term (6 to 12 weeks);
- in the long term (over 12 weeks); and
- in the very long term (12 months or more).

The guidance recommends:

Primary care practitioners should take the opportunity, whenever possible, to identify inactive adults and advise them to aim for 30 minutes of moderate activity on 5 days of the week (or more). They should use their judgement to determine when this would be inappropriate (for example, because of medical conditions or personal circumstances). They should use a validated tool, such as the Department of Health's general practitioner physical activity questionnaire (GPPAQ), to identify inactive individuals.

When providing physical activity advice, primary care practitioners should take into account the individual's needs, preferences and circumstances. They should agree goals with them. They should also provide written information about the benefits of activity and the local opportunities to be active. They should follow them up at appropriate intervals over a 3 to 6 month period.⁵

Key health facts

A study from Australia demonstrated that three to five minutes of brief advice from a General Practitioner, supported with written materials, could lead to an increase in the proportion of patients meeting recommended levels of physical activity 24 weeks after the intervention.²⁰

A study on the effects of three brief sessions of lifestyle counselling conducted by practice nurses, on patients with risk factors relating to cardiovascular disease, also showed significant increases in physical activity at four months.²¹

The evidence for the impact of health professionals encouraging physical activity continues to grow.²²

About motivational interviewing

Critical to the delivery of brief interventions is the way they are implemented.

NICE guidance²³ on behaviour change interventions delivered to individuals recommends that practitioners select interventions that will motivate and support patients to think about the consequences of their current behaviour, consider the positive consequences of changing and plan for change in small steps.

LGM utilises motivational interviewing (MI), a patient-centred behaviour change methodology which elicits and strengthens people's intrinsic motivation to change their behaviour. MI is currently being used by a variety of healthcare professionals to deliver improved outcomes across a range of settings, including primary care.²⁴

A review of MI intervention studies promoting health behaviours has shown that motivational interviewing can have a positive effect on a range of health behaviours, including diet and physical activity.²⁵

How motivational interviewing works

MI aims to help people explore and resolve their ambivalence about changing behaviour. It selectively elicits and reinforces the patient's own arguments and motivations to change, rather than imposing reasons for change on them. When done well, MI can assist an initially ambivalent patient in increasing their motivational readiness to change, and help them develop a plan for change and commit to it.

Effectiveness is enhanced when MI is provided with fidelity and skill. Research in providing training on MI shows that health professionals can become proficient MI practitioners, although gaining proficiency is not easy. A series of steps for developing proficiency have been identified that include initial training followed by some ongoing supervised practice.²⁶ As with any new skill, a combination of practice and coaching will, over time, produce a competent and confident practitioner.

Return on investment: counting the cost of brief interventions

NICE has conducted the most comprehensive economic modelling on the topic of cost implications and return on investment for brief interventions for physical activity in primary care.

Costs and benefits: the NICE approach

The NICE approach is to conduct a cost utility analysis which compares the additional costs of running a new programme with its likely benefits. Costs are estimated on the basis of time taken for a consultation, printed materials, and other associated costs. The likely benefits of the intervention are then estimated, using a number of assumptions based on best available evidence. The important point to note is that the analysis takes account of the effectiveness of the intervention, including its likely reach, its effectiveness in increasing activity among the target population, and the likely health outcome of any increase in physical activity.

The outcome measure used is the number of additional quality adjusted life years (QALYs) that would result from the intervention. QALYs are a measure of disease burden, including both the quality and the quantity of life. This approach enables NICE to estimate the cost of the intervention per additional QALY.

Cost per QALY is increasingly being seen as the standard measure of the cost-effectiveness of healthcare interventions, as it enables comparisons across interventions with different health outcomes.

In summary, NICE normally assumes that if an intervention (including a new drug) costs less than £30,000 per QALY, it is deemed to be cost-effective and can be used in the NHS.

NICE established that **brief interventions for physical activity cost between £20 and £440 per QALY** (when compared with no intervention), which is significantly below the £30,000 threshold and represents exceptional value for money.

The return on investment in brief interventions for physical activity in primary care demonstrated by the **net costs saved per QALY gained varies from £750 to £3,150.**⁵

Alongside the human benefits in terms of reduced morbidity and mortality, brief interventions for physical activity result in net cost savings to the health service compared with no intervention.

In comparison to the cost of statins, at between £10,000 and £17,000 per QALY:

Physical activity as a primary prevention strategy for sedentary adults compares very favourably with the use of statins. Indeed, physical activity remains an excellent choice as a secondary prevention option compared to statins. In secondary prevention the cost per QALY of statins was estimated to vary between around £10,000 and £17,000 for patients between the ages of 45 and 85.²⁷

In comparison to smoking cessation costs of between £221 and £9,515 per QALY:

The cost of brief interventions for physical activity compares favourably with the cost per QALY of brief interventions for smoking cessation – a common and well-accepted NHS service of between £221 and £9,515.⁵

According to the NICE guidance, LGM provides a robust vehicle to implement brief interventions for physical activity while harnessing the health benefits of this clinically effective and cost-effective methodology.

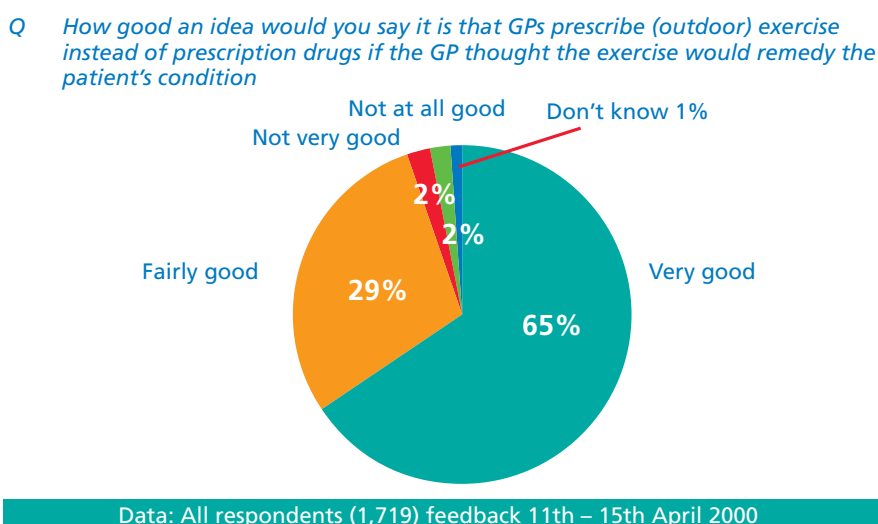
6. How Let's Get Moving meets national priorities and local targets

There is a goal to have a public health service that achieves excellent results, unleashing innovation and liberating professional leadership. *Healthy Lives, Healthy People: Our strategy for public health in England*²⁸ outlines the principles and framework for ensuring that local government and local communities will be at the heart of improving health and wellbeing for their populations.

*The health service is not always good enough at helping people make the right choices – 54 per cent of patients said that their GP had not provided advice on diet and exercise.*²⁹

The demand for the promotion of physical activity in primary care is further demonstrated by Natural England's Ipsos MORI survey summarised in figure 5.

Figure 5. Public attitudes to GPs prescribing exercise



Source: Ipsos MORI

LGM responds to this agenda by:

- raising standards of care;
- facilitating patient choice; and
- meeting the prevention agenda and supporting adults with long-term conditions.

National policy

Physical activity is integral to national public health policy; LGM is specifically mentioned in the public health strategy, *Healthy Lives, Healthy People*.²⁸ LGM can also support individuals to achieve the recommended levels of physical activity for health as quoted in the UK Chief Medical Officers' guidelines.

Healthy Lives, Healthy People: Improving outcomes and supporting transparency

A public health outcomes framework for England, 2013–2016

In January 2012, the Department of Health published the public health outcomes framework. Within the document there are a number of indicators that will help focus the understanding of how well we are doing year by year, nationally and locally, on those things that matter most to public health.

An indicator has been included specifically for physical activity; it focuses on the proportion of physically active and inactive adults (the indicator is reproduced in table 2). This will be measured using the data from Sport England's Active People Survey.

Table 2. Physical activity indicator 2.13: Proportion of physically active and inactive adults

2.13i Proportion of adults achieving at least 150 minutes of physical activity per week in accordance with UK CMO recommended guidelines on physical activity	Numerator: Number of adults (16+) doing at least 150 minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more.
2.13ii Proportion of adults classified as 'inactive'	Numerator: Number of adults (16+) who do less than 30 minutes of moderate intensity physical activity per week in bouts of 10 minutes or more.

National ambition for physical activity

A year-on-year increase in adult physical activity, measured by the proportion of those achieving at least 150 minutes of physical activity per week (with the aim of being active every day), and a year-on-year decrease in the proportion of those classed as 'inactive'.

The national ambition represents a 'call to action' for all of the sectors to link together to influence individuals' physical activity levels and support them to be active daily. LGM can contribute to this by supporting the least active to change their behaviour and increase their physical activity levels.

Key health fact

Being physically active reduces the risk of a COPD patient being readmitted to hospital by 46%.³⁰ Each admission costs the NHS £2,400; with 100,000 admissions in England alone each year, there is significant potential for the NHS to save costs on this condition by promoting activity.³¹

Meeting local commissioning needs

LGM can also be used as a bespoke solution to improve outcomes at a local level across a range of programmes, such as NHS Health Check, Stop Smoking services, weight management clinics, COPD management, cancer survivorship, learning disabilities health check and action plan, falls prevention and mental health management. For details of how LGM can support these areas and other public health initiatives, please refer to annex 3.

chapter 2

The Let's Get Moving Intervention

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Introduction

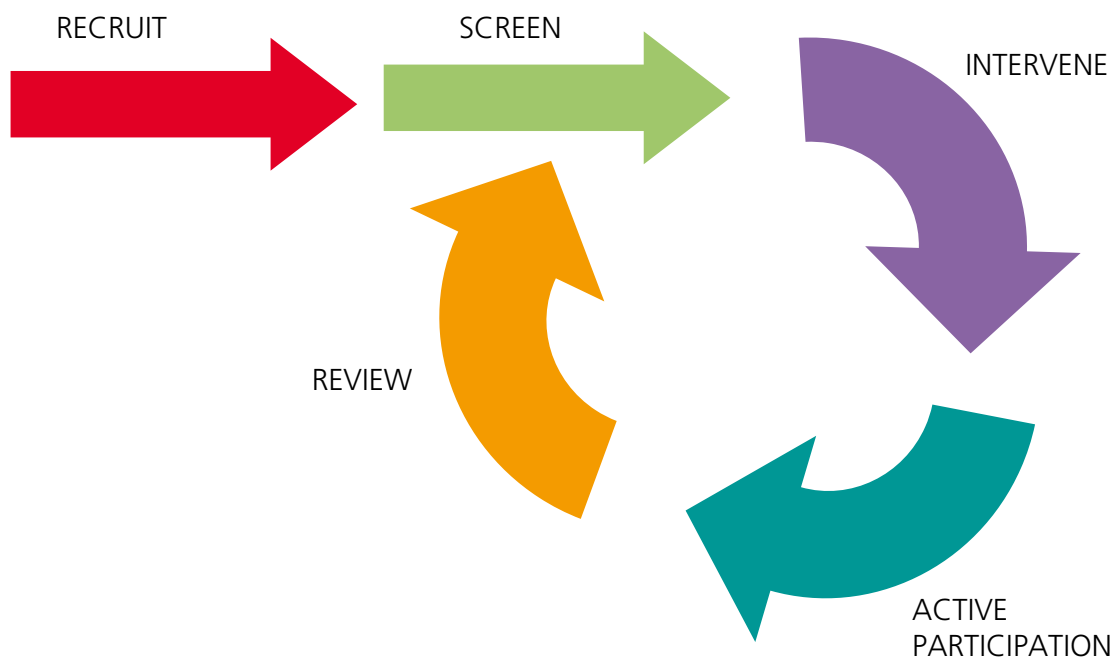
This chapter guides you through Let's Get Moving (LGM) and shows, step by step, how to apply the intervention in primary care (or as an alternative service provider).

The LGM physical activity care pathway has five stages:

1. Recruit
2. Screen
3. Intervene
4. Active participation
5. Review

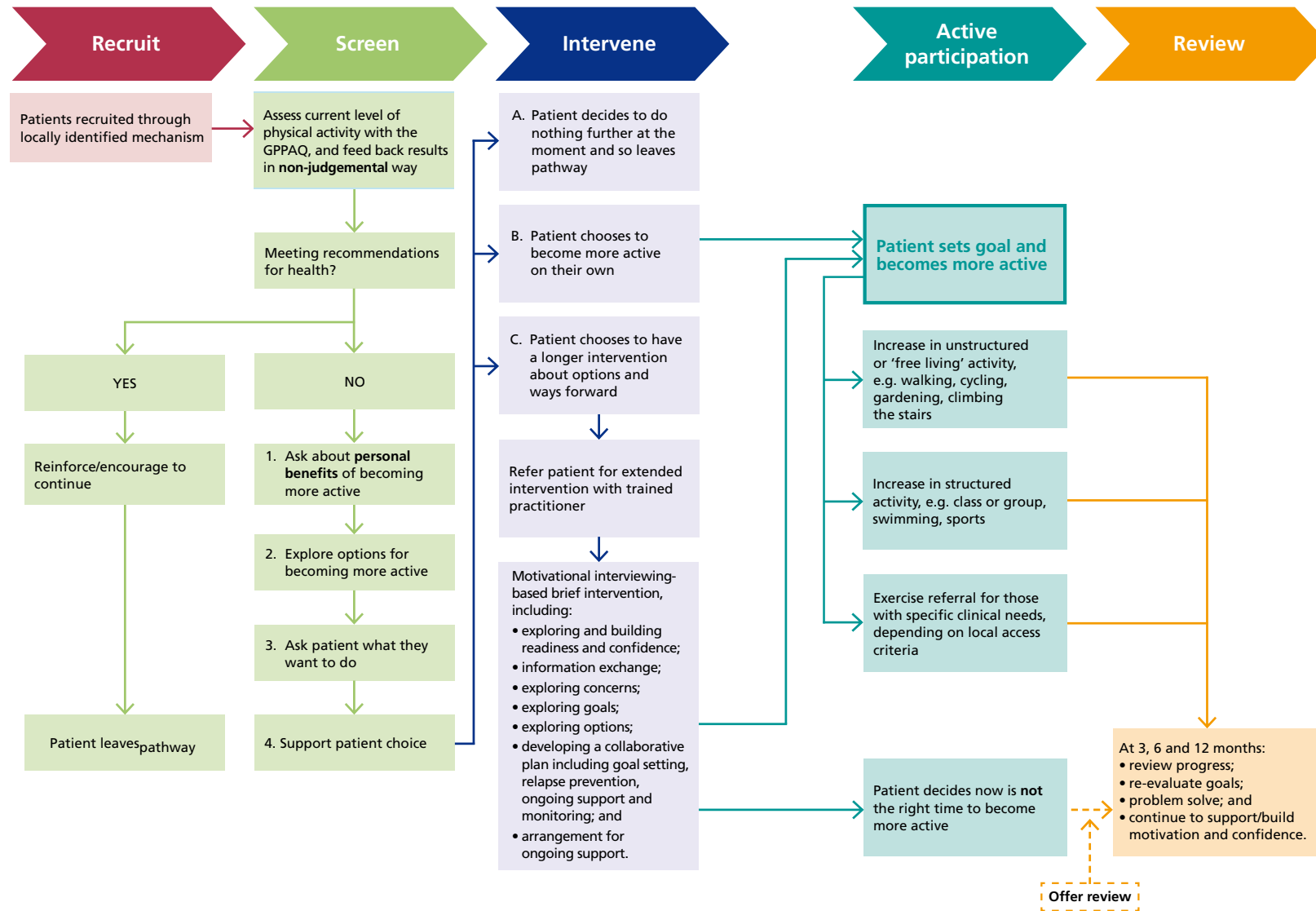
The intervention is designed to be cyclical in nature (as shown in figure 6 below) to reflect the fact that many people will benefit from ongoing support and encouragement in their efforts to become and remain sufficiently physically active to improve their health and well-being.

Figure 6. The cyclical nature of LGM intervention



The full physical activity care pathway schema is provided on page 25.

Figure 7. Let's Get Moving: A physical activity care pathway



The following sections provide more information on each of the five stages.

1. Recruit

Effective patient recruitment is key to the successful local implementation of LGM. The primary aim of this physical activity care pathway is gradually to increase the physical activity levels of adults (16+) not meeting the Chief Medical Officer's (CMO's) recommendations for physical activity. There are a range of possible entry routes onto this care pathway for patients, and these can be stipulated as part of the commissioning process.

Entry routes

Entry routes onto the pathway can include:

- new patient registrations;
- existing and new clinical pathways, for example NHS Health Check, the adult obesity care pathway;
- existing disease registers or other practice records;
- existing condition-specific clinics, for example weight management, diabetes management and stop smoking clinics; and
- opportunistic entry from routine clinical consultation.

Recruiting

The most effective means that the feasibility study identified of recruiting patients onto the pathway are face-to-face, in writing and by telephone. SMS messaging, while less effective for initial recruitment, proves to be an effective follow-up prompt.

Promotion

Promotion of LGM in primary care or other settings which deliver the intervention will be key to creating further awareness and availability of the service among the local patient population. For example, informative posters and leaflets can be displayed in waiting areas or at reception, which will encourage patients to participate in LGM.

2. Screen

The screening of patients for eligibility to enter the care pathway uses a validated and concise questionnaire, the GP Physical Activity Questionnaire (GPPAQ). Further practical implementation advice for the GPPAQ is available under the Publications section on the Department of Health website.

Completion of GP Physical Activity Questionnaire

The GPPAQ has been tested and validated for patient self-completion.

Patients can be encouraged to complete the questionnaire in the reception/waiting area, by post or during a consultation. It is important to note that patients who don't speak English as their first language may require assistance in completing this questionnaire. Completion of the GPPAQ is estimated to take approximately 2 minutes.

Analysing the GP Physical Activity Questionnaire

The GPPAQ classifies patients into one of four physical activity categories, collectively known as the Physical Activity Index (PAI):

- inactive;
- moderately inactive;
- moderately active; and
- active.

Patients classified as inactive, moderately inactive or moderately active are not meeting the CMO's physical activity recommendations and can be invited to participate in LGM. Patients classified as 'active' – that is, already completing at least 150 minutes of moderate activity a week – are to be encouraged to remain active in future and exit the pathway. **Please note that as patients over-report walking, this is not included in the PAI calculation.**

Technical details

The GPPAQ has an algorithm (a software formula) that automatically calculates what category a patient is in. There is an Excel spreadsheet available with the questionnaire and algorithm, which can be used to calculate the PAI, after which the appropriate 'Read Code' can be input into the patient record. In addition, this algorithm is available within the majority of software systems.

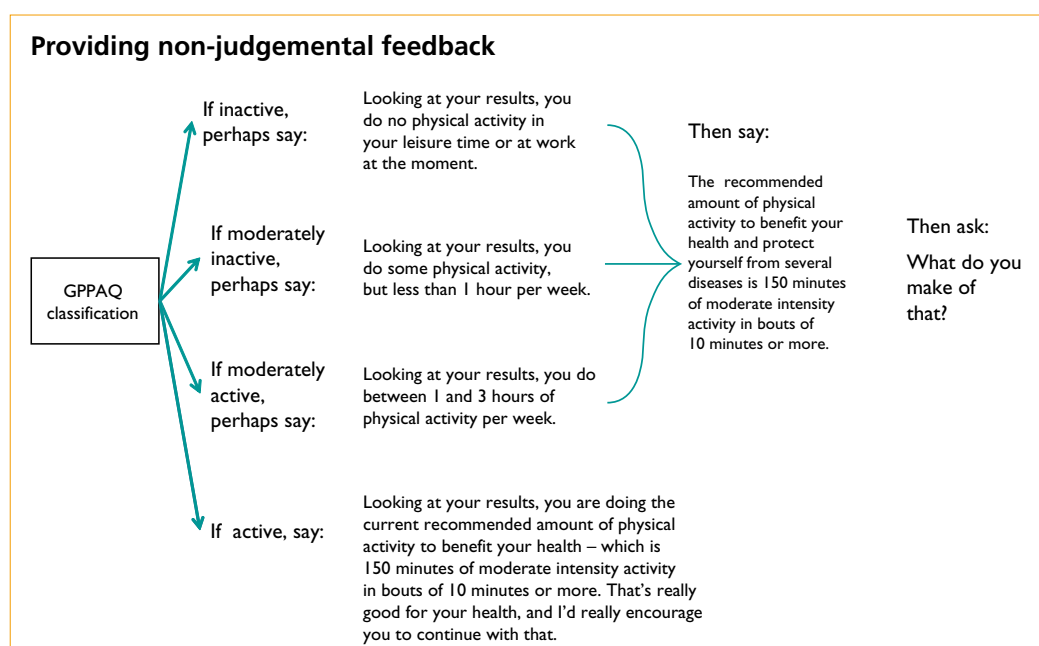
There are Read Codes available for each category – these should be recorded on patient record templates. There is also an additional Read Code that practitioners can use to record any additional assessment of walking levels. This records '30 minutes a day of at least moderate intensity walking on five or more days of the week'.

Feeding back the results of the GP Physical Activity Questionnaire

The way in which the results of the screening test are communicated to the patient may influence the likelihood of the patient acting on the information and becoming more active.

LGM recommends that a neutral, non-judgemental approach is adopted, using open questions to explore what the results mean for the patient – in line with a motivational interviewing (MI) approach.

Figure 8. Illustration guideline to feeding back GPPAQ results in an MI-based, patient-focused consultation



The practitioners' ability to adopt the above tried and tested approach is integral to the success of the intervention. This feedback takes a matter of minutes and done well can significantly influence the patient's likelihood of behaviour change. Therefore, supporting and helping practitioners to develop an MI patient guiding style will form a vital part of the LGM training package.

Recording and measuring behaviour change

While the GPPAQ is an effective tool to measure a patient's physical activity levels and correlates to CVD risk, it is less useful for measuring more specific changes in physical activity levels over time, as walking is specifically not included in the GPPAQ calculation due to over-reporting.

There are other options for tracking changes in a person's level of physical activity. One of these is a single-item seven-day recall measure, validated to measure physical activity levels and used mainly in community physical activity programmes. This can be used for associated local physical activity opportunities and also, if desired, be used in addition to the GPPAQ in the screening consultation and then also at follow-up. Further research aims to determine its validity to measure an individual's changes in physical activity levels over time.

3. Intervene

The 'intervene' stage is designed to support patients in becoming more active, using an MI guiding style which encourages (rather than directs) and strengthens patients' intrinsic motivation to change. It is defined as:

A collaborative, person-centred form of guiding to elicit and strengthen

It is important to note that the **screening and results feedback** phase can be considered to contribute to an abridged version of the intervention and can be delivered by practitioners who have completed module 1 of the LGM training. Done well, this phase can increase the likelihood of patient behaviour change.

It is anticipated that after screening and feedback have taken place, **patients will choose one of the following options:**

- a) Do nothing just yet – continue with current activity levels.
- b) Become more active on their own.
- c) Have a longer conversation with a trained MI practitioner.

Detailed information about how to support patients making each of these choices will be provided during the LGM training programme, which supports the local roll-out of the pathway (see annex 7).

Those patients wishing to have a longer conversation (option c from above) should either be offered a brief intervention immediately or be referred to a local practitioner to deliver this. The person who delivers a full brief intervention must have completed module 2 of the LGM training or already be experienced in MI. This MI-based brief intervention includes:

- exploring and building patient readiness and confidence;
- information exchange – in a neutral, patient-engaging style;
- exploring patient concerns;
- exploring patient goals;
- exploring options;
- developing a collaborative plan, including goal-setting, relapse prevention, ongoing support and monitoring; and
- making arrangements for ongoing support.

Signposting to activity – ensuring patient safety

For most patients, the risks to health of remaining inactive far outweigh the transient and small increases in health risk associated with becoming more active. These risks associated with becoming more active can be further reduced by:

- encouraging patients to build up their activity levels gradually and to a moderate intensity (following the CMO's recommendations);
- advising patients to avoid vigorous intensity exercise until ready;
- advising patients to stop activity and seek advice if they develop new or worsening symptoms; and
- signposting individuals with specific conditions to undertake a period of appropriately supervised physical activity, if appropriate, desired by the patient and in line with local guidelines – for example exercise on referral programmes. Such programmes should follow Department of Health policy on exercise referral schemes (which can be found at: www.dh.gov.uk or the appropriate National Institute for Health and Clinical Excellence guidance as set out in annex 6.

Further advice and guidance for practitioners on ensuring patient safety will be provided during the training courses which form part of the LGM programme.

Key health fact

The absolute risk of sudden death during and up to 30 minutes after vigorous activity is extremely low, even in individuals with cardiac disease (1 sudden death per 1.51 million episodes of physical exertion).³³

The Let's Get Moving patient support pack

It is recommended that the patient support pack is offered to every individual who:

- chooses to become more active through the abridged version of the intervention; or
- chooses to take up the longer 'brief intervention'.

It is recommended that patients who choose not to participate in the intervention and leave after being screened are provided with a generic British Heart Foundation (BHF) physical activity leaflet.³³

The LGM patient pack is designed to support patients in their efforts to become more active and contains helpful hints, practical examples, simple visual tools and personal planning exercises (practitioners might also wish to use the resource to guide patients towards becoming more active).

The pack has templates for relevant local information on indoor and outdoor activity opportunities. These templates should be completed locally, printed and inserted into the LGM patient pack prior to distribution to the service deliverers. There is also an online search tool available on NHS Choices (www.nhs.uk/letsgetmoving). Maps of local walking routes and green space are another supportive tool that can be included in the patient pack: these were very well received by patients in the LGM feasibility pilot.

The BHF also provides a good selection of leaflets on becoming more active in relation to specific diseases, as does SportEX. These can also be used to complement the LGM pack (details are given in annex 9).

4. Active participation

This stage does not directly require practitioner involvement – but some patients will benefit from a degree of ongoing support, for example from a health trainer.

It represents a period of up to 12 weeks between the 'intervene' and 'review' stages of the pathway, in which patients work towards their physical activity goals that were set during the intervene stage. Physical activity goals will include unstructured activity (e.g. walking, cycling, gardening, taking the stairs) and structured activity (e.g. walking groups, exercise classes) that suits the patient's needs and interests them.

Examples of activities some patients will choose to set goals around include:

- active travel (walking and cycling);
- recreational walking;
- recreational cycling (e.g. British Cycling-led Skyrides);
- locally led walk groups (e.g. Walking for Health);
- dance classes;
- informal/recreational sport (e.g. frisbee in park, football with friends);
- swimming;
- gardening and active conservation;
- introductory sports sessions (e.g. Get Back into Netball or beginners' badminton);
- local leisure facilities;
- condition-specific services (e.g. exercise on referral, falls prevention, cardiac rehabilitation); and
- community and third sector class and course programmes.

During this phase of the pathway the LGM patient support pack can act as a helpful and motivating resource for patients.

Many patients will benefit from a degree of professional support during this phase of the pathway – this could be agreed during the brief intervention conversation.

Patients may also benefit from knowing how to engage with local health trainers or exercise professionals working within the leisure services.

5. Review

The programme recommends that patients are followed up over 3, 6 and 12 months following the initial intervention (or more if deemed necessary). Ideally, this follow-up will be conducted by the professional who undertook the original LGM intervention.

During the follow-up intervention, the practitioner will reassess the patient's physical activity levels and check for any changes compared to when the patient started on the pathway (for example via verbal feedback on achievement from the patient, or using the single-item measure). In this consultation the practitioner should be supportive of the patient and continue to help them develop their belief ('self-efficacy') in their ability to become and stay more active.

The practitioner will then recomplete stages 2 to 4, continuing to implement an approach that is guiding and supportive, helping the patient explore the progress they have made towards their physical activity goals, as well as the difficulties they may have encountered and possible solutions to these.

It is important to remember that many people find it hard to become and remain sufficiently physically active to benefit their health, so the need for support and encouragement is to be expected.

Follow-up interventions should be recorded on the patient record.

chapter 3

Commissioning Let's Get Moving

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Introduction

This chapter and its linked annexes provide a framework for commissioning Let's Get Moving (LGM). It is intended to equip commissioners with the necessary knowledge to commission and ensure the delivery of a high-quality, integrated physical activity screening and brief intervention service.

The LGM commissioning guidance:

- demonstrates the benefits of working with local partners, to commission an effective and high-quality LGM service;
- supports commissioners in using LGM to meet local health needs priorities;
- supports commissioners in prioritising and making sound financial investments, specifically assisting the move towards lower-cost, more efficient and effective services in primary care, reducing the demand for and costs of acute care;
- assists commissioners in completing a needs assessment in order to implement the LGM service;
- creates flexibility for commissioners to establish the best model and identify the most appropriate service providers to deliver LGM and health outcomes for the locality;
- highlights how best to engage clinicians in implementing and delivering LGM in a general practice environment;
- provides information on suggested approaches to the evaluation of LGM services; and
- promotes improvement and innovation by providing measures to monitor quality and improvement, to use in service specifications for service providers delivering LGM.

It should be noted that this guidance cannot fully reflect the proposed changes to the health and care system. Subject to Parliamentary approval, local authorities will be given the duty from April 2013 to take steps to improve the health of their local populations, which could include commissioning physical activity programmes. Decisions on how physical activity services are commissioned, including LGM, will be determined locally. If local authorities choose to commission LGM, they are encouraged to look at a number of different models for delivery of the programme to best suit local priorities.

1. Commissioning explained

LGM can be commissioned locally using the agreed systems and procedure to secure budget approval.

Local areas can decide whether they wish to commission LGM as part of their strategy to improve the health of their local population, meet local priorities and support the achievement of financial balance.

The service can be tailored by the commissioners to meet local needs:

- by targeting specific population groups or geographic areas. LGM might be commissioned across the whole area, or used selectively, for example in a selection of wards, to tackle areas with high levels of health inequality; and
- as a solution to meet the needs of other initiatives such as NHS Health Checks.

The delivery method for LGM is flexible and can be adapted to the needs of your locality. The recommendations set out in this commissioning guidance are based on the NICE public health guidance,⁵ and are supported by key learnings from the LGM feasibility study. As such, LGM is primarily aimed at delivery by health practitioners in primary care.

In line with best practice and procurement principles, you may also wish to draw on wider evidence (for example, from Local Exercise Action Pilots) to commission other service providers such as exercise professionals delivering LGM in the surgery or pharmacists delivering it in the community – for further details, see annex 4.

2. Key principles

LGM is a behaviour change programme that incorporates a physical activity care pathway, designed to assist adults to become more active. The approach is based on the recommendations of the NICE public health guidance,⁵ which endorses the delivery of brief interventions for physical activity in primary care as being both clinically effective and cost-effective in the long term.

The intervention can be accessed by any patient between 16 and 74 years of age who is classified as being less than physically active. The age range is restricted to 16 to 74 as the General Practice Physical Activity Questionnaire (GPPAQ) is only validated for this population.

For the purpose of the LGM intervention, being 'less than physically active' is defined as adults who are not meeting the Chief Medical Officer's (CMO's) recommendation for general health of at least 150 minutes of moderate intensity physical activity a week. Although LGM is appropriate for all those not achieving the CMO's recommendations (as classified by GPPAQ), commissioners might want to focus specifically on patients who are inactive (achieving less than 30 minutes of moderate intensity activity a week) where significant health gains can be quickly accrued.

LGM can be used for both the prevention and management of all physical activity-related chronic disease, including cardiovascular disease (CVD), coronary heart disease, stroke, type 2 diabetes, chronic kidney disease, some cancers, chronic obstructive pulmonary disease (COPD), obesity, musculoskeletal conditions and some mental illness.

LGM can be integrated into other care pathways where physical activity has a role to play, including NHS Health Check, COPD, obesity, stop smoking adherence, falls prevention and cancer (six-month follow-up). See annex 3 for more details.

In order for a service provider to be deemed suitable to deliver LGM, they must have completed the LGM training and follow the five key processes of: recruit, screen, intervene, active participation and review (see the LGM physical activity care pathway schema in chapter 2).



LGM offers a practical, innovative way to support people to lead more active lives and to improve their quality of life, whether they are living with a chronic disease or are at risk of developing one. As part of an overall approach to prevention, LGM has the potential to reduce the burden of disease and create savings in the long term. Working in partnership with local authorities and the voluntary sector will open up new opportunities for people to become active.

Sarah Price, Director of Public Health, NHS Islington

3. A step-by-step guide to commissioning

The following section facilitates commissioners as 'place shapers' to make local decisions to suit local circumstances and provides a checklist for the commissioning process to ensure the delivery of a high-quality service. For further details of these sections please refer to the annexes.

	Action	How to
1.	Identifying and establishing local population's physical activity requirements	<ul style="list-style-type: none"> • Obtain local prevalence data for physical inactivity. This information can be sourced from the Active People Survey or other local surveys. • Review physical inactivity prevalence data by different demographic factors in order to identify local trends and associations. You can also access data on the local health cost of inactivity for a range of conditions on the Department of Health website. • Obtain data that relates chronic disease levels to physical inactivity. For regions, the Promoting Activity Toolkit (www.promotingactivity.com) holds a planning tool which can help correlate physical activity to chronic disease levels, or your region's public health observatory may be able to help you collate this data. • Consider the information contained within your local Joint Strategic Needs Assessment (JSNA) in conjunction with the data sets identified in the points above, plus local priorities and targets, in order to identify the 'at risk' target population most appropriate for the LGM intervention in your area. • Refer to the Department of Health's LGM economic analysis in this document (page 44) to help identify the costs of the intended delivery model for your area. • Delivering good-quality physical activity care will require organisations to demonstrate competence in identifying and taking action on inequality issues, and will also require engagement with communities that have experienced difficulty in accessing public services. The LGM Equality Impact Assessment can be used to support this process.
2.	Prioritising commissioning	<ul style="list-style-type: none"> • Use the NICE research report <i>Modelling the cost effectiveness of physical activity interventions</i>³⁴ to compare LGM to other public health interventions in order to assess value for money for specific target populations and/or disease groups.

	Action	How to
3.	Ensuring delivery capacity	<p>Ensure the capacity of primary care/other service deliverers for LGM is sufficient to meet patient demand generated by the implementation of LGM for your target population. It is recommended that commissioners consider the following:</p> <p>A. Models for delivering LGM</p> <ul style="list-style-type: none"> • When considering which model to commission, take into consideration: <ul style="list-style-type: none"> – the capacity and ability of local providers to deliver the intervention in relation to other competing priorities; – how the intervention will align with local priorities and other initiatives such as NHS Health Check; and – the number of practitioners the commissioner will need to train to ensure that the anticipated demand for the intervention can be met. LGM can only be delivered by appropriate healthcare professionals who have successfully undertaken the minimum LGM training required. <p>B. Incentives for GP surgeries/service providers</p> <ul style="list-style-type: none"> • If commissioned directly by the Public Health Team, develop an agreement which can utilise the service objectives and health outcomes provided in annex 1 where possible. The agreement should clearly stipulate methodology, target audience, quality and service levels expected (see annex 2 for supporting cost information). <p>C. Physical activity services</p> <ul style="list-style-type: none"> • Adopt a leadership role, developing partnership between the local authorities, the voluntary sector and the County Sports Partnerships to ensure provision of local physical activity services appropriate for adults new to physical activity. See annex 4 for further information and case studies.
4.	Supporting LGM take-up	<ul style="list-style-type: none"> • Consider the capacity of the commissioner to coordinate and lead the implementation of the LGM intervention and to support the service provider. • Where an agreement is in place, consider the following actions to encourage GP surgeries to implement the LGM intervention: <ul style="list-style-type: none"> – Undertake visits to surgeries to explain the benefits of LGM, an overview of commitments and LGM protocol. – Coordinate a working group involving local practitioners to drive the delivery of the LGM intervention. – Identify GPs and practice nurses willing to champion the promotion of physical activity and drive implementation. – Highlight successful case studies. <p>The above is important for all models of implementing LGM, as health professionals should be trained and encouraged to signpost to LGM whoever the service deliverer may be.</p>

	Action	How to
5.	Information management and auditing	<ul style="list-style-type: none"> • When commissioning the LGM intervention, it is recommended that commissioners consider selecting a set of appropriate measures to assess service delivery. As with other services, the commissioner should consider how these and other measures are used to ensure that the quality of the service is continuously improved. For example, the commissioner may consider using a balance of the following measures in order to monitor quality of the intervention, equity of access and patient outcomes: <ul style="list-style-type: none"> – GPPAQ: Physical Activity Index Score (developing a GPPAQ register); – number of people given a brief intervention; – age, ethnicity, gender and postcode of patients; – follow-ups undertaken at 3, 6 and 12 months; – physical activity single item measure at initial assessment and follow-up; – patient experience; and – practitioner experience. <p>If aligning with other NHS initiatives you may also wish to measure other health outcomes, for example blood pressure, body mass index (BMI) and blood glucose.</p> • The focus of this service is on delivery in GP surgeries; if local commissioners choose to commission LGM in other primary care services such as pharmacies and dietetic and physiotherapy departments, systems should be implemented to ensure that the physical activity index generated by the GPPAQ is recorded and that patient history and any existing clinical conditions can be taken into consideration. • There are established Read Codes aligned with the GPPAQ physical activity index and walking measure that can be used to record activity levels directly into patient records. These are available in the GPPAQ document on the Department of Health's website (see annex 9 for details). • Any communications strategy or provision should be coherent with, and follow, local policies, the NHS Confidentiality Code of Practice and vulnerable adult protection procedures. It should outline the mechanisms to safeguard patient information when shared within an integrated service. Procedures should be put in place to obtain patients' consent for the onward transmission of their records. Providers should comply with the commissioner's policies on secure data transmission.

	Action	How to
6.	Patient and public involvement in LGM	<ul style="list-style-type: none"> • When commissioning a service provider to deliver LGM it is suggested that the specification require them to demonstrate: <ul style="list-style-type: none"> – active engagement with people and local communities in developing services; and – how they will respond to patient feedback: this data should be used to shape and improve physical activity services. • For example, as part of the regular evaluation of patient experience, service providers could be asked to use the monitoring data within the information management section to help achieve the above. • Involving family carers and supporters will help deliver the components within this service specification. Local HealthWatch, the voluntary sector and patient advocacy organisations are further mechanisms to seek active involvement in service planning, delivery and monitoring of the LGM care pathway.
7.	Clinical governance	<ul style="list-style-type: none"> • Clinical governance arrangements with your service provider must be proportionate to the service provided and comply with any local expectations or requirements of the commissioner. • Providers should be required to demonstrate their coordination of and involvement in regular inter-professional and inter-agency meetings and regular clinical audit of the service interventions. This audit can be carried out by extracting data using the Read Codes provided and any other measures set by the commissioner (for example using additional measures set out in annex 1). • Any commissioned service must meet existing relevant national and local standards of service quality and clinical governance.
8.	Professional competency, education and training	<ul style="list-style-type: none"> • The Department has developed a standardised LGM training package: <ol style="list-style-type: none"> 1. Training module 1 (3 hours): comprehensively covers physical activity for health, and provides an overview of the pathway and an introduction to motivational interviewing (MI). This module enables providers to deliver an abridged (but not full) version of the brief intervention. Those already experienced in MI who attend this module will be able to deliver a full brief intervention. 2. Training module 2 (1.5 days): develops MI skills; when incorporated with module 1, enables practitioners to provide the full intervention. Unless already MI trained, all providers delivering the full brief intervention will be required to attend both modules 1 and 2. • All service providers delivering the LGM intervention will be required to have all practitioners complete training module 1. • Where there is capacity, training module 1 can be delivered in-house by an individual who is competent and confident in training professionals. If there is limited capacity, an external organisation can be commissioned to deliver the training. • Commissioners may also wish to consider some form of equalities training for their service provider.

	Action	How to
9.	Patient, public and staff safety	<ul style="list-style-type: none"> • In commissioning providers, commissioners should consider requiring the following: <ul style="list-style-type: none"> – providers demonstrate that evidence-based clinical guidelines are being used, i.e. NICE public health guidance 2006;⁵ – providers have in place appropriate health and safety and risk management systems, and ensure that the required premises standards are met and that any risk assessments and significant events are both documented and audited regularly and outcomes of these implemented; – services comply with national requirements for recording, using an agreed process for risk reporting, investigation and implementation of learning from incidents. Further details can be found on the National Patient Safety Agency website (www.npsa.nhs.uk); and – providers ensure that staff undertaking patient assessments have full Criminal Records Bureau checks/clearance.
10.	Managing complaints	<ul style="list-style-type: none"> • In commissioning providers, commissioners should consider requesting providers to ensure that responsive protocols and procedures are in place for managing patient complaints. These should be available in easy-to-read format so that they are accessible to people with limited communication skills. Complaints should be reviewed at regular intervals and learning from these shared and applied as appropriate to ensure that services are continually improved.
11.	Marketing	<ul style="list-style-type: none"> • It is recommended that local areas put in place a programme that informs local people of the service and its benefits. Social marketing is an important approach to ensuring the success of this service. • The Promoting Activity Toolkit (www.promotingactivity.com) provides physical activity insight into adult population groups. There are communication plans for individual groups, with tested marketing statements that inspire adults to consider becoming more active. An online design tool can be used to produce promotional material that targets specific local populations. The toolkit also links to the Change4Life programme and appropriate Change4Life messaging and branding. • LGM can be linked locally to Change4Life. Change4Life continues to develop messages to support the work around the physical activity guidelines and increasing physical activity participation. The campaign has expanded its reach to include adult focused activity, which includes the 'Get going every day' campaign to support individuals to increase their physical activity levels. • Commissioners could also consider other ways of promoting physical activity directly to patients. For example, by using community network television in waiting rooms as an effective way of reaching patients. • Marketing to target specific groups, in terms of both the design of and the location of marketing, can support take-up of the intervention and also of related physical activity opportunities by hard-to-reach groups.

	Action	How to
		<ul style="list-style-type: none"> • In developing any local marketing material, the following guidance may help: <ul style="list-style-type: none"> – Ensure material is agreed/signed off in advance by the commissioner to ensure consistency of messaging. – Use language appropriate to the target audience. – Reflect different cultural health beliefs.
12.	Patient support	<ul style="list-style-type: none"> • The LGM patient pack is available to order from the Department of Health (see resources annex 9). In addition, template sheets for featuring local activities are available for download from the Department website. The activity templates should be completed and copies printed for insertion into all LGM patient packs before they are distributed. The templates will allow you to feature local indoor and outdoor physical activity opportunities. • A helpful online search tool which can be promoted to the public and can also help with collating information for the templates is at: www.promotingactivity.com or www.nhs.uk/letsgetmoving. • You can also consider including information on national initiatives that are available locally, such as Walking for Health (previously WHI) groups. You may also want to include a local walking map.

Annexes

Supporting information for commissioning Let's Get Moving

Annex 1: Developing a Let's Get Moving service specification

In commissioning **Let's Get Moving** (LGM), commissioners may find the following measures set out below in the service objectives and health outcomes sections useful. This list is not exhaustive, and local leads might want to add additional outcomes when commissioning service providers.

a) Service objectives

When providing LGM to your local population, the following service objectives and measures are suggested for adoption when commissioning service providers. This list is a guide, neither mandatory nor exclusive.

Pre-intervention planning	
Service objective	Measure/benchmark
Effectively engage target population(s) to assess physical inactivity systematically.	Commissioning of LGM meeting local health needs – for example Joint Strategic Needs Assessment (JSNA). Numbers of patients who have a General Practice Physical Activity Questionnaire (GPPAQ) score and are given a brief intervention, correlated against key health inequalities and other relevant demographics.
Target services appropriately to reduce, rather than widen, health inequalities.	Commissioning of LGM meeting local health needs – for example JSNA. Numbers of patients (including demographics) who have a GPPAQ score and are given a brief intervention.
Improve access to high-quality physical activity services in primary care (and the local community).	Commissioning of LGM in conjunction with local commissioning processes and adhering to the National Institute for Health and Clinical Excellence (NICE) public health guidance <i>Four commonly used methods to increase physical activity</i> . ⁵
Complement and reinforce other prevention and management services where physical activity has an impact.	Consider commissioning LGM to support other services such as NHS Health Check, chronic obstructive pulmonary disease (COPD) etc. – see annex 3 for full list.

Pre-intervention planning	
Service objective	Measure/benchmark
Provide a seamless, integrated protocol that supports patients in accessing local physical activity opportunities, delivered by a variety of partners.	<p>Engage with local partners to review physical activity opportunities and ensure that they are available.</p> <p>Ensure LGM patient pack template activity leaflets are completed and sent to the service providers. Should service providers prefer to order their own stock of LGM patient packs directly from the Department's order line (www.orderline.dh.gov.uk), they will be required to download the LGM activity templates from the physical activity section on the Department website for completion, printing and insertion into the patient packs.</p>

Service delivery	
Service objective	Measure/benchmark
Promote better physical inactivity management among healthcare professionals.	<p>The number of locations/service providers commissioned to deliver LGM.</p> <p>Number of professionals trained to deliver LGM.</p>
Provide inactive patients with targeted advice and appropriate signposting.	<p>The number of service providers delivering LGM.</p> <p>Evaluation of both service provider and patient experiences of the service.</p>
Establish an up-to-date and complete register of the GPPAQ physical activity index for appropriately targeted populations, recording and monitoring read codes in patient records.	<p>Auditing of service providers at regular intervals, requesting GPPAQ data and demographic information.</p>

b) Intended health outcomes

When providing LGM to your local population, the following health outcomes and potential measures are suggested and can be used to assess service providers' performance. This list is not exclusive – alternative measures can be adopted.

Health outcome	Measure/benchmark
Contribute to increasing life expectancy and reduction in premature mortality.	Suggest evaluating intervention including patient health outcomes, for example body mass index (BMI), hypertension, blood glucose, cardiovascular disease (CVD) risk score, cholesterol.
Reduce inactivity levels in areas with particularly high levels of health inequalities.	<p>Audit patient records for GPPAQ score and patient behaviour change. Reflect on these in relation to your local inequality indicators.</p> <p>Until a national Read Code is available for follow-up on physical activity levels, a local Read Code could be developed.</p>
Raise awareness among patients and their families of the health problems associated with physical inactivity and enable them to take greater responsibility for their own health.	<p>Audit the delivery of the brief intervention; until a national Read Code is available a local Read Code could be developed.</p> <p>Qualitative research on patient experience of LGM can also assist evaluation of this health outcome.</p>
<p>Reduce the prevalence of physical inactivity by increasing:</p> <ul style="list-style-type: none"> • the number of adults who achieve incremental increases towards the Chief Medical Officer's (CMO's) recommendation on physical activity; and • the number of adults who meet the CMO's recommendation. 	<p>The following can assist evaluation of this measure:</p> <ul style="list-style-type: none"> • auditing the GPPAQ; • using the single-item measure for physical activity; and • reviewing the annual Active People Survey scores.
Reduce the prevalence of physical inactivity-related chronic disease.	Audit patient health outcomes such as BMI, hypertension, blood glucose, CVD risk score and cholesterol.

Annex 2: Cost implications – return on investment

There are two key sources of information to help you assess the set-up costs and return on investment from LGM in your local area. These are the NICE research report³⁴ and the Department of Health economic analysis (in this annex):

In the NICE research report and costings template:

- NICE has calculated the likely costs of implementing its guidance on brief interventions in primary care.
- This includes a costing report and a local costings template. This is a simple spreadsheet that can be used to estimate the local cost of implementation of the recommendations on brief interventions for physical activity.
- This produces specific estimates for each PCT based on population size and estimated levels of physical activity, the number of consultations per year, and the cost of 'normal care'.

The Department of Health analysis includes details of:

- predicted patient uptake of LGM;
- predicted increase in physical activity as a result of LGM;
- relative CVD risk reduction from LGM intervention;
- estimated workforce costs of delivering LGM;
- projected lifetime cost of the LGM intervention; and
- projected lifetime quality-adjusted life year (QALY) gain from LGM.

Areas where commissioners can expect to incur direct costs for setting up LGM include:

- training practitioners to deliver LGM;
- providing practitioner (locum) cover to allow primary care staff to attend LGM training;
- officer time, for example promoting LGM to and supporting GP surgeries;
- completing and printing bespoke inserts featuring local activity information for inclusion in LGM patient pack;
- incentivising GP practices and other service providers for LGM intervention delivery and follow-up; and
- commissioning of any additional physical activity services, for example Walking for Health (formerly WHI) groups.

Using the costing methodologies available, the two examples overleaf provide indicative information that can support commissioners to assess set-up costs and return on investment.


NICE: indicative costs

Please note that these costs are based on PCT populations.

An example of a PCT is shown below, which using the NICE costings template takes account of the cost of the existing brief intervention programme and the cost of developing a new programme, including customised printed materials.

The estimates relate to the whole PCT population, and are based on a number of assumptions:

- percentage of consultations where a brief intervention is appropriate;
- percentage of GPs who undertake brief interventions;
- percentage of cases where follow-up appointments are arranged; and
- percentage of cases where printed materials are provided.

		
Costing summary for public health intervention no. 2 Four commonly used methods to increase physical activity		
Cost of fully implementing the guidance nationally and for Sample PCT		
	National estimate £000s	Local estimate £000s
Current cost of follow-up to brief interventions	10,732	34
Current cost of printed materials	302	1
Total current cost	11,034	35
Predicted cost of follow-up	21,464	67
Predicted cost of printed materials	1,209	4
Total predicted cost	22,673	71
Net cost of implementation	11,639	36

The above example provides an indication cost for a PCT with a population of approximately 122,000. The PCT can expect to incur costs of approximately £36,000 for the establishment of a new brief interventions programme.

This is set against net costs saved per QALY of between £750 and £3,150.



Department of Health: indicative costs

This Department economic analysis is intended to be indicative; local costs will vary according to the delivery methodology chosen and the number and characteristics of the patients targeted.

Based on the NICE public health guidance⁵ and the LGM feasibility study, the following assumptions underlie this indicative costing.

- Workforce cost assumptions:
 - GP – £138 per hour per patient;
 - practice nurse (PN) – £28 per hour per patient;
 - healthcare assistant (HCA) – £22 per hour per patient.³¹
- Training:
 - one GP for 3 hours (module 1) – no cost attached;
 - one PN for 12 hours (modules 1 and 2) – cost incurred;
 - one HCA for 12 hours (modules 1 and 2) – cost incurred;
 - cost of training 2 practitioners for module 2 – approximately £400, i.e. £200/practitioner; and
 - cost of on-going practice support – approximately £200.
- Assessment and brief intervention takes 14 minutes.
- Support activity following brief intervention and follow-up costs, £5 per patient undertaking intervention.
- The average QALY gained per referral is 0.17;⁵ this results from approximately 6% of patients referred for a brief intervention interview achieving an increase in the number of moderate activity sessions.

For a sample surgery, as an example:

- 500 patients are assumed to be assessed in one year;
- 80% of these undertake the physical activity recommended; and
- 25% of these complete the programme and achieve an improvement in their health.

Indicative set-up costs per surgery

Cost of staff training (time): £414 (GP) + £336 (PN) + £264 (HCA)	= £1,014
Cost of training consultant	= £400
Cost of on-going practice support	= £200
Total training and support	= £1,614

500 patients are assessed and receive brief intervention in one year

	Delivered by GP	Delivered by PN	Delivered by HCA
Cost of assessment and brief intervention	£32 per patient	£6.50 per patient	£5.15 per patient
for 500 patients	£16,000	£3,250	£2,575

80% of patients undertake intervention = 400 patients			
Cost of support activity following brief intervention and follow-up	£5 per patient	£5 per patient	£5 per patient
for 400 patients	£2,000	£2,000	£2,000
Total cost for one year (including training and support)	£19,614	£6,864	£6,189
25% of patients complete programme and achieve health gain = 100 patients			
QALY gain per patient undertaking intervention	0.17	0.17	0.17
Total QALY gain	68	68	68
Cost per QALY gain	£288/QALY	£101/QALY	£91/QALY
The relative CVD risk reduction from this intervention is 14%			



These costs will be specific to the locality and will vary according to set-up, for example the LGM delivery method chosen (see annex 4), how service deliverers are commissioned and so on.

GP surgery incentives

Currently, there is no fixed or nationally agreed price for this service. Commissioners and providers may wish to access alternative funding mechanisms, and should agree provider remuneration to a level which reflects the local service objectives. This could include:

- basic funding for achieving the minimum requirements within the service specification, for example completing the GPPAQ and setting up a GPPAQ register for the target population; and
- additional funding or financial incentive for delivering specific local patient outcomes, for example, delivery of the brief intervention and follow-up.

There are Read Codes aligned with the four GPPAQ physical activity categories, and these can be used as the basis of the monitoring process.

The NICE QALY modelling, supported by the Department of Health economic analysis in this annex, can also support any incentivisation.

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is a voluntary quality incentive scheme which rewards GP practices for the quality of care provided to patients.

There are two QOF cardiovascular disease indicators (PP1 and PP2), which include screening for physical inactivity and delivering a brief intervention. Practices can refer to NICE clinical guideline 67³⁵ and NICE public health guidance PH2⁵ to support delivery of PP2.

Local commissioners may consider promoting the use of QOF indicator PP2 with local primary care providers as a delivery mechanism for LGM.



Annex 3: Let's Get Moving – role in public health initiatives

This section highlights how LGM can help support the delivery of national initiatives and policy at a local level.

Reducing the risk of heart disease, stroke, diabetes and kidney disease

NHS Health Check, aimed at those aged 40–74, will assess an individual's risk of heart disease, stroke, diabetes and kidney disease and provide them with the necessary lifestyle advice and interventions to manage or reduce that risk.

LGM can support the lifestyle and risk management element of the national NHS Health Check programme. It offers a way of providing the brief intervention on physical activity that many individuals will need in order to support them in managing or reducing their risk. Importantly, it will also support the provision of an intervention that is suited and tailored to an individual's needs, which is an important element of the NHS Health Check programme.

In addition, being active supports the prevention of muscle wasting that carbolic stress caused by chronic kidney disease can lead to. LGM can support this specific health issue.

Smoking

In relation to smoking cessation, the authors of a recent Cochrane review found strong evidence supporting the role of regular physical activity in reducing tobacco withdrawal and cravings. LGM can be used to promote being active within the Stop Smoking Service environment.³⁶

Obesity

LGM can be used as a support tool to help overweight/obese patients to increase physical activity and reduce sedentary behaviours, as part of the multi-component approach to weight management recommended by NICE.³⁷

Chronic obstructive pulmonary disease

The outcomes strategy for COPD and asthma seeks to tackle related health inequalities by ensuring better prevention strategies and quicker identification of those at risk, and gives examples of best practice treatment across England.

The current NICE public health guidance states that “pulmonary rehabilitation should be offered to all patients who consider themselves functionally disabled by COPD (usually MRC [Medical Research Council] grade 3 and above)”.

As outlined in the consultation draft of the outcomes strategy, those with COPD who are not sufficiently disabled by their condition to warrant participation in formal pulmonary rehabilitation programmes (MRC dyspnoea grades 2 or 1) should receive the same physical activity message as the general population. This message may need to be tailored to overcome negative expectations about physical activity, including getting out of breath.

LGM offers an opportunity to triage patients to pulmonary rehabilitation and support patients with MRC grade 2 or below.

Cancer prevention and survivorship

The evidence is growing to support the role of physical activity during and after cancer treatment. Keeping active throughout the cancer journey can preserve or improve physical function and psychological well-being, reducing the negative impact of some cancer-related side effects. Regular physical activity also has a potential role of reducing risk of cancer recurrence and increasing survival.

LGM can be utilised by the NHS to enable health professionals to integrate the evidence-based promotion of physical activity appropriately into patient care at a number of points along the cancer care pathway.

Learning Disabilities: Health Check and Action Plan

Directed Enhanced Service for Health Checks for Disability – LGM can be used as a support tool for both the health check and the resulting health action plan. It is essential to ensure that this group has the opportunity to become more active. There may be a need for reasonable adjustments, for example the use of the easy-read leaflets, support to use community facilities or training for leisure centre staff.

Mental health

The NICE clinical guidelines for depression advise that patients of all ages with mild depression should be advised of the benefits of following a structured and supervised exercise programme, typically up to three sessions per week of moderate duration (45 minutes to one hour) for between 10 and 12 weeks. LGM can be used to support this process.

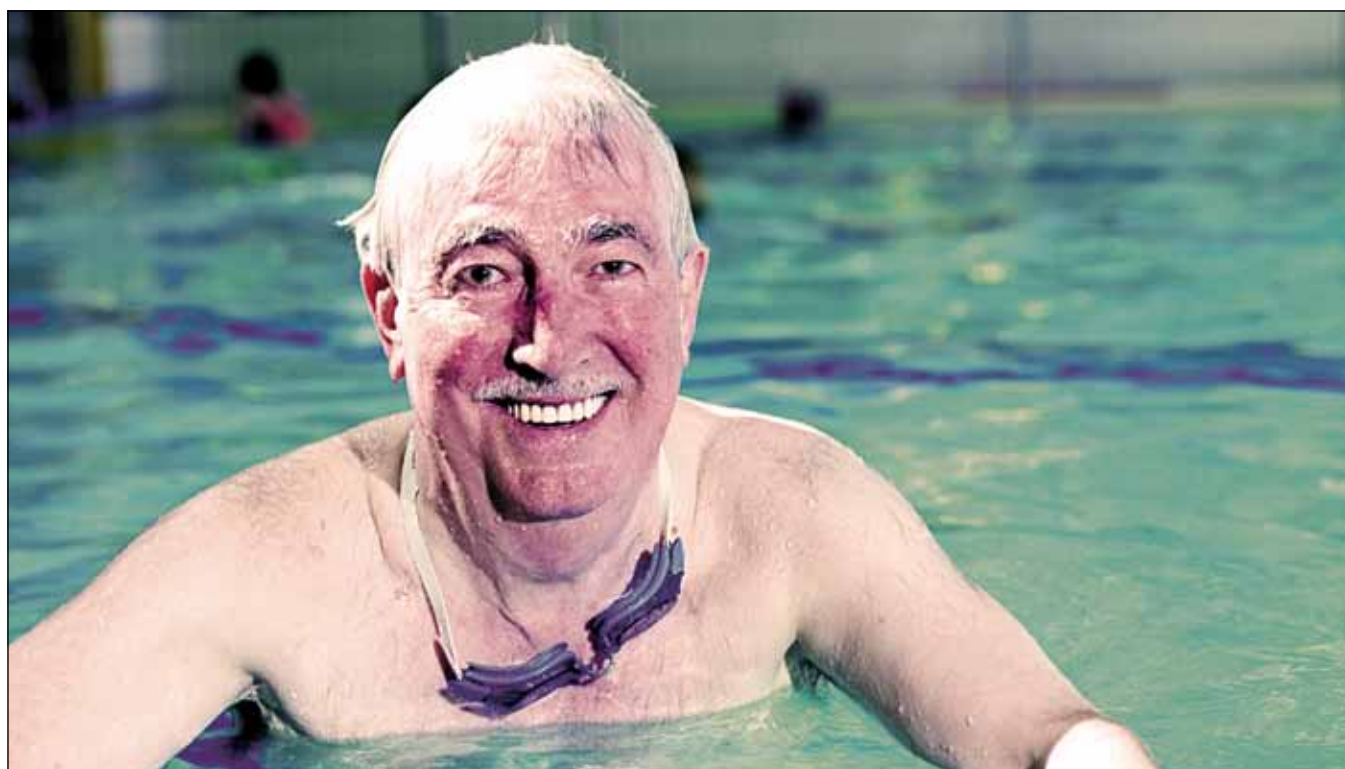
Older people

The NICE public health guidance *Occupational therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care*³⁸ recommends physical activity interventions including led health walks, education and tailored programmes. LGM offers a way to support primary care in delivering this.

Acute care and mental health trusts

The LGM pathway is ideal for inclusion as the physical activity strand of a wider health gain schedule for use by local authority and NHS providers, and could contribute to the ability of acute care and mental health trusts to meet the criteria set out in the Care Quality Commission's Core Standards.

The promotion of physical activity using brief interventions also features in other NICE public health guidance, for example the clinical guideline *Irritable bowel syndrome in adults: diagnosis and management of irritable bowel syndrome in primary care*,³⁹ which stipulates that healthcare professionals should assess the physical activity levels of people with irritable bowel syndrome, ideally using the GPPAQ (see annex 9). People with low activity levels should be given brief advice and counselling to encourage them to increase their activity levels, so offering an opportunity for LGM to act as a solution to this guidance.



Annex 4: Let's Get Moving models

LGM is designed to allow a variety of delivery models to be commissioned to meet the needs of your local population. This section shows how different models can be used to provide the LGM intervention within GP surgeries, using pharmacies, health trainers, dieticians, physiotherapy and other service providers.

Delivery within the GP surgery

As chapter 2 shows, a number of professionals can play a role within the surgery, supporting the completion of LGM at every stage (recruiting patients, screening for inactivity, delivering the intervention, supporting active participation and following up).

Suggested healthcare professionals best placed within the surgery setting to:

1) Support completion of the GPPAQ	2) Delivering the abridged LGM intervention (as defined in chapter 2)	3) Delivering the full LGM intervention and follow up (as defined in chapter 2)
<ul style="list-style-type: none"> • Self-completion by patient • Receptionist • Health trainer • GP • Practice nurse • Healthcare assistant • Exercise professional (commissioned specifically to deliver brief intervention in the surgery) 	<ul style="list-style-type: none"> • GP • Practice nurse • Healthcare assistant • Exercise professional (commissioned specifically to deliver brief intervention in the surgery) 	<ul style="list-style-type: none"> • GP • Practice nurse • Healthcare assistant • Exercise professional (commissioned specifically to deliver brief intervention in the surgery)

Delivery outside the GP surgery

Pharmacies delivering LGM

Community pharmacies are ideally placed to promote health and well-being messages to the millions of people who visit every day. For many, pharmacies represent convenience through:

- easy accessibility, including for people from deprived communities, who may not access other conventional NHS services;
- long opening hours;
- being a local health resource on the high street, in supermarkets, in every shopping centre and in many health centres;
- providing a flexible setting within an informal environment; and
- being a local business well connected to their local community, with staff who tend to reflect the social and ethnic backgrounds of the populations they serve.

Providing opportunistic and prescription-linked healthy lifestyle advice, including advice on increasing physical activity, is an essential service within the community pharmacy contractual framework provided by all pharmacies in England.

In addition to their role in optimising the safe use of medicines, community pharmacies are increasingly delivering a wide range of public health services, from weight management, including increasing physical activity as part of a comprehensive weight reduction programme, to stopping smoking and alcohol intervention services.

Healthy Living Pharmacies, underpinned by the right workforce, premises that are fit for purpose and appropriate stakeholder engagement, are supporting their local communities to improve their lifestyle through providing advice on diet and nutrition and increased physical activity.

One of the key distinctions of a Healthy Living Pharmacy is having a health trainer champion on site, who enables and supports other staff in promoting health and well-being messages to the public, such as the benefits of increasing physical activity, with a dedicated health promotion zone within a health-promoting environment.

Health trainers

Health trainers offer an excellent opportunity to provide behaviour change support to those who have had a brief intervention in physical activity in the community. Health trainers work with clients to assess their health and lifestyle risks, helping to build their motivation to change.

Other service providers

It is also intended that LGM could be delivered through other service providers and settings such as: leisure operators, community centres, private gyms, workplaces, dietetic and physiotherapy services, acute and secondary care and so on. This may be particularly important to reach groups not registered at a GP surgery who would benefit from this intervention.



Case studies: Let's Get Moving in action

NHS Haringey, Let's Get Moving pilot

NHS Haringey took part in the Let's Get Moving physical activity care pathway pilot. As a result of this involvement, staff at Pandya Practice recognised the importance and value of physical activity, and realised the potential of the pathway for improving the health of their patients.

Both Dr Sejal Pandya and Nurse Practitioner Sharon Seber were involved in delivering LGM. They found the pathway to be particularly useful in opening up a dialogue about physical activity with patients and for supporting patients in making these important health behaviour changes. To support the care pathway, a health walk from the practice was also established which continues to be well attended by patients.



Embedding the physical activity care pathway (LGM) within the primary care setting will provide a systematic approach to addressing the issue of inactivity. In addition, research indicates that healthcare professionals are a trusted and credible source of information.

The LGM pathway is innovative and evidence-based. It uses a person-centred approach to facilitate behaviour change, which research suggests patients prefer.

The roll-out of the new care pathway is hugely welcomed for many reasons: for example, in helping to raise the profile of physical activity among both patients and health professionals. In addition, it will provide support for other health interventions such as NHS Health Checks and will assist efforts made in primary care to prevent and manage a range of long-term conditions, for example, diabetes, obesity and CHD [coronary heart disease].

Given that those who are the least active have the most to gain from increasing their activity levels, this intervention needs to be given the high priority it deserves by PCTs. Let's Get Moving should be embedded into primary care as part of routine care in the same way that smoking cessation has been to ensure that this important health issue is addressed appropriately.

Dr Vanessa Bogel, Public Health Strategist (Long Term Conditions), NHS Haringey

Health trainer supporting physical activity behaviour change

Using the local health trainer service, a GP in Northumberland referred a visually impaired man who was both sedentary and obese for one-to-one support in increasing his physical activity levels and healthy eating. As the client was extremely low in confidence, the health trainer supported and mentored him by travelling with him to a local gym and a weekly tenpin bowling group. As his confidence increased, he was subsequently able to access these social physical activity opportunities independently and has continued to be active. He is now working with the health trainer on a food diary, with the aim of eating healthier, balanced meals. This achieved the following outcomes:

- MDS outcome 2: Reaching the 'hard to reach';
- MDS outcome 3: Delivering sustained improvement to the health of the people of England through behaviour change; and
- MDS outcome 4: Providing access to and encouraging the appropriate use and uptake of NHS and other local services.

Natural England, Green Exercise pilot, Cullompton

In 2008 the Culm Valley Integrated Centre for Health in Cullompton, Devon, partnered with Natural England to launch an intervention which, using a similar model to LGM, recruited inactive patients, delivered a brief intervention (using motivational interviewing) and signposted patients to local Green Exercise opportunities in their local areas, including walking, cycling and step-o-meters. From May 2008 to April 2009, 188 patients aged between 19 to 82 years, suffering from a variety of conditions including depression, obesity and hypertension, attended a brief intervention in the surgery.

Patient response

Norma is a patient who attended the clinic. At 61 years old she is hypertensive and obese. Following the brief intervention, Norma set a goal to increase her walking. On return to the surgery over the course of the year, Norma reported that she was steadily increasing her physical activity levels. Further tests confirmed that Norma has reduced her BMI from 40.9 to 37.22 and has also reduced her blood pressure.

For further details, see: www.naturalengland.org.uk/ourwork/enjoying/health/ournaturalhealthservice/default.aspx

Natural England, Green Exercise pilot, Carlisle

Dr Charlotte Asquith, lead GP at Fusehill Medical Centre, Carlisle, is working with Natural England to promote physical activity, linked to the local health walk scheme:

"As a GP and commissioner of local health services, I am charged with reducing morbidity and mortality, reducing health inequalities, promoting behavioural change, and using available resources to gain the best health outcomes. Although in my surgery I see individual patients, I am also conscious of a wider duty to improve the health and well-being our local population.

Many interventions leave patients as passive recipients of healthcare, increasing their own sense of helplessness. Often very expensive interventions benefit only a very few. There is a high value placed on pharmaceutical treatments. However, if we really want to improve the health of the whole population we must encourage people to take matters into their own hands, to develop personal responsibility, with our support, for their own health outcomes.

Much has been done to reduce the prevalence of smoking, reduce alcohol use, combat obesity and educate patients with chronic diseases, such as diabetes, in self-care. However, little emphasis has been placed on the value of exercise to promote and maintain both physical and mental health.

Yet there is plenty of evidence that regular exercise is hugely beneficial for everyone, including vulnerable groups such as those prone to mental health problems and social isolation, those at risk of or suffering from obesity, diabetes, heart and lung disease, to name but a few. Our task therefore is to present exercise in a 'user friendly' way, to engage people who might think otherwise that exercise should be a key component of their life plan. It must be individually sustainable, preferably cheap and certainly enjoyable. Daily integrated physical activity should be a mantra for all from cradle to grave.

To achieve this we must promote a concept of exercise that is not limited to gyms and pools, or requires special equipment, or teams of players, or high levels of fitness. These are valuable but will not engage the majority. Walking with the children to school, taking the grandchildren to the park, walking to the shops, cycling to work, taking the stairs not the lift, walking in the countryside at weekends – we underestimate the wide-ranging benefits to both individuals and society of such rewarding activities.

When I was approached by Natural England to promote the Walking the Way to Health scheme, I was delighted to give my support. I could immediately think of so many patients who would benefit from the opportunity to meet with others in a pleasant environment in order to walk within their capacity while supported by trained staff. In my practice the clinicians involved in chronic disease management were equally supportive in promoting the scheme. We hope to encourage other practices to become involved and have also passed the information to the 'DESMOND' scheme for the promotion of self-management in people with newly diagnosed diabetes.

In summary, the benefits of regular exercise in all its forms, tailored to individual needs but applied to the whole population, cannot be over-emphasised. As healthcare professionals, we should take every available opportunity to promote this undervalued means of maintaining and improving health and social outcomes."

Patient response

Mrs Shirley Rae, aged 66, had been overweight for some time, and wanted to do something about it. After a visit to her GP's surgery, she picked up a leaflet, *Walking the way to Health*, which promoted 'Doorstep Walks in and around Carlisle'.

Realising the importance of being more active and having the desire to lose her excess weight, Mrs Rae has since enjoyed the great benefits of the led walks. So much so, that she's discovered new areas of interest in her home town and even recruited a number of her friends to take part.

While becoming more active was a little challenging to begin with, Mrs Rae is now enjoying the benefits, particularly of being less tired and more mobile.

"Being more active now plays a more important role in my life, and it's essential for my health and well-being. I had no idea just how much I would enjoy the led walks; it's a great way to meet other people socially and everyone goes at their own pace – there's no pressure on anyone to do more than they are capable of. I also think it would be helpful for GPs to play a more active role in promoting physical activity to their patients, particularly those at risk of inactivity, by simply giving a leaflet with their prescription, or even the chemist could pop a leaflet in with prescriptions when patients collect their medication."

Annex 5: Physical activity services and the Let's Get Moving patient pack

When commissioning LGM, commissioners may also want to identify existing physical activity services and consider whether any further services may be required locally to assist patients in increasing their physical activity levels. Having an appropriate selection of physical activity opportunities may support take-up by specific groups who are at serious risk of inactivity, such as certain black and minority ethnic groups, older adults and disabled adults.

County Sports Partnerships

As the recognised local strategic delivery network for sport and physical activity across England, County Sports Partnerships (CSPs) are well placed to help with the effective commissioning and delivery of LGM.

Often the CSPs play a brokerage role, managing the interface between public health and the physical activity and sport sector, providing support to health professionals and commissioners to design and develop bespoke, innovative solutions to meet local people's needs, and overseeing delivery by a complex network of public, private and civil society physical activity providers.

Local primary care professionals and public health commissioners are encouraged to engage with CSPs to secure their support for the implementation of LGM and explore other ways to maximise the contribution of sport and physical activity to local health outcomes.

More information can be found at: www.cspnetwork.org

Local opportunities

The LGM patient pack has inserts for local physical activity opportunities that have to be completed and printed locally before being inserted into the patient pack and delivered to the service providers. There is a helpful online search tool which is available for promoting physical activity to the public (www.promotingphysicalactivity.com), and can also assist with the completion of the LGM patient pack activity insert templates.

There are also a number of national initiatives that you can link to local LGM schemes, including: Walking for Health, Walk4Life miles, British Cycling-led Skyrides and Blue Gyms. See annex 9 for more information on these initiatives.

Walking Maps

Walking Maps are another physical activity tool that can be considered for supporting patients to become more active. The Maps were used in the LGM feasibility pilot and proved extremely popular. See page 57 for a Walking Map case study.



Case studies: physical activity services

The Walking Map prescription

To encourage sedentary patients to walk more, Walk England and NHS Camden have worked together to develop a series of accessible, safe and attractive 30-minute walks around doctors' surgeries. Maps of the walks have been distributed by health staff at the surgeries and have also been made available at local libraries and community centres. They are used by health trainers to encourage physical activity with their clients.

Walk England consulted and involved sedentary people, older people's groups, minority ethnic groups and people with pre-existing health conditions to help choose and audit the best walking routes and ensure that the maps were practical and easy to use.

Routes were chosen to reflect desires to be more socially connected; to help them get 'away from it all'; and to set personal health challenges. A selection of interconnecting walks from each surgery reflected these criteria, using measured distances, in order to allow walkers to benchmark their walking ability, giving them the opportunity to improve their health over time by walking faster and for longer.

Evaluation of the impact of the maps on patients' physical activity levels is ongoing. However, preliminary findings indicate that the maps are being positively received. Telephone interviews were carried out with 58 people who were given a copy of the Dr. Walk Map, and a standard questionnaire was used to gather quantitative and qualitative data. This revealed that:

- 54% of respondents had used the maps;
- 51% said the maps had encouraged them to walk more; and
- 62% would recommend the maps to someone else.



They are proving to be a good way of introducing the benefits of exercise. Working like a prescription – clinical staff can prescribe a walk and give the maps to all our patients, regardless of nationality, to get them thinking about exercising and taking control of their health.

Health trainer, NHS Camden

Get Active in the Forest, South Derbyshire

Set up in a three-way partnership with Walking for Health (formerly WHI), Derbyshire County Council and the Forestry Commission, Get Active in the Forest offers a variety of Green Exercise opportunities, including health walks, cycling and outdoor conservation.

The programme of health walks covers a number of locations across South Derbyshire, including walks starting from local GP surgeries. A leaflet showing local green spaces and identifying opportunities to get active is also available in local surgeries. Walking groups are run for Asian men and women and for mental health patients, and there are buggy walks for mothers and young children.

The scheme is currently being evaluated by Natural England; see: www.naturalengland.org.uk/ourwork/enjoying/health/ournaturalhealthservice/default.aspx.

Annex 6: Exercise on referral

This statement clarifies the position with respect to local commissioning of exercise referral schemes in England (it can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072689).

The Department of Health urges commissioners, practitioners and policy makers to continue to provide high-quality exercise referral schemes for their local population where these address:

- the medical management of conditions, e.g. type 2 diabetes, obesity and osteoporosis; and/or
- approaches specific to preventing or improving individual health conditions (e.g. falls prevention), which fall outside the overarching advice to achieve 150 minutes' moderate activity a week.

Schemes should be commissioned and managed in accordance with the National Quality Assurance Framework for exercise referral in England.

Exercise referral schemes solely for the purpose of promoting physical activity (i.e. where there is no underlying medical condition or risk) should only be commissioned or endorsed by commissioners, practitioners and policy makers when they are part of a properly designed and controlled research study to determine effectiveness.

Where NICE guidance promotes the use of condition-specific classes for specific conditions, this guidance should be followed. For example:

- NICE clinical guideline 88 (2009), *Early management of persistent non-specific low back pain*;
- NICE clinical guideline 12 (2004), *Management of chronic obstructive pulmonary disease in adults in primary and secondary care*;
- NICE clinical guideline 23 (2004, amended 2007), *Depression: management of depression in primary and secondary care*; and
- NICE public health guidance 16 (2008), *Occupational therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care*.



Annex 7: Let's Get Moving training

The Department has developed a standardised LGM training package. The skills acquired from the training will be transferable and useful for the delivery of other interventions such as NHS Health Check.

All professionals delivering the LGM intervention must complete training module 1. All providers delivering the full brief intervention will be required to attend both modules 1 and 2 (if they are already proficient in motivational interviewing (MI), they only need attend module 1).

We also advise the training provider to consider running a health walk for LGM service providers; this proved to be a necessary training tool in the feasibility pilot so that practitioners can understand properly what it means and feels like to be active at a moderate level.

Training module 1 (3 hours)

This module enables providers to deliver an abridged (but not full) version of the brief intervention. Those already experienced in MI attending this module will be able to deliver a full brief intervention. Module 1 could also serve as useful refresher training in the future.

The training session incorporates:

- Let's Get Moving: an overview of the physical activity care pathway and how to deliver;
- Physical Activity for Health: messages and recommendations;
- using the GPPAQ: raising the issue of inactivity and managing patient risk; and
- motivational interviewing: introduction to approach and style.

Where there is capacity, training module 1 can be delivered in-house by an individual competent and confident in training professionals. If there is limited capacity, then an external organisation can be commissioned to deliver the training.

Training module 2 (1.5 days)

This module develops MI skills when incorporated with module 1, and enables practitioners to provide the full intervention. It supports the practitioner in developing a motivational patient guiding style and develops MI skills that enable the practitioner to:

- explore patient readiness and confidence;
- explore patient concerns;
- explore physical activity options; and
- develop a collaborative plan to increase patients' physical activity goals.

It has been agreed that the LGM module 2 can be delivered by a trainer who fulfils the following competencies:

- is competent in delivering MI as a practitioner, as an absolute minimum they must have been on an MI course;
- is a skilled behaviour change trainer;
- is confident in training different health professionals, often with strong and opposing views; and
- understands LGM and has attended module 1.

The local commissioner/provider will have to provide their chosen trainer with training module 2.

Training resources to support delivery of modules 1 and 2 will be available to order from the Department's order line (refer to annex 9 for details on how to order the full LGM training package).

Training resources include:

- PowerPoint presentation slides featuring embedded LGM videos;
- a training plan featuring a range of training methods including role play, group work and individual tasks; and
- an LGM practitioner workbook.

Annex 8: The Let's Get Moving feasibility pilot

LGM was trialled in a feasibility pilot in 14 GP surgeries across London, with an external evaluation undertaken by the British Heart Foundation National Centre for Physical Activity and Health based at Loughborough University. Details of the pilot can be reviewed or downloaded from the physical activity section on the Department website.

The pilot objectives included:

- assessing the feasibility of two different patient recruitment methods (opportunistic and disease register);
- the feasibility of delivery by different health professionals;
- identifying the characteristics of patients recruited on to the care pathway;
- an economic analysis of the pilot implementation; and
- collation of feedback from practitioners about their experiences of implementation.

	Method	Quantitative results
Recruitment:	Restricted to opportunistic or hypertensive disease registers for effective evaluation	
Screening:	GPs or practice nurses screened for inactivity, patients completing GPPAQ in consultations	526 adults screened (N=526) Of whom: <ul style="list-style-type: none"> • 86% were assessed to be less than 'Active' • 83% were interested in becoming more active and attending a brief intervention
Brief intervention:	Delivered immediately following screening or Referred to the brief intervention delivered by practice nurses or healthcare assistants All outcomes recorded within patient records Signposting – patient choice based on LGM patient pack opportunities	315 attended a brief intervention (N=315) <ul style="list-style-type: none"> • mean age 54 (range 16 to 84) • 54% black and minority ethnic; 21% white; 25% missing • gender: 59% women, 41% men Activity goals set: <ul style="list-style-type: none"> • 49% leisure centres • 44% self-directed outdoor activity/pedometer • 6% dance and sports clubs • 1% condition-specific Brief intervention discussion took between 3 and 21 minutes

	Method	Quantitative results
Follow-up:	Letter or text message invitations Follow-up with same practitioner as brief intervention	101 attended a follow-up consultation (N=101) Of whom: <ul style="list-style-type: none"> • 59% opted for self-directed outdoor activity and pedometer • 27% went to leisure centres • 62% self-reported a physical activity increase • 21% on completing the GPPAQ were now classified as active

Summary

Feedback from practitioners revealed that many aspects of the care pathway approach to the assessment and promotion of physical activity were liked, were considered to be feasible and were seen to be well received by patients.

The design of LGM, with its specific focus on how to promote physical activity, helped practitioners raise the topic with patients and emphasise the importance of physical activity to patients.

- Specifically, the training raised practitioners' knowledge and awareness of the role of physical activity in promoting the health of patients and in the prevention of chronic disease.
- Practitioners specifically cited the assessment of patients' levels of physical activity using the GPPAQ as helpful when initiating discussions about physical activity as well as being useful for raising patients' awareness of their current physical activity levels.

The patient-centred method of the brief intervention, with the use of motivational interviewing techniques, was considered to be useful and potentially beneficial in improving the chances of patients changing their physical activity behaviour.

Although this study was not designed to demonstrate the effectiveness of the care pathway to deliver short- or long-term behaviour change, qualitative feedback from practitioners suggests that patients experienced a number of health benefits, including:

- weight loss, breathing better and feeling healthier – these were reported as common patient outcomes;
- increase in physical activity and decrease in blood pressure for hypertensive patients; and
- achieving 10,000 steps a day for patients who were issued with pedometers.

The result showed the physical activity care pathway to be feasible and, with refinements, this systematic approach to counselling on physical activity in primary care is suitable for wider implementation.

Following this feasibility study, all the elements proposed for review have been taken into consideration. This includes a review of and improvements to the practitioner training, improvements to the methodology of the physical activity care pathway schema, and review of the patient pack and guidance and of supporting materials provided to PCTs and GP surgeries.

The evaluation report is available on the Department of Health website; see annex 9.

Annex 9: Accessing supporting Let's Get Moving resources

Resource	Audience	Format	Access via
<p>LGM patient resource</p> <p>The healthcare professional and the patient are encouraged to work through the pack during the LGM brief intervention, which includes goal-setting and signposting information.</p>	Patients	Hard copy	<p>www.orderline.dh.gov.uk Tel: 0300 123 1002 Email: dh@prolog.uk.com</p>
<p>LGM patient resource activity templates</p> <ul style="list-style-type: none"> The template sheets will enable the programme to feature local indoor and outdoor activity within the LGM patient pack. These sheets should be completed by the local lead and copies inserted into to all LGM patient packs before they are distributed. To enable service providers to feature local physical activity based information on the indoor and outdoor activity sheets, a helpful online search tool is available for obtaining specific details. Details of specific national physical activity initiatives. 	<p>Local commissioners/ providers</p> <p>Service providers</p> <p>All</p>	<p>Online</p> <p>Online</p> <p>Online</p>	<p>www.dh.gov.uk</p> <p>www.nhs.uk/letsgetmoving</p> <p>Walking for Health: www.wfh.naturalengland.org.uk</p> <p>Walk4LifeMiles: www.walk4life.info</p> <p>British Cycling-led Skyrides: www.goskyride.com</p> <p>Blue Gyms: www.bluegym.org.uk</p>

Resource	Audience	Format	Access via
General Practice Physical Activity Questionnaire <ul style="list-style-type: none"> • GPPAQ Report • GPPAQ Questionnaire • GPPAQ Excel spreadsheet • GPPAQ Read Codes. 	GP surgeries/ local commissioners	Online	Download from: www.dh.gov.uk
General Practice Physical Activity Questionnaire <ul style="list-style-type: none"> • Embedded algorithm within GP software systems. 	GP surgeries	GP software	Local software systems
LGM training package for practitioners <ul style="list-style-type: none"> • Trainer support pack including modules 1* and 2 training content, training plan and LGM PowerPoint slides with embedded DVD • LGM training support pack for practitioners. 	Service deliverers/ local commissioners	Hard copy with memory stick	www.orderline.dh.gov.uk Tel: 0300 123 1002 Email: dh@prolog.uk.com
Accredited motivational interviewing trainers	Local commissioners	Online	www.motivationalinterviewing.org/trainer-listing
Promoting the LGM intervention to patients The website provides an easy-to-use professional design tool with access to high-quality professional imagery and tested messaging.	Local commissioners/ GP surgeries	Online	www.promotingactivity.com

*Module 1 is available in hard copy.

Resource	Audience	Format	Access via
<p>British Heart Foundation: 'Get active, stay active' booklet</p> <p>This booklet explains the benefits of regular exercise and how to get started, and suggests activities to help keep the heart strong and healthy. It also explains where to get started and where to get more information.</p> <p>This is a good leaflet to give to those who say they are currently not interested in becoming more active.</p>	GP surgeries	Hard copy	www.bhf.org.uk/publications
<p>Change4Life</p> <p>Resources to support behaviour change for adults – specifically the 'Get going every day' campaign for adults' physical activity.</p>	All	Hard copies/ electronic resources	www.nhs.uk/change4life
<p>Sportex: leaflets about getting more active, for patients with existing health conditions</p>	GP surgeries	Hard copy	www.sportex.net
<p>Presentation to promote LGM to GPs and other professionals</p>	Commissioners/ GPs	PowerPoint – online	www.dh.gov.uk
<p>Presentation to promote LGM to interested partners</p>	Various	PowerPoint – online	www.dh.gov.uk
<p>Leaflet to promote LGM to GPs/local partners</p>	GPs/local authorities etc	Hard copy and online	www.dh.gov.uk Prolog

Resource	Audience	Format	Access via
<p>NICE public health guidance PH2 (2006), <i>Four commonly used methods to increase physical activity</i></p> <p>This includes a costing report and a local costing template.</p> <p>Additional NICE guidance for physical activity, behaviour change and specific conditions is also available on the NICE website.</p>	Local commissioners/ GP surgeries	Online	www.nice.org.uk/PH2
<p>NHS LifeCheck</p> <p>NHS LifeCheck can be promoted to patients as an online tool to support behaviour change.</p>	Patients	Online	www.nhs.uk/Tools/Pages/LifeCheck.aspx
<p>LGM Commissioning Guidance (this document)</p>	Local commissioners	Online	www.dh.gov.uk Prolog
<p>Walking for Health</p> <p>For information on how to join and find walks, and buying and using pedometers.</p>	GP surgeries/ patients	Online	www.wfh.naturalengland.org.uk
<p>Start Active, Stay Active</p> <p>A report on physical activity for health from the four home countries' Chief Medical Officers (2011).</p>	Local commissioners/ GP surgeries/ local authorities	Online	www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128209
<p>DH statement on Exercise Referral, 2007</p>	Local commissioners/ GP surgeries	Online	www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072689
<p>Let's Get Moving feasibility study</p>	Local commissioners/ GP surgeries	Online	www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_105975
<p>Falls and fractures resources</p>	Local commissioners/ GP surgeries	Online	www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103146

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408803 1p 7.5k February 12 (ESP)
Produced by COI for the Department of Health

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