



Public Health
England

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Engaging NHS system leaders in whole systems approaches to physical activity

Contents

Executive summary	4
Chapter 1: Introduction.....	8
Chapter 2: Methods	13
Research design.....	13
National stakeholder interviews	13
Local case studies	13
Analysis	14
Whole systems webinar.....	14
Ethics.....	15
Chapter 3: Results	16
Chapter 4: Discussion.....	26
Engaging and integrating the NHS in whole systems approaches to promoting physical activity	26
Between-site variation	28
Strengths and limitations of research	28
Barriers to engaging the NHS.....	29
Enablers for engaging the NHS	30
Chapter 5: Key messages and opportunities for action.....	33
Key messages	33
Opportunities for action	33
Chapter 6: Concluding remarks	37
The implications of the COVID-19 pandemic.....	37
Chapter 7: Glossary	38
References.....	41
Appendix 1: Case studies	44
Dorset case study.....	44
Essex case study.....	47
Kirklees case study.....	50
South Tees case study	52
Appendix 2: Interview schedule	55

Engaging NHS systems leaders in whole systems approaches (WSA) to physical activity (PA): interview questions.....	55
Appendix 3: Making the case outline	59

Executive summary

Introduction

Low levels of physical activity are a major public health challenge, contributing to the national burden of non-communicable disease and demand on health and social care services. Addressing the lack of physical activity in the population is a complex issue, a classic 'wicked problem' that requires a whole systems approach.

Public Health England (PHE) is currently supporting whole systems approaches to physical activity as a key element in the [Whole Systems Approach to Obesity](#) and through partnering with Sport England to support 12 local delivery pilots (LDPs). There are however a number of examples of systems approaches to promoting physical activity without the support of a LDP, with the development of these diverse local approaches providing a useful natural experiment to learn from.

The focus of this project was to explore the role of NHS systems leaders in whole systems approaches to increase physical activity including how and what is needed to engage and support them in these, and how to integrate this with local government led place-based approaches.

Methods

The research was conducted on the principle of co-production between the University of the West of England, Bristol (UWE Bristol) and PHE. This was a qualitative study based on semi-structured interviews with national stakeholders and local informants from 4 case study sites. Initial findings, themes, enabling factors and barriers were shared in a webinar in April 2020 to test and explore the findings, and inform the final report.

Results

Ten themes emerged from the analysis of the data which were:

- the importance of a shared vision
- collective systems leadership is crucial, not individual system leaders
- systems leadership is needed at all levels of the system
- place-level is a crucial focus for physical activity work
- relationships are crucial; relationship-building really important
- enthusiasm and commitment are as important as formal seniority
- there is a key facilitation role on physical activity for public health across the system
- a range of resources is required
- central pressures are driving siloed working
- quantifiable outcomes are wanted in unrealistic short timescales

Across the 4 case studies, there were a number of common barriers and enablers for engaging the NHS in whole systems approaches to physical activity.

Common barriers were:

- capacity – for the NHS and other sectors
- NHS culture
- engaging the acute sector
- difficulty in demonstrating quantifiable impact in the short to medium term
- difficulty in seeing opportunities for innovation that do not involve significant new resources
- maintaining long-term partnership relationships at a time of organisational change and staff turnover
- the whole systems concept and terminology may not always be recognised or seen as relevant by those in the NHS

Common enablers were:

- recognising and facilitating shared system leadership
- key individuals or core teams championing the whole systems approach
- a key facilitation role for public health across the system
- balancing senior buy-in with working with enthusiasts
- taking time to build relationships and develop a shared vision
- utilising system mapping
- development support for systems leadership

Key messages

A whole systems approach to physical activity should recognise that NHS system leaders may include a wide range of NHS actors working at a variety of levels.

Building long-term high quality personal relationships and trust are key factors in enabling system leadership on physical activity.

Engagement with and championing of physical activity by clinicians and within clinical pathways can be a highly effective way of engaging NHS staff in promoting physical activity and developing their role in whole system approaches.

Making physical activity a priority at Integrated Care System (ICS)/ Sustainability and Transformation Partnership (STP) level means it then appears throughout the system and with other regional bodies.

Taking a whole systems approach to physical activity is in keeping with current NHS policy the move to ICSs and Primary Care Networks (PCNs), and the wider prevention

agenda. However, other policy streams send different short-term messages and drivers to the NHS.

Local authorities, and Active Partnerships can play a key role in supporting NHS engagement in whole systems approaches to physical activity.

Promoting physical activity for good physical and mental health, through COVID-19, offers new opportunities to build on consistent messages and to engage the NHS in whole systems working on physical activity.

Opportunities for action

The report presents a breadth of possible opportunities for action across the system at all levels from local places through to national. It is important to recognise that these opportunities will vary, and some flexibility is needed, in accordance with the structures, priorities and roles of the systems at differing levels. The full list of opportunities can be found in [Chapter 5](#), with example opportunities from across the system detailed below:

For organisations working at regional and national level including PHE, NHS England and NHS Improvement (NHSE&I) and Sport England

Consider how the impact of different NHS policy decisions and drivers can positively impact on the degree to which the NHS engages at different levels of the system, with the physical activity agenda.

For ICSs and STPs

Ensure that population health and population health management programmes recognise the important role of physical activity as a key part of a holistic approach and facilitate a joined-up approach to embedding physical activity in commissioning plans.

For CCGs and NHS trusts

Ensure physical activity is integral to place-based health and wellbeing strategies, working with wider partnership bodies led by local authorities.

For those at neighbourhood or PCN level

Ensure that community health services are supported to integrate the promotion of physical activity into clinical and social care via social prescribing, workplace health promotion and community engagement.

For local authorities and health and wellbeing boards (linking with Active Partnerships)

Align and connect (but do not subsume) physical activity with obesity whole systems approaches at local level and seek to engage all NHS organisations (in particular NHS trusts) in a shared vision for physical activity.

Strengths and limitations

Strengths of this study include that it captured views from a diverse range of local areas and stakeholder who were engaged in promoting physical activity through a whole systems approach. These findings have been validated by both respondents and a wider group of stakeholders. The limitations include that this study is not representative but rather is illustrative of the experiences of selected local areas. This research also commenced as the Coronavirus (COVID-19) pandemic began to affect the UK, which unfortunately impacted on the availability of some key stakeholders for interviews.

Chapter 1: Introduction

Background

Physical activity and systems approaches

Low levels of physical activity are a major public health challenge, contributing to the national burden of non-communicable disease and demand on health and social care (1, 2, 3). Lack of physical activity is a complex issue, that is the consequence of societal, cultural, economic and environmental changes over time that cannot be solved by individual sectors or players. Data demonstrate that declining physical activity is a greater issue in high income countries and, in the UK, has been in decline since the 1960s, although recent figures suggests this may have stabilised (4).

Our understanding of the drivers and potential solutions of complex issues has developed significantly in the last 5 to fifteen years (for example through work undertaken by Government Office for Science's Foresight Tackling Obesities Future Choices – Project Report (5) and academics). 'Whole systems working' at national and local levels is supporting the translation of this knowledge into practical place-based action rooted in and driven by local context, needs, assets, aspirations, partnerships and leadership. Rutter and colleagues have described the underpinning thinking necessary behind a whole systems approach:

"Systems thinking provides a framework to help examine the factors involved in a problem, the relations between these factors and changes over time; it views actions as integrated across political, social, cultural, economic and scientific domains within a system. A system is more than the sum of its parts, encompassing the interactions between these parts and the actors involved. This approach differs from traditional linear models of cause and effect that underpin much of the existing evidence base and takes account of factors such as adaptation, the ways in which a system responds to interventions within it, and feedback, which drives some of those responses (6)."

The national physical activity framework, 'Everybody Active Every Day' (7), and World Health Organization's 'Global Action Plan on Physical Activity' (8) and subsequent work (9) has suggested the specific potential of whole systems approaches to address declining physical activity and its associated negative impacts on health and wider outcomes. It also identifies a unique role for health and social care systems in increasing population physical activity, both through direct interventions and indirectly through local leadership. UK specific evidence also demonstrates direct and preventable costs to both the NHS and social care systems (10).

Public Health England (PHE) is currently supporting whole systems approaches to physical activity as a key element in the PHE 'Whole Systems Approach to Obesity' (10) (although the benefits of physical activity extend much further than tackling obesity), and

is already working closely with the NHS through a variety of initiatives including the PHE/Sport England Physical Activity Clinical Champions , Active Hospitals and the wider Moving Healthcare Professionals Programme (11, 12, 13).

A key recent systems initiative has been to partner with Sport England to support 12 local delivery pilots (LDPs). The PHE 'Whole Systems Approach to Obesity' (14) and Sport England LDPs are helping to mainstream and support local areas with systems thinking and approaches across obesity and physical activity agendas. The 'Whole Systems Approach to Obesity' is a practical guide accompanied with tools and resources to support local areas across England with implementing whole systems approaches to tackle obesity, with increasing physical activity an integral part of the approach. As part of its systems obesity work, PHE commissioned a systematic review from Leeds Beckett University (15) on whole systems approaches to obesity and other public health problems which helpfully documents the key features of a systems approach (Table 1).

The 12 Sport England LDPs are testing systems approaches to increase physical activity in local communities:

"We've chosen 12 places we'll work with on bold new approaches to build healthier, more active communities across England. Around £100 million of National Lottery funding will be invested through these places in the pilot scheme over 4 years, to create innovative solutions that make it easier for people in these communities to access sport and physical activity.

"By focusing intensely in 12 areas, we want to identify better ways to address the stubborn inequalities and break down the barriers that stop people choosing to be active, such as poor transport, safety, cost and confidence. And we want to encourage wider, collaborative partnerships which look at how all parts of a community can better work together to help the most inactive. From the transport links and street lighting to the quality of parks and open spaces, to how sport and activity is promoted by GPs. Partnerships will encompass organisations beyond the sport sector such as voluntary groups, social enterprises, faith organisations and parenting groups (16)."

There are, however, also a number of examples of systems approaches to promoting physical activity in areas of England without the additional support of a LDP for example Move More Sheffield and North Kesteven (one of the pilot sites in the whole systems obesity programme). A key driver of local physical activity approaches are the Sport England funded Active Partnerships. There are 43 partnerships across England and whole systems work is integral to the programmes mission, which recognises that "[physical] activity levels are affected by a complex system of influences and no single organisation or programme [can] create sustainable change at scale (17)." The development of diverse local approaches to whole systems working on physical activity

in areas with and without LDPs provides a useful natural experiment to learn from. Local places that are implementing whole systems approaches are engaging different sets of stakeholders in their areas, but in general local authorities and Active Partnerships have been central to these partnerships with communities, with varied levels of engagement from local NHS organisations.

Table 1: Ten features of a systems approach to tackle public health problems	
Identifying a system	Explicit recognition of the public health system with the interacting, self-regulating and evolving elements of a complex adaptive system. Recognition given that a wide range of bodies with no overt interest or objectives referring to public health may have a role in the system and therefore that the boundaries of the system may be broad.
Capacity building	An explicit goal to support communities and organisations within the system.
Creativity and innovation	Mechanisms to support and encourage local creativity and/or innovation to address public health and social problems.
Relationships	Methods of working and specific activities to develop and maintain effective relationships within and between organisations.
Engagement	Clear methods to enhance the ability of people, organisations and sectors to engage community members in programme development and delivery.
Communication	Mechanisms to support communication between actors and organisations within the system.

Embedded action and policies	Practices explicitly set out for public health and social improvement within organisations within the system.
Robust and sustainable	Clear strategies to resource existing and new projects and staff.
Facilitative leadership	Strong strategic support and appropriate resourcing developed at all levels.
Monitoring and evaluation	Well-articulated methods to provide ongoing feedback into the system, to drive change to enhance effectiveness and acceptability.

Source: Bagnall et al. 2019 (11)

NHS and whole systems approaches

Recent changes to NHS structures, including the development of integrated care systems (ICSs)¹ and primary care networks (PCNs), and the greater NHS commitment to prevention and population health management, present an opportunity for strengthening the role of the NHS and care systems within whole system approaches and to learn how best to engage the NHS in whole systems approaches to physical activity in terms of prevention at primary, secondary and tertiary level.

The ‘NHS Long Term Plan’ (18) has emphasised the critical role that the NHS plays in prevention and as a key “anchor institution” in local communities. Anchor institutions are large, public sector organisations that are called such because they are unlikely to relocate and have a significant stake in a geographical area – they are effectively ‘anchored’ in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land (19). The important role that NHS organisations play in their communities as anchor institutions has been explored by the Health Foundation (19) particularly with respect to the large numbers of staff employed.

¹ <https://www.england.nhs.uk/integratedcare/integrated-care-systems/>

The 'Long Term Plan' identifies 3 important levels at which decisions are made. These are:

- neighbourhoods (populations circa 30,000 to 50,000 people) served by groups of GP practices working with NHS community services, social care and other providers to deliver more coordinated and proactive services, including through primary care networks
- places (populations circa 250,000 to 500,000) served by a set of health and care providers in a town or district, connecting primary care networks to broader services including those provided by local councils, community hospitals or voluntary organisations
- systems² (populations circa 1 million to 3 million) in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale (20)

Purpose and research questions

The purpose of this research was to explore with key system stakeholders in the NHS, local authorities and other sectors:

- the role of NHS systems leaders in whole systems approaches to increase physical activity aligning with their prevention and population health management remit
- how and what is needed to engage and support the NHS role in whole systems approaches to increase physical activity

Following from this purpose, there were 2 key research questions, which were:

- What is required to engage and integrate key NHS systems leaders in systems approaches to promoting increased physical activity in local populations, working together with local authorities, and other local systems leaders?
- What are the local and national barriers and enablers that discourage/encourage collaboration across the system?

COVID-19

This research commenced in January 2020 just as the COVID-19 pandemic began to affect the UK, and fieldwork took place during February and March as the pandemic increasingly affected the NHS and local authority public health teams. This unfortunately impacted on the availability of some key stakeholders for interviews, in particular Regional Directors of Public Health (RDPHs) and ICS/STP-level stakeholders.

² It should be noted that in the NHS and more widely the term 'systems' is used both to describe the local system across which a whole systems approach is taken and to describe this specific ICS organisational form, whilst either meaning may be present in this report the context should make it clear which is being referred to.

Chapter 2: Methods

Research design

This research was conducted on the principle of co-production between the University of the West of England, Bristol (UWE Bristol) and PHE, that is there was close working and collaboration between the 2 partners in the planning and management of the project. PHE was particularly involved in identifying relevant national stakeholders and potential case studies. UWE Bristol approached individuals and case studies for involvement and conducted the data collection and analysis. Both partners took part in planning and contributing to a webinar where the initial analysis was discussed and the learning and implications explored.

This was a qualitative study based on semi-structured interviews with national stakeholders and local informants from 4 case study sites (21). The interview schedule is included in [Appendix 2](#). Interviews were undertaken by telephone or Skype, audio-recorded and transcribed by a professional transcription service. Corrected transcripts were imported into NVivo-12 for analysis (see below).

National stakeholder interviews

Sixteen national stakeholders who worked across different parts of the national system and had an interest/expertise in systems approaches, physical activity and/or local decision making were identified as potential interviewees. The aim of these interviews was to gain a high-level overview of NHS engagement in whole systems activity. Stakeholders identified included those from NHS England and NHS Improvement (NHSE&I), Sport England, the Leadership Centre, the Local Government Association, Active Partnerships and other parts of PHE (for example RDPHs and physical activity clinical champions). Eight national stakeholder interviews were sought and obtained.

Local case studies

Potential case studies were identified by discussion with the PHE national team, PHE places and region physical activity leads, NHSE&I and Sport England. Selection was based on seeking maximum diversity across 5 criteria which were:

- at least one of the 12 Sport England LDPs
- other examples where local partners have adopted systems approaches to increasing levels of physical activity in their local areas
- an area with more developed ICS
- at least one area with low baseline levels of physical activity
- geographical diversity across England

Eight potential local sites for case studies were identified which met the selection criteria and 4 were approached, based on consensus of opinion and ensuring a diverse range of sites was included.

Each case study commenced with liaison with a key local contact with whom up to 5 other local stakeholders were identified for interview. Again, maximum diversity was sought within this number by seeking local authority, NHS and other sector informants. Informants were sought at different levels of the local system as defined in the NHS 'Long Term Plan' that is neighbourhood (primary care network), place-level (local authority, clinical commissioning group and or/ NHS trust) and the system-level (ICS/STP). A total of 22 informants were interviewed across the 4 case studies.

Analysis

Thematic analysis was undertaken in NVivo-12, with both deductive codes (codes derived from the research questions) and inductive codes (codes emerging from the data) (22). Two of the research team (DE and EB) independently coded half of the transcripts each, and independently organised the coded data into themes; the 2 sets of themes were then compared, and a high degree of overlap was found between the 2 sets of initial themes (10 common themes out of 12 identified by each researcher). Through discussion within the research team a final set of 10 themes was identified and agreed.

Whole systems webinar

Initially a whole-day whole systems event was planned with national and local case study stakeholders to discuss and test the initial findings, however due to COVID-19 restrictions, this was changed to a two-hour webinar held in April 2020. The aims of the webinar were to:

- explore and test the findings from the case studies and the national interviews
- discuss and agree the nature of outputs from the project which will be of use to national and local stakeholders

Invitations were extended to all national interviewees, case study participants and other national stakeholders and local partners engaged in whole systems approaches to physical activity. Fifteen participants attended the webinar in addition to the UWE Bristol and PHE teams. During the webinar a summary of the project findings were presented to participants who agreed that these were themes they recognised and experienced. Further useful insights and implications and suggestions for future work were shared, and the preferred nature of outputs from the project discussed. Bullet point notes on the discussion were independently recorded by 4 members of the UWE Bristol and PHE teams; key points raised are summarised in Chapter 3 and have informed the discussion

in Chapter 4 and have been synthesised and prioritised into the key messages and opportunities outlined in Chapter 5.

Ethics

An assessment of potential ethical risks was undertaken prior to submission for ethical review and the project was considered to be relatively low risk as there was no need or intention to collect sensitive personal data. The main potential risks identified concerned possible breaches of confidentiality and data protection. The protocol and associated ethical material (participant information sheet, consent form, privacy notice) were reviewed by the UWE Research Ethics Committee and approval given to proceed, reference HAS.20.01.095. In the Results that follow, each interviewee has been given a code to preserve anonymity; N for national and L for local interviewees.

Chapter 3: Results

National respondents

Sixteen national stakeholders were approached for interviews of whom 8 were interviewed. Interviewees came from NHSE&I, PHE, the Local Government Association, the Leadership Centre, Active Partnerships and Sport England.

Local case studies

Each of the 4 approached local areas agreed to be a case study. The 4 selected were Dorset, Essex, Kirklees and South Tees (see [Appendix 1](#) for a summary of each case study). In each site, discussions were held with a key local contact who helped identify at least 5 other potential interviewees. Again, due to COVID-19 pressures a number of potential interviewees were unavailable, but in the end 6 interviews were held in each of 2 sites, whilst 5 interviews were held in the other 2 sites

Themes

Ten themes emerged from the analysis of the data which were:

- the importance of a shared vision
- collective systems leadership is crucial, not individual system leaders
- systems leadership is needed at all levels of the system
- place-level is a crucial focus for physical activity work
- relationships are crucial; relationship-building really important
- enthusiasm and commitment are as important as formal seniority
- there is a key facilitation role on physical activity for public health across the system
- a range of resources is required
- central pressures are driving siloed working
- quantifiable outcomes are wanted in unrealistic short timescales

The importance of a shared vision

A common theme in the wider literature on systems leadership (23), our informants also emphasised the importance of developing a shared vision (sometimes called a common purpose) for a whole systems approach to physical activity.

“First and foremost, common purpose. A group of people who are really clear about what it is that they want to do and why and for whom and what they’re committing to is going to mean for every person or every organisation around that table. And so, it means talking things through from the start, not just decreeing something and then expecting other people, other organisations or sectors to come on board.”

(National non-NHS stakeholder, N6)

Informants recognised that developing a shared vision does not happen spontaneously and may take some time and effort to come to agreement on.

“I think spending a little bit of time to understand whether or not there is actually a shared vision and shared values and kind of shared function across partners, because quite often what we’ve found is that we might assume that everybody thinks this particular thing and then when you actually do a little bit of work with people you realise there’s a bit more of a distribution of, like, different attitudes or beliefs about whatever it is you’re talking about. So, having that clarity or common purpose, is I think really important.”
(Assistant Director of Health and Communities, L8)

It was also recognised that the exact original shared vision may not be achieved in its envisaged form, but that the process of developing a shared vision was important in enabling wider necessary changes.

“We have a vision of a destination in sight – whether we will ever get to that, truly get to that destination or not, is less important, I think, than actually the fact that we’re on that road and keep going along that road and keep heading in that direction, because, if we do that, we will make the differences that we need to make, and there’ll always be another challenge and another issue that we’ve got to deal with. But I certainly think people feel empowered to be able to go and do that. We don’t have to sit and wait to be told to go and start having conversations with people, and I think that’s probably one of the key areas that has never been forced upon us but has certainly been enhanced and promoted through the work that we’ve been doing.”
(Development Manager, Sports & Physical Activity, L17)

Collective systems leadership is crucial, not individual system leaders

Whilst our remit was to ask about how to engage NHS systems leaders, many of our informants felt we were not asking the right question.

“So, I think from your question in terms of who are the right people, I’d almost flip it around and think about how we can get the system to ensure that physical activity is embedded as part of the approach to population health and population health management, is a tool in which to ensure that they are actually utilising the evidence to invest in the right things to make physical activity more prevalent in the community.”
(National NHS stakeholder, N5)

Instead of focusing on those in senior NHS positions, informants emphasised the importance of systems leadership at all levels and in all sectors, including members of the community.

“We need to develop system leaders and that mind-set of everybody is a system leader.”
(Consultant in Public Health, L18)

“In our systems leadership work we took a conscious decision to focus the bulk of our effort on people who are not already in formal leadership roles.”

(Place Programme Director, L19)

Some informants were more comfortable with the concept of champions rather than leaders.

“If you’ve got a systems leader who’s leading from the front, if they then go, possibly it all crumbles down behind them... So, we’re trying very hard in terms of the way that our systems leadership is working, not to have that kind of single system leader. I mean, we do have champions, but we don’t have a single system leader because we don’t want it to be all resting on one person and when that one person goes it all kind of just fizzles away; we want it to be about distributed leadership. Everybody understands their role but also feels that they can be a leader of their part.”

(Consultant in Public Health, L5)

Systems leadership is needed at all levels of the system

We asked informants about systems leadership at different levels of the system (ICS), place (local authority and/or CCG) and neighbourhood, and the need for systems leadership was recognised at all 3 levels.

“So, physical activity at a neighbourhood level is very different obviously from something you do at a system level which might look at actually how do we look at our public transport and encourage walking as part of that? Or how do we set up in place levels sort of walking routes like they have in [town]?”

(National NHS stakeholder, N5)

Although needed at all 3 levels, the focus of systems leadership for physical activity would thus be very different at the different levels.

“Within the ICS we have a number of collaborative transformation programmes, the things we are working on collectively across the whole system. Some of those are the classic NHS themes like mental health, urgent care. But we also have what we call an improving population health programme, and that brings together a number of themes like prevention of ill health, but also the work we are doing on the wider determinants of health, also things like climate change.”

(ICS Director, L20)

Place-level is a crucial focus for physical activity work

The last ICS informant went on to explain the rationale for what was done at the different levels, in particular why the place-level was the appropriate focus for physical activity

work, and that the ICS had an explicit process for deciding what issues to address at a system level.

“[We] need to think about the tests we set ourselves for when it’s appropriate to work at system level rather than organisational or place level. Our default is that things that need to be done in health and social care will be done locally, in our neighbourhoods, the primary care networks, operating in our 6 places. And by exception we will, there may be things that are worth doing at scale, across the whole [ICS name] system level.”

(ICS Director, L20)

Another participant emphasised the importance of:

“the local place-based alliances as the delivery arms of the ICS where the place agenda and the health inequalities and LDP relationships really lie. We have great shared leadership in the alliance and the governance for the LDP is aligned through there to ensure we shared ownership of the obesity agenda.”

(CCG Accountable Officer, L14)

Overall, the place-level was the arena that most of our informants focused on, and they would often return to discussions of involvement at the place-level with community organisations and local communities even when asked specifically about NHS engagement. And within the NHS, most responses focused on the involvement of CCGs, and to a lesser extent PCNs, rather than the acute sector or ICSs.

“I think it’s very difficult to get acute trusts or even community providers, to be honest, to kind of have a very, very specific conversation about what is their role in increasing the amount of physical activity, because I think you’d get batted away very, very quickly.”

(Place Programme Director, L19)

Relationships are crucial; relationship-building is really important

Another theme from the wider systems leadership literature strongly reflected in our data was the importance of consciously building and sustaining relationships (10,11,19).

“The key with this is about building those relationships with those people who work in fields that you might not have previously consciously thought of engaging with so that you’re not left out of those conversations when they do take place and that people actually think about it, and I think that relationship-building is really, really important.”

(Development Manager, Sports & Physical Activity, L17)

“So, it’s not just all the big wigs in the local system getting together and saying we are going to work together. You know it’s probably richer and deeper and more organic than that.”

(National non-NHS stakeholder, N1)

Several informants stressed the very long-term nature of relationship building.

“The work started in 2013, so it’s taken quite a long time, I think, to get the right people in place and the right ideas, kind of spread around the system about the approach that we want to take. I would say 5 or 6 years ago the kind of space we were in was ‘physical activity, that’s public health, let’s start a project’ and where we are now is lots and lots of people across the system recognising that being clear on providing brief and very brief physical activity interventions is you know, a quick and easy thing that they can do.”

(Director of Public Health, L3)

Several others also emphasised the value of the bidding process for building and sustaining relationships, even when in some cases the bids were not successful.

“We’ve worked with a number of partners to bring money into the city around physical activity, and I think, you know, bringing the money in is great but actually just the process of working with people is a really valuable endeavour as well.”

(PHE Physical Activity Clinical Champion, N7)

Enthusiasm and commitment are as important as formal seniority

A number of our informants stressed that finding and working with partners with enthusiasm and commitment was as important as formal seniority; the phrase ‘coalition of the willing’ was used several times.

“I think first and foremost it’s about the individuals in the places and finding a small group of people, you know, a coalition of the willing...and coming together informally.”

(National non-NHS stakeholder, N6)

“Where I’ve seen these system leaders operate really well is that – it’s where it’s a kind of senior clinician who really understands that they need to be doing something differently and they can then go back and start to win over the acute trusts and say to the medical director, look, why is it that we’re not looking outside the walls of our hospital? We need to be doing more than this. I think they can be a really strong ally if you can find them in a local system.”

(National NHS stakeholder, N4)

There was one very striking example described by several informants in one case study, with different perspectives but telling a very consistent story of the importance of individual enthusiasm, rather than purely the place in a management hierarchy.

“You know without blowing my own trumpet, which I don’t actually do very often, but I had to fight with the team really, because they had other agendas and I was saying, you know, I need help here, we need to get this report [on a physical activity pilot programme] out. Then when it got out, everybody realised, why I’d made a fuss about it, I could see, you know, rather than the shop floor fire fight that we faced day to day, I

could see in the distance why this would be instrumental and why it might be a... not a game changer for us, but an important piece of work.” (NHS Consultant, L10)

“We are genuinely so lucky that we’ve got [name, NHS Consultant] locally. And somebody with that kind of passion for physical activity in himself, because he is really passionate about physical activity per se. It is like gold dust to people like us at that level in an organisation.” (Advanced NHS Public Health Practitioner, L6)

There is a key facilitation role on physical activity for public health across the system

Despite the diversity of our case studies, in each case the local authority public health team played a crucial facilitating role in bringing together and sustaining a whole systems approach to physical activity.

“I guess my personal reflection would be that we’ve become, it’s going to sound a bit weird this, but we have become a bit less ‘public healthy’... there was a tendency in the past for public health teams to be viewed as teams of technical experts... We tended to be on the outside, sort of chipping in. We don’t work so much like that anymore as a team. About 3 years ago we decided to train most of our team in client centre consulting methods which is just a way of basically just getting the consultants to listen a bit more. Understand how some of these challenges might look in the eyes of partner organisations of the system, and to become more skilled at developing ownership that rests with the organisations that make up our local system.”

(Director of Public Health, L3)

“Let’s focus on [local authority] just as it’s the specific site for you, I would expect the director of public health to be working closely with the accountable officer of the 2 CCGs, and her senior team, so I’d suggest that they would be the 2 senior leaders in the system for that particular place.”

(ICS director, L20)

Public health teams played this role at every level – system, place and neighbourhood.

“We now have a public health worker, a link worker, who works with every primary care network. We’ve tried to embed a public health approach and they will bring the strategy to [authority name] around physical activity, whether that’s children and young people, adults of working age, or the elderly. They’ll try and help bring that strategy into the front line of primary care networks where the GPs are working with all their local partners in that environment. So, what we’re starting to see now is the real green shoots.”

(ICS Clinical Lead, L2)

A range of resources is required

Resources were an important issue, but it was not necessarily the case that the additional resources provided by LDP status were seen as an essential enabler for system-wide action; it was equally important to think about how to mobilise existing local financial, human and knowledge resources.

“We still have commissioners and as long as we’ve still got commissioners, we’ve still got capability to change the way that we incentivise providers. So, we can do something there in terms of saying, ‘well, actually, let’s not worry about CQUINs³ coming down from on high to promote physical activity; let’s do that locally’.”

(National NHS stakeholder, N4)

“There are some places where I think the individuals often come together despite the system rather than because of it. They won’t say, ‘no, I can’t do this because of the financial pressures on me’, but ‘I can do this’. I don’t think that they are necessarily everywhere, but I think there is a real willingness to work, and a lot of people expending time and other resources, you know, really committing to work together.”

(National non-NHS stakeholder, N6)

Nevertheless, both the bidding process itself and if successful, the additional financial resources could be a key catalyst for action.

“I started having conversations with my public health colleagues in [area]. I met with the director of public health, or a couple of them as it was at the time, this was 2015 I think, ‘16 and said, look, I think we should just get a [physical activity] programme up and running. They were keen, the CCG were keen, the trust was keen, but nobody had any money. Our usual story. So, after wasting about a year trying to get people to release money I decided just to apply for a Health Foundation Innovation Grant. In September ‘17 I got a Health Foundation Innovation Grant and I got some small match funding from the CCG, trust and Public Health and we ran a pilot. And, basically, this has enabled us to start this seamless piece of work, where the Health Foundation funded the original pilot, but the LDP funding has now enabled us to take that work forwards into a further 3 years.”

(NHS Consultant, L10)

Leadership programmes, as exemplified by the Kirklees Integrated Systems Leadership Development Programme in our case study, could also be important local resources.

³ Commissioning for Quality and Innovation, a NHS quality improvement tool.

Central pressures are driving siloed working

In terms of barriers a number of informants talked about the continued central pressures for siloed working, and in particular what some interviewees referred to as a NHS culture of command and control.

“Sometimes I think NHS England, less so around CCGs, because I think they get the local system, but I think national players don’t always see themselves in the picture, and I think they have a different culture, which is very much a centralised command and control culture.”
(National non-NHS stakeholder, N2)

“The thing about the NHS, and it is a central command and control model, so if the Secretary of State says jump, then the NHS jumps. I mean there's a few different heights to jump maybe locally but that's the, they usually have a target how high they've got to jump. So actually I think the key for Public Health England, the drive to achieve physical activity in the NHS would be to set central targets, central expectations in order that they do so because they work very well to the command and control model. Otherwise you can work locally with them but sometimes it's about box ticking...”
(Director of Public Health, L13)

Quantifiable outcomes are wanted in unrealistic short timescales

Closely related to the theme of siloed working was the issue of wanting to see quantifiable outcomes in unrealistically short timescales, particularly within the NHS performance management culture.

“I also think the organisations that we’re working with are relatively risk-averse – probably because they have to be. So, working with, for example, local authority, NHS, primary schools, they’re quite risk-averse organisations. Changing, doing something differently, the implications can be quite huge, obviously, if it goes wrong in some cases – in some areas. Well, they have very robust, you know, processes of how things get signed off, how they get agreed, what are the protocols for different services, and how things have to be delivered and quality-measured – all for good reason. That sometimes challenges your ability to be innovative and do things differently.”
(Local non-NHS stakeholder, L1)

Respondents involved in the evaluation of whole systems work on physical activity, particularly related to LDPs, discussed the difficulties of evaluating impact and outcomes given the complexity of the factors influencing people’s choices around physical activity.

“It all boils down to, and it’s never easy in my view to be able to evidence separate interventions impact in a way you can say X saves Y.”
(National NHS stakeholder, N5)

“It is really hard to measure on a population basis and again we've been working with quite a lot of national expert groups on this and we're kind of, despite my best efforts we're kind of moving away from it. I think that the levels of increase in physical activity one might see in an LDP given the sort of background noise are very, very difficult to identify a real change.”
(Director of Public Health, L13)

Areas identified by webinar participants

At the whole systems webinar in April 2020, the 15 participants identified a number of specific areas for advancing the NHS engagement in whole systems approaches to physical activity:

There has been a very clear message through the COVID-19 lockdown that daily exercise is necessary for mental and physical health. Although it may be that overall levels of physical activity declined due to COVID-19 restrictions, particularly for those in older age groups, with disabilities and those who were shielding, the clear message to get out and take exercise every day during the lockdown was seen as one to build on across systems at local level. They were also keen that work in this area that had been suspended by COVID-19 remained a priority in the recovery phase.

NICE guidance contains a lot of physical activity recommendations embedded within clinical pathways which though sometimes hard to find, can be synthesised and built upon. For example, there are opportunities around the draft NICE guidance on pre-habilitation for orthopaedic surgery (24). These provide a first opportunity to engage health professionals in promoting physical activity, which could then potentially lead to system wide engagement.

The medical royal colleges are influential and very involved in the development of care pathways; thus, working with the royal colleges could be a real opportunity to embed physical activity into care pathways in a way that would support a whole systems approach.⁴

There is real value in sharing real world experiences of systems working on physical activity. Stories matter; people listen and can change their mind-sets. More case studies would be good to bring messages to life.

⁴ PHE is already working with some royal colleges, notably the Royal College of General Practitioners on whole systems approaches to physical activity (see for example <https://www.rcgp.org.uk/about-us/news/2019/august/gp-practices-supported-to-recommend-active-lifestyles-to-patients-and-staff.aspx>)

RDPHs have an important role in the new NHS structures. They provide an important potential resource to influence the NHS on promoting physical activity at the regional and ICS/STP level.

NHS organisations need evidence to make the case of the financial and patient benefits for the NHS engaging in systems approaches to physical activity within the one to 3-year time scales they have to work to, rather than the longer term over which public health interventions are often seen to work.⁵

ICS prevention and population health management leads are key actors who need to be engaged in whole systems approaches to physical activity.

There may be opportunities to support and engage the NHS workforce around whole systems approaches to physical activity through population health management and leadership courses.

⁵ Some research has already been done in this area (25, 26), but more evidence and synthesis is needed to effectively make the case to NHS organisations.

Chapter 4: Discussion

Engaging and integrating the NHS in whole systems approaches to promoting physical activity

Research, inquiry and informed commentary over decades have highlighted the challenges the NHS faces in shifting the balance from treatment and care to prevention. From 'Prevention and Health' (27) in the 1970s to the 'Wanless Report' (28), and most recently the 'NHS Long Term Plan' (18) and the 'Prevention Green Paper' (29), the need for the NHS to refocus on prevention and population health has been cogently made.

Whilst it is easy to make the case for change it is more difficult to see how to enable the change in practice in such a complex system as the NHS, where a focus on treatment and care is driven by a range of factors including popular conceptions of health and illness, medical culture, political timescales, economic interests and a focus on short term performance targets and plans. It is perhaps unsurprising that promoting physical activity sits alongside other public health and prevention issues in being topics with which it can be difficult to fully engage the NHS.

However, opportunities to facilitate this do exist. There is an emerging evidence base including academic commentaries (1, 6), systematic reviews (3, 10) and evidence-based reports (2, 7, 8) which describe whole systems approaches either specifically to physical activity or to obesity, which can easily and equally be applied to physical activity. These offer opportunities to engage the NHS in system wide approaches, highly consistent with the direction of travel in the 'NHS Long Term Plan', the development of population health management approaches and ICSs. In particular ICSs are uniquely well placed to engage with whole systems working as they have been established precisely to ensure an integrated approach to improving population health and minimising or avoiding siloed working.

Increasingly the important role of NHS organisations as anchor institutions within communities (19) is being recognised and understood, and this brings new opportunities. For example, NHS organisations can be exemplars in supporting active travel for staff, visitors and patients (30). Thus, it is clear the NHS can and should play a key role in whole systems approaches to promoting physical activity. The question therefore is not what the NHS should be doing, but how to support NHS organisations to recognise and undertake their role in promoting physical activity both within their own organisations and across local systems. This is not just about the NHS prioritising and doing work on physical activity but about being active partners in shared system leadership across every level of the system from neighbourhood to national. NHS actors need to recognise their place in the system both within their own organisations but also as partners advocating for collective action across the system and working in

partnership to strengthen and align approaches. Where NHS trusts are carrying out work to embed physical activity across their culture and process, for example, they need to ensure their work aligns with other action across the local system and share their good practice and learning about enablers and barriers with partners locally and nationally.

One key message to come out of this research is that a whole systems approach requires rethinking who we view as NHS systems leaders, away from only those in senior management or senior clinical roles to include a wide range of NHS actors working at a variety of levels. Thus, we also need to widen the focus of our first research question to include how we engage and integrate the range of NHS actors in whole systems approaches to promoting physical activity. Everyone potentially has a role in this from the General Practitioner (GP) receptionist, to the GP to the CCG accountable officer, the Director of Public Health (DPH), the ICS director of transformation to the chief executive of NHSE&I. And all these different actors will have different roles to play in a whole systems approach to physical activity. We suggest some of the opportunities for action to engage the NHS in whole systems approaches to physical activity at these different levels in Chapter 5.

At all of these levels there is an opportunity for NHS actors to play a role in wider formal and informal partnership bodies concerned with health and wellbeing, in developing shared visions for physical activity, in system mapping, aligning actions and developing and implementing action that addresses physical inactivity within the context of the complex factors which shape individual and community choices around health and wellbeing.

As well as contributing to formal and informal partnerships NHS leaders can also take practical steps to promote physical activity for staff, visitors and patients as part of a whole systems approach. This should include the whole organisation, from logistics and estate management to human resources and working patterns. Practical steps that can be taken include developing active travel plans, outside space, and adopting established programmes such as Moving Healthcare Professionals and Active Hospitals. Physical activity should be embedded within staff health and wellbeing programmes, and NHS staff should be encouraged to be advocates for physical activity within their communities and outside traditional boundaries.

Taking a whole systems approach to physical activity is entirely in keeping with current NHS policy on population health management, the move to ICSs and PCNs, and the wider prevention agenda; the issue is that other policy streams, in particular around NHS performance, financial and quality management, may send different short term messages and drivers to the NHS which may not encourage or facilitate engagement with the physical activity agenda where the benefits mainly accrue over a longer term timescale. There was a sense that the COVID-19 pandemic has highlighted the importance of physical activity to health, both physical and mental wellbeing, and that

there is an opportunity to build on this in the recovery phase. However, it must be acknowledged that there are particular barriers and challenges to those in older age groups, with disabilities, shielding, and living in areas with lack of access to high quality green space (31).

While we have good evidence on the value of and models for whole systems approaches to physical activity, there is little existing evidence on how best to effectively engage the NHS in whole systems approaches. This is the gap in evidence that this research has sought to help fill. We know that such culture change in the NHS can be challenging and take time, but evidence from other policy areas such as clinical governance, patient safety and patient-focused care show that it can be done (32). It should also be noted that one of the research participants observed that NHS partners can also find local authority culture a barrier to engaging, so that effective whole systems working on physical activity may require greater culture understanding and culture change across and within wider organisations. By examining the examples of how the NHS was engaged in our 4 case studies, the barriers they experienced and the enabling factors that supported engagement, this small study can contribute to the knowledge base on how to engage the NHS in whole systems approaches to physical activity. There are lessons to be learnt here both by NHS actors but also by the wide range of partners who need to support and engage the NHS in these whole systems approaches.

Identifying who within the NHS system to engage with around physical activity and who feels that whole systems working is within their remit can be difficult. Whilst clinical champions within trusts have shown evidence of active engagement, it may not always be easy to identify who to engage in partnership working around whole systems approaches. There are opportunities to clarify these roles and empower these staff to participate.

Between-site variation

The 4 case studies were chosen to achieve maximum diversity across 5 criteria: including levels of physical activity, development of integrated care systems, and engagement in the Sport England LDPs. Thus the 4 sites presented distinct examples of whole systems working with different emphases; there was, however, a congruence of themes across all sites, with no notable conflicting accounts regarding any of the themes identified.

Strengths and limitations of research

The strengths of this study are that it successfully explored the views of those working in diverse settings around England from a wide range of different parts of the system engaged in promoting physical activity through a whole systems approach. The findings

were validated by respondents and by a wider group of stakeholders at a webinar. The limitations include that it is a small scale qualitative study with a relatively small sample size in each case study, completed over a short time period, that not all participants conceptualised their work in the language of whole systems (and so focused more narrowly on interventions to promote physical activity). Local stakeholders were likely to be those with an interest in physical activity, so the research may not capture the views of senior clinicians, managers and others who did not believe that this was within their remit or a priority area. Some local areas not known to NHSE&I, PHE or Sport England may have had different experiences to those selected as case studies. Respondents did not identify any individuals working in NHS facilities, transport or estates to be interviewed, although they might be important agents of change at local level due to their responsibilities for aspects like travel and parking. Due to unplanned COVID-19 pressures in most local areas high level ICS system leads and nationally RDPHs were not available for interview.

The findings of this research are summarised below as barriers and enablers. Key messages and opportunities arising from the key themes, enablers and barriers are then presented in Chapter 5.

Barriers to engaging the NHS

Capacity

A clear message from across the case studies was that everyone in the NHS – and other sectors – has many competing priorities, and their capacity to engage with the physical activity agenda is often experienced as limited.

NHS culture

Respondents perceived that drivers from NHS performance management focus on clinical treatment and care, quality and finance, and despite the stated commitment to prevention, do not currently encourage a refocus on the long-term benefits of engaging with promoting physical activity.

Engaging the acute sector

Across the case studies there was considerably more engagement with CCGs and primary and community care than there was with the acute sector. Promoting physical activity was still something that was not usually seen as acute sector core business.

Difficulty in demonstrating quantifiable impact in the short to medium term

The main benefits of greater physical activity are likely to accrue over a long-time period – 5 to 10 years or more (29) – whilst the NHS is looking for short term reductions in indicators like bed days and GP visits.

Difficulty in seeing opportunities for innovation that do not involve significant new resources

Although our key informants did not necessarily see a lack of resources as a barrier to innovation around physical activity, their experience was that other stakeholders in the NHS and other parts of the system often did.

Maintaining long term partnership relationships at a time of organisational change and staff turnover

Systems working is enabled by long term partnerships which themselves are facilitated by long term relationships, but these are often disrupted by continuing organisational change and related staff turnover in the NHS.

The whole systems concept and terminology may not always be recognised or seen as relevant by those in NHS

There may be an opportunity to learn how to increase understanding in the sector from work in other sectors, for example Sport England offer a leadership programme around Systems Leadership, punctuated with stories – a 3-day programme targeted to all sectors – and comprises presenters, stories and personal experiences from local level.

Enablers for engaging the NHS

Across our 4 case studies there were a number of common enablers which were identified as supporting the engagement of the NHS in whole systems approaches to physical activity. These are consistent with the literature on systems leadership outlined in the systematic review by Bagnall (15).

Recognising and facilitating shared system leadership

In each of our case studies there was an explicit commitment to both a whole systems approach to physical activity at the place level (local authority and CCG level within the NHS), and to facilitating shared systems leadership. This took different forms, for example by engaging CCG accountable officers in the place-based ‘keeping active’ leadership groups.

Key individual or core team championing the whole systems approach

Although overall leadership needs to be shared, it was clear from our case studies that motivated individuals or small core teams working across local authorities and the NHS (particularly in CCGs) could and did make a difference in championing the whole systems approach to physical activity.

Key facilitation role for public health across the system

All actors brought their different knowledge and skills to the table, but public health professionals uniquely were seen by those in the system to have the evidence-based knowledge about effective physical activity interventions, the understanding of systems approaches, the partnership skills and the remit to play a key facilitation role in promoting physical activity across sectors including in the NHS. This was recognised by those in the NHS. In some cases, this expertise and resources was provided through Active Partnerships and their role working with and in local authority public health teams.

Balancing senior buy-in with working with enthusiasts

Gaining 'buy-in' from senior managers in the NHS was seen as important (particularly to secure any necessary financial support) but it was recognised that they would often or usually have little time to personally engage, and once they had given broad approval for physical activity work, they might have relatively little engagement with or knowledge of the detail. Achieving real change was therefore often achieved more by working opportunistically with enthusiasts, whatever their formal status or level of authority whilst securing in principle support and buy-in from those in more senior leadership positions.

Taking time to build relationships and develop shared vision

The themes of the importance of relationship building (including the time it takes build trust in relationships) and developing shared vision (sometimes referred to as common purpose) and shared values were not only present in our case studies but reflect key features of the wider literature on whole systems approaches and leadership (14,15,23).

Utilising system mapping

Those of our case studies which began with a systems mapping exercise found it a very valuable experience both for the intelligence it gleaned but also for the time it provided for thinking and relationship building between all partners, including those from the NHS.

Development support for systems leadership

All our case studies provided some support for the development of systems leadership, in particular in one case, an innovative programme across sectors and with those not in formal senior leadership roles. Such a place-based systems leadership programme

could be an important mechanism for developing the necessary collective ownership and shared values for whole systems working on physical activity.

Chapter 5: Key messages and opportunities for action

Key messages

A whole systems approach to physical activity should recognise that NHS systems leaders may include a wide range of NHS actors working at a variety of levels. Whilst senior manager support is important, there is a need to engage a wider range of NHS actors.

Building long-term high quality personal relationships and trust are key factors in enabling system leadership on physical activity.

Engagement with and championing of physical activity by clinicians and within clinical pathways such as pre-habilitation can be a highly effective way of engaging NHS staff in promoting physical activity and developing their role in whole system approaches.

Making physical activity a priority at ICS/STP level means it then appears throughout the system with other regional bodies in planning and transport, and at clinical commissioning group (CCG), primary care network (PCN) and trust level.

Taking a whole systems approach to physical activity is entirely in keeping with current NHS policy on population health management, the move to ICSs and PCNs, and the wider prevention agenda. However, other policy streams, in particular around NHS performance, financial and quality management, send different short-term messages and drivers to the NHS.

The response and recovery phases for COVID-19 may offer new opportunities to build on the consistent messages of the importance of daily physical activity for good physical and mental health, to extend to engaging the NHS in whole systems working on physical activity (for example on active travel). There will however continue to be barriers to be addressed for those with disabilities, Black, Asian and Minority Ethnic communities, older adults and those who are shielding.

Opportunities for action

These opportunities present possible areas of action at organisational level, with an indication of potential responsible organisations. It is important to recognise this will vary and be flexible in accordance with the structures, priorities and roles of the systems at national, regional and local levels. In line with a whole systems approach these

partnership opportunities are likely to be influenced and supported by the range of stakeholders and organisations, therefore whilst one or multiple organisations may take a lead there will be a need for shared ownership and action across organisations and level (local, regional and national).

For organisations working at regional and national level including PHE, NHS England and NHS Improvement (NHSE&I), Sport England

Understand what is needed to ensure ICS population health and population health management programmes recognise the important role of physical activity as a key part of a holistic approach to prevention and improving people's physical, mental and social health and wellbeing.

Consider how the impact of different policy decisions and drivers around NHS performance and quality management, funding and workforce development, can positively impact on the degree to which NHS organisations and professionals engage with the physical activity agenda.

Support ICS/STP leads in this work through formal or informal networks (for example via RDPHs or the [Population Health Management Academy](#)(33)).

Support the development and dissemination of learning and networks from areas with good engagement with the NHS in whole systems approaches.

Ensure that the principles of whole systems approaches are embedded within NHS leadership and population health management programmes.

Include learning and information sharing on physical activity whole systems approaches to physical activity at key NHS webinars, events and conferences and in NHS policies and guidance.

Develop and disseminate easily accessible resources on physical activity that would support conversations with different audiences within the NHS to develop whole systems approaches at local level, for example infographics, case studies, stories, identification of menu of points amenable for change in local systems (for example upskilling staff, clinical pathways, impact on workforce sickness absence; active travel by staff, visitors and patients; system mapping tools). A possible approach to 'making the case' documents is provided in [Appendix 3](#).

Consider an evidence review on the financial and other benefits for the NHS of increasing population physical activity by patients and staff that would really speak to senior NHS leaders.

Work with medical royal colleges and faculties to ensure their members are aware of importance of physical activity to health and wellbeing and can see its role in clinical pathways, prevention and chronic disease management.

Seek opportunities to develop and embed systems approaches into existing or new systems leadership programmes, to support partnership working across local and regional systems.

For ICSs and STPs

Ensure that population health and population health management programmes recognise the important role of physical activity as a key part of a holistic approach and facilitate a joined-up approach to embedding physical activity in commissioning plans.

Facilitate a joined-up approach to embedding physical activity in commissioning plans work with strategic partners to embed promotion of physical activity into spatial and transport planning.

Recognise and utilise the role of physical activity for mitigation and building health resilience within COVID-19 response and recovery planning.

Identify a lead champion with responsibility for engaging with other partners in whole systems approaches to physical activity.

For CCGs and NHS trusts

Ensure physical activity work is integral to place-based health and wellbeing strategies, working with wider partnership bodies led by local authorities concerned with health and wellbeing.

Embed physical activity within clinical pathways.

Recognise their own role as anchor institutions to promote physical activity and active travel within their own staff and local population.

Identify a lead champion with responsibility for engaging with other partners in whole systems approaches to physical activity.

For those at neighbourhood or PCN level

Ensure that general practice and other community health services are supported to integrate the promotion of physical activity into clinical and social care via social prescribing, workplace health promotion and community engagement.

For local authorities and health and wellbeing boards (linking with Active Partnerships)

Map physical activity systems across the place working in conjunction with other stakeholders including NHS organisations across the local system.

Align and connect (but do not subsume) physical activity with obesity whole systems approaches at local level.

Seek to engage all NHS organisations in a shared vision for physical activity recognise that bringing partners together to bid (for example Active Hospitals, LDPs) is helpful in catalysing action irrespective of the success of the bid.

Showcase and share examples of successful systems approaches to physical activity, to the local ICS/STP and more widely.

Identify a lead champion with responsibility for engaging with other partners in whole systems approaches to physical activity.

Chapter 6: Concluding remarks

The implications of the COVID-19 pandemic

This research has taken place during the most unprecedented global, national and local public health crisis caused by the COVID-19 pandemic. As was clear to participants in our webinar, the need for the NHS to engage in a whole systems approach to physical activity, and for other issues such as obesity, is likely to become more urgent in the light of COVID-19. There appears to have been a net decline in physical activity in England during the initial COVID-19 lockdown, with a disproportionate impact exacerbating existing inequalities for key groups, including those with or at risk of health conditions (34); there has been an ongoing declining in activity levels from April 2020 to September 2020, with levels seemingly stabilising below pre-COVID-19 levels (35). Figures from the leisure sector suggest negative short and long term consequences, with half of leisure sectors not reopening after the initial lockdown and many facilities at risk of long-term closure (including one in 5 swimming pools) (36). Furthermore issues within the health care system include delays in care for those with long term conditions that physical activity can help manage and risks of fragility and falls from individuals deconditioning through lack of activity (37). Physical activity is both part of the Government's COVID-19 recovery plan (38) but will also be important for managing non-COVID-19 related demand on health and care services.

What is crucial is that the NHS and its partners including local authorities, PHE and Sport England continue to work together in partnership to develop and deepen whole systems approaches to promoting physical activity. Learning on how to do this is captured in our case studies, in the LDPs and in other local examples of whole systems working on physical activity. It is highly encouraging that the need for this whole systems approach is widely shared by key national organisations including NHSE&I, PHE and Sport England as well as local health and wellbeing partnerships. Sport England for example are developing their new 5-year strategy for 2021-25 explicitly on a whole systems basis, framed around the key themes of 'purpose,' 'people,' 'place' and 'partnership' (39). These themes reflect and reinforce themes from our data and our key messages of the importance of shared vision, collaborative systems leadership, place-based focus and building and sustaining relationships. Although the urgency of the COVID-19 response will inevitably have diverted some attention and resources away from physical activity work in the short term, the opportunity is there longer term to more fully and effectively engage the NHS in whole systems working on physical activity.

Chapter 7: Glossary

There are many different perspectives on whole-systems and place-based approaches with systems language sometimes used differently across organisations. An overview of whole-systems approach concepts and behaviours is available in the Whole Systems Approach to Obesity guide (14). The following table describes how terms are used in this document.

Active partnerships	Locally based strategic organisations funded by Sport England who work collaboratively with local partners to create the conditions for an active nation (17)
Anchor institution	Large, public sector organisations that are unlikely to relocate and have a significant stake in a geographical area. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land.
Integrated Care System (ICS)	Integrated care systems (ICSs) have evolved from Sustainability and Transformation Partnerships (STPs). NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS care, and improving the health of the population they serve (40).
Neighbourhood level	A level of ICS served by groups of GP practices working with NHS community services, social care and other providers to deliver more coordinated and proactive services, including through primary care networks (populations circa 30,000 to 50,000 people) (20).
Place-based approaches	Focuses on how the local system can work together utilising civic, service and community centered approaches to reduce health inequalities. For more information please see PHE Place-based approach guidelines (41).
Place level (NHS)	A level of ICS served by a set of health and care providers in a town or district, connecting primary care networks to broader services including those provided by local councils, community hospitals or voluntary organisations (populations circa 250,000 to 500,000) (20).
Population health management programme	An emerging technique for local health and care partnerships to use data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources (33).

Primary Care Network (PCN)	A network of general practices typically covering 30,000-50,000 patients that provide the structure and funding for services to be developed locally, in response to the needs of the patients they serve (42).
Shared vision	A clear and aspirational statement of what the whole systems approach is trying to achieve (14).
Sustainability and Transformation Partnership (STP)	Partnerships between NHS organisations and local councils that are designed to run services in a more coordinated way, to agree system-wide priorities, and to plan collectively how to improve residents' day-to-day health (43).
System	<p>A system is a collection of interdependent and interconnected parts. If something happens to one part of the system, other parts of the system will be affected. A complex system is made up of many parts which interact in a disordered and unpredictable way (14).</p> <p>In the NHS and more widely the term 'systems' is used both to describe the local system across which a whole systems approach is taken and to describe a specific ICS level (see below). Whilst either meaning may be present in this report, the context should make it clear which is being referred to.</p>
Systems leadership	Systems leadership is about working across services and organisations, often in circumstances of considerable complexity and building relationships with others to improve outcomes for the populations served, despite the challenges faced (44).
System level (NHS)	A level of ICS in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale (populations circa 1 million to 3 million) (20).
System mapping (for physical activity)	A process to identify and visually represent how the local causes of physical activity are linked (14).
Systems thinking	A way of looking at, learning about, and understanding complex situations (14)
Whole systems approach	A local whole systems approach responds to complexity through an ongoing, dynamic and flexible way of working. It enables local stakeholders, including communities, to come together, share an understanding of the reality of the challenge, consider how the local system is operating and where there are the greatest opportunities for change.

	Stakeholders agree actions and decide as a network how to work together in an integrated way to bring about sustainable, long term systems change (14).
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Appendix 1: Case studies⁶

Dorset case study

Context

Dorset is a county in South West England covered by the 2 unitary authority areas of Dorset and Bournemouth, Christchurch and Poole (BCP). The county is part of an NHS integrated care system (ICS), known as 'Our Dorset', which is comprised of one NHS Clinical Commissioning Group, 6 NHS foundation trusts and Public Health Dorset.

Dorset's population stands at just above 800,000 and is increasing. It is a largely rural area with no cities and few small towns. It has an ageing population, with the proportion of adults aged 65 and above much higher than the England average (28% vs 18%, respectively), and one third of the population lives with one or more long-term health conditions. The population has significantly lower levels of Black, Asian and Minority Ethnic residents than the national average (4.4% vs 19.5%, respectively). Almost 10% of the population live in the most deprived areas of England. Physical activity levels are largely comparable with the England average, although there are pockets where physical inactivity is high.

Whole systems approach to physical activity

Dorset has been developing its own whole systems approach to physical activity for many years. Investment from Sport England and local partners led to the establishment of Active Ageing - a whole systems approach to embedding physical activity for the 55-65 population. Active Dorset collaboratively leads this work, and is one of 43 Active Partnerships across England, designed to provide a set of core services to strengthen the local delivery of physical activity. Whole systems work is integral to the Active Partnerships mission, which recognises that "[physical] activity levels are affected by a complex system of influences and no single organisation or programme [can] create sustainable change at scale."

NHS support for physical activity is highlighted in the 'Our Dorset: Sustainability and Transformation Plan' (STP) and the 'Dorset Integrated Care System (ICS) Operational Plan'. It has 3 inter-related programmes of work which are:

- prevention at scale
 - integrated community services
-

⁶ Data presented in context sections are all sourced from resources listed in web links for each case study

- One Acute Network, with physical activity featuring most prominently in the prevention at scale programme of work, which aims to help people to stay healthy and avoid getting ill

Activities include: the development of a systematic physical activity programme; taking a whole school approach to increase physical activity levels; and, maximising the built and natural environment to improve health and wellbeing outcomes, including physical activity.

Another area of whole systems work, driven largely by collaboration between Active Dorset, Public Health Dorset, and the NHS CCG, is focused on 3 areas of physical activity promotion: primary and secondary care (targeted at individuals receiving advice from a health professional); workforce (targeted at public sector workers nearing retirement); and, localities and schools (targeting inactive parents and grandparents of children). The aim is to work across systems, care pathways and specialties to identify points in the system at which physical activity messages or interventions can be delivered; shifting the focus from individual-level behaviour change to a whole systems approach to physical activity.

A key activity has been the development of system changes at primary and secondary care levels. Examples of changes made to primary care pathways include: physical activity promotion training for all primary care staff; the inclusion of physical activity in the specification for commissioning of the National Diabetes Prevention Programme and re-commissioning of the NHS Health Checks programme. Efforts have also been made to embed physical activity into secondary care pathways, including cancer, musculoskeletal disorders, and pre-habilitation.

Enablers

Whole systems working on physical activity in Dorset has been enabled by a variety of factors. Firstly, Dorset has benefitted from intensive input from Active Dorset in creating and influencing physical activity system change. This has occurred through the provision of physical activity-specific skills and expertise from Active Dorset to NHS and Public Health Dorset partners. Second, time has been essential for building trust and relationships across sectors. The presence of enthusiastic, committed and connected individuals working across local authority public health teams, the voluntary and community sector, and CCGs has been integral to progress. Further, the identification and engagement of key partners working in specific primary and secondary care speciality areas has created a sense of shared ownership and provided opportunities for shared learning across NHS care pathways.

Challenges

Key challenges include the pace of change within the NHS and high levels of disruption in the system; this has resulted in physical activity promotion within NHS settings not always being seen as a priority. Second, physical activity is not traditionally considered or embedded when designing NHS services or pathways, or when commissioning programmes or projects; whole systems approaches to physical activity therefore challenge the status quo. Third, despite positive engagement from NHS systems leaders at some levels, the identification of 'change agents' within acute settings has been difficult to establish. This is coupled with the issue of limited capacity and financial resources, which has made it difficult for partners to work effectively across sectors.

Key learning

The Dorset case study has shown that whole systems approaches to physical activity require time to build trust and relationships. It also highlights the importance of finding and working with enthusiastic and committed key partners from all sectors. The engagement of NHS systems leaders in whole systems approaches to physical activity may require a culture change, which moves away from the traditional medical model of care, to a place where NHS systems leaders are supported to consider and embed physical activity throughout treatment pathways.

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Web links

Active Dorset Strategy 2020-2025 [short version]. Available from <https://www.activedorset.org/active-dorset-strategy-2020-2025>

Our Dorset Sustainability and Transformation Plan for local health and care. Available from <https://www.dorsetccg.nhs.uk/project/stp/>

Dorset Integrated Care System Operational Plan 2018/19 Refresh. Available from <https://www.dorsetccg.nhs.uk/wp-content/uploads/2018/03/Dorset-ICS-Operating-Plan-V7-01.05.2018.pdf>

Essex case study

Context

Essex is a two-tier authority with Essex County Council and 12 district or borough councils. It is one of the largest local authorities in England and includes the city of Chelmsford as well as the towns of Basildon and Colchester. In addition, there are 2 unitary authorities not included in the County Council: Thurrock and Southend-on-Sea. There are 7 CCGs in Essex, 5 in the area covered by the County Council. The Suffolk and North East Essex ICS covers part of Essex whilst there is also a Mid and South Essex Health and Care Partnership in the rest of the county.

The population of Essex County Council is approximately 1,400,000. The population of the county is ageing (with more over 65s on average than England as a whole) and the life expectancy gap is widening with significant health inequalities (although deprivation scores are slightly better overall than for England). One in three 10 and 11 year olds and two-thirds of adults are overweight or obese. Mental health issues are common, and the number of suicides has increased. Approximately 24% of the population are classified as inactive.

Whole systems approach to physical activity

Essex was successful in becoming one of 12 Sport England funded local delivery pilots (LDP). The pilot is being tested in the low-income communities of Basildon, Colchester and Tendring which together represent 37% of all inactive people in Essex and represent areas with a range of barriers to physical activity such as post war urban planning, coastal deprivation and poor social mobility. The LDP has identified 3 priority groups to work with: older people, people with mental ill-health and families with dependent children. The LDP is Essex-wide, with a commitment to rapidly scale up the successful testing across the county.

The LDP is hosted by the County Council and managed by Active Essex, funded by Sport England and involves a large number of stakeholders and partners. NHS commitment to the LDP is reflected by the membership of one CCG accountable officer on the Board of Active Essex, the partnership commitment of the 2 CCGs that cover Basildon, Colchester and Tendring, and the strategic stewardship of the LDP by the Essex Health and Wellbeing Board. The LDP partners with Intelligent Health to provide expert advice on physical activity, and partners with the University of Essex to provide robust evaluation of the LDP. Public Health England is also a strategic partner through their East region. The progress of the LDP is documented on the Active Essex website.

From the outset the LDP has been committed to a whole systems approach. Active Essex are working with a main whole system change partner, Collaborate CIC on a range of activities to support whole systems working. In the first phase diagnostic work

identified the strengths and weaknesses of system leadership in Essex, and the need for bespoke training and development programme. The work includes evaluation of the impact of the systems work and development of toolkits and resources to help translate the learning from the 3 districts to other parts of Essex. The first year was mainly focused on diagnostic and discovery work, having conversations, building relationships, developing the shared vision, and agreement on priorities and plans going forward; the focus then switched to delivery, particularly upskilling the workforce across sectors to be able to integrate physical activity into their existing delivery.

Enablers

The LDP is a key enabler in Essex. It provided time – time to think, to do the discovery phase and the diagnostic, to build the shared vision and identify priorities, to get the sign-up from partners, especially leaders across 7 different system settings. Building relationships was also a key enabler with regard to the NHS, particularly with CCGs, getting the LDP recognised as a CCG priority, having CCG input at Board level. Getting senior buy-in was crucial from the Health and Wellbeing Board, the councils and CCGs. Having a respected doctor from Intelligent Health as one of their expert partners was important in engaging GPs and other health professionals.

Challenges

A key challenge was the constant change in the system, particularly in the NHS, just when they thought they had a grip on the architecture, it would then change. The LDP needed to make multiple attempts to engage the NHS, and sometimes it was just not the right time, so they would have to wait and try again. NHS trusts were not easy to engage with, often conversations had to be mediated through the CCGs. There appeared to be a lack of joined up working on both the commissioning and delivery sides of the NHS. Commissioning appeared more transactional than collaborative. There were a number of examples of lack of joined up thinking, for example, physical activity is meant to be a priority in mental health, but mental health staff lack training in how to promote it. There were challenges in evaluating the LDP, and some tensions between the extent to which evaluation could focus on hard outcomes as opposed to process. The culture and language of the NHS was often difficult to understand for the LDP team, and the inclusion of Intelligent Health acted as a positive bridge between the LDP and health agencies and professionals.

Key learning

Key learning in Essex included the importance of taking the time to do the discovery and diagnostic phase, to map the system and build the shared vision. Other learning was the need to find champions with credibility in other organisations/sectors, for example senior managers within the CCGs and keen GPs in PCNs who would advocate the critical role of physical activity. The nurturing of these relationships was critical to the impact of the LDP. The involvement of a credible and expert external partner in Intelligent Health in

providing briefings and training to board members and senior CCG managers was also crucial. The Essex experience was that CCGs were key to engaging with the wider NHS as was gaining ownership from the Health and Wellbeing Board as well as that of local alliances bringing together NHS organisations and the community and voluntary sector.

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Web links

Active Essex <https://www.activeessex.org/>

Essex LDP <https://www.activeessex.org/essex-local-delivery-pilot/>

Kirklees case study

Context

Kirklees is an area of West Yorkshire covered by one local authority, Kirklees Council, and 2 NHS clinical commissioning groups, Greater Huddersfield and North Kirklees. It is also part of a NHS integrated care system: West Yorkshire and Harrogate Health and Care Partnership. Around 440,000 people live in Kirklees with the population spread between the larger town of Huddersfield and a number of smaller towns. The population of Kirklees is diverse, around 79% White and 21% from Black, Asian and Minority Ethnic backgrounds. There are significant levels of health inequalities, particularly affecting Black, Asian and Minority Ethnic communities. The population is also ageing, with particular growth in the over 65s. Levels of physical activity are significantly lower than the average for England overall, and have been declining.

Whole systems approach to physical activity

Kirklees was unsuccessful in its bid to host a Sport England local delivery pilot but has sought to develop its own whole systems approach to physical activity. Support for physical activity is a key theme of the 'Kirklees Health and Wellbeing Plan 2018-2023'. In addition there is an 'Everybody Active: Kirklees Physical Activity and Sports Strategy 2015-2020', overseen by a Kirklees Everybody Active Board. Activities have included the Board bringing together a range of stakeholders to develop a whole systems approach to tackling physical activity across the district. The local physical activity system was mapped, to help identify priorities and future planning, and ultimately raise physical activity rates.

Another whole systems initiative was the Kirklees Healthy Weight Declaration, endorsed and owned by the Health and Wellbeing Board, the Council, the CCGs and other partners. The Declaration was launched in March 2019 and a Health Weight Declaration Strategic Steering Group has now been set up to oversee implementation, including co-production with local communities.

A further systems approach, not limited to physical activity but benefiting this area of work among others, has been the 'Kirklees Integrated Systems Leadership Development Strategy 2019-2021'. Masterclasses on systems leadership have been offered across Kirklees partner organisations in the public and voluntary and community sectors, with a particular emphasis on involving those not formally in senior roles. Similarly, work in progress on the Kirklees-wide 'Estates Strategy' includes a focus on how to use the estates of all partners to encourage physical activity rather than simply address issues of managing 'bricks and mortar.'

Enablers

Whole systems working on physical activity in Kirklees has been enabled by a variety of factors. There are long term relationships between some of the key individuals involved and an active district activity partnership. There is a virtual core team of individuals working across the local authority and the CCGs who see their role as working for the system rather than for individual organisations. The strategic sign-up of the council, the CCGs and other partners through the Joint Kirklees Senior Management Team and the Chief Executives Group mean that the key individuals feel empowered to take forward the whole systems approach without needing to continually seek permissions for individual initiatives.

Challenges

Everyone in the local authority, the NHS and other sectors are very busy and capacity to engage is limited without the additional resource the LDP would have brought. Resources are often seen by partners as a barrier when trying to innovate. It has been easier to engage the CCGs and primary care than it has been to engage the NHS acute sector.

Key learning

Even without addition resources, it is possible to adopt a whole systems approach to physical activity. The Kirklees case study demonstrates the value of explicitly adopting a whole systems approach by providing systems leadership development opportunities to local stakeholders and to conducting early systems mapping. Underlying such activities are the importance of a shared vision, executive level buy-in and building and sustaining good personal relationships between key individuals facilitating the systems work.

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Web links

Everybody Active: Kirklees Physical Activity and Sports Strategy 2015-2020
www.kirklees.gov.uk/beta/planning-policy/pdf/supportingDocuments/healthCommunities/EverybodyActiveStrategy.pdf

South Tees case study

Context

South Tees comprises the 2 unitary authority areas of Redcar and Cleveland and Middlesbrough in the North East of England. The area sits within the Tees Valley integrated care partnership (ICP), one of 4 partnerships making up the North East and North Cumbria NHS integrated care system (ICS). Joint working is a key feature of the 2 authorities of South Tees, with many services and agencies specifically servicing the area, including: NHS South Tees Clinical Commissioning Group; South Tees Hospitals NHS Foundation Trust; and the South Tees GP Federation. Public leisure facilities are managed by Everyone Active on behalf of both boroughs. The 2 boroughs share a joint Director of Public Health and jointly commission a wide range of services.

The population of South Tees is approximately 280,000. It is geographically diverse, with the rural area of East Cleveland, coastal communities of Redcar and Saltburn, and the large town of Middlesbrough. It has significant social and economic issues, which contribute to significant inequalities in health. Physical activity levels in Redcar and Cleveland are largely comparable with the England average, while levels in Middlesbrough are significantly below the national average.

Whole systems approach to physical activity

Investment in December 2017 from Sport England's local delivery pilot (LDP) initiative is supporting the area to increase physical activity through whole systems change. South Tees' vision for the LDP, also known as 'You've Got This', is to "use sport and physical activity to drive improvement to wider social determinants across health, educational attainment, employment and community cohesion". LDP work is led by the Programme Management Office, with membership comprising senior officers of the 2 local authorities, the Director of a key voluntary sector partner, a Senior Manager of a commercial sector partner, a senior officer from the Active Partnership, the Sport England LDP Manager, and members of the core delivery team. The general principles and vision for the LDP were identified and agreed by more than 160 local stakeholders at a whole system change conference held soon after receipt of funding.

One area of LDP whole systems work closely linked to the NHS is focused on 4 communities of interest: people suitable for pre-habilitation prior to surgery; people with type 2 diabetes; people accessing community-based commercial weight loss services; and, health professionals. These streams represent areas of work where cross-sector relationships and/or partnerships may have already existed but have not developed beyond initial discussions or the delivery of small-scale behaviour change interventions. Group membership of each stream represents a broad range of organisations: the local NHS trust; Clinical Commissioning Group; national agencies and local leaders across a

range of occupational levels, including a Clinical Director, specialist nurses, consultants, dieticians, public health specialists and academics from a range of institutes. Members of each stream are working together to develop “deeper insight into the barriers, levers, challenges and opportunities” to progress physical activity ambitions for South Tees. The ultimate aim of the South Tees LDP is to use learning to develop appropriate interventions that support and facilitate a positive change in behaviour.

One example of good practice comes from the pre-habilitation workstream, led by an NHS Consultant with a keen interest in physical activity, with support from the local authority public health team and other organisations. As part of the pre-habilitation pilot, a face-to face community based physical activity programme was offered to patients in the 6 to 8 weeks prior to surgery. The programme was developed over the course of a year, based on a cardiac rehabilitation model. Patients completed a lifestyle assessment and were supported to agree a personalised programme with additional activities at home. Lessons learned are now being used to remodel the pre-habilitation service and are being shared with other workstreams and wider primary and secondary care pathways.

Enablers

Time to build and sustain relationships has been central to whole systems work in South Tees. While some cross-sector relationships and/or partnerships were already established, LDP investment created opportunities for more formal collaboration. As seen in other case studies, the presence of partners working across the system with enthusiasm and commitment to physical activity promotion has been integral to success.

Challenges

Even with LDP funding, central pressures on the NHS – particularly in the acute sector – (for example siloed working, limited time, target culture, and high staff turnover) have made cross-sector engagement difficult. Related to this, the physical activity agenda is not always seen as a priority among those in NHS leadership roles.

Key learning

The South Tees case study identified the importance of individual enthusiasm and commitment in driving forward the physical activity agenda. The case study also emphasised the value of taking time to build relationships across sectors and develop a shared long-term vision.

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Web links

You've Got This Pathfinder Submission

Sport England Local Delivery Pilots www.sportengland.org/campaigns-and-our-work/local-delivery

Appendix 2: Interview schedule

Engaging NHS systems leaders in whole systems approaches (WSA) to physical activity (PA): interview questions

Three categories of interviewees, requiring slightly different interview schedules, are:

- national stakeholders
- local (non-NHS) stakeholders in WSA to PA
- local NHS systems leaders

National stakeholders

What is your role and interest in whole systems/system-wide/place-based approaches to physical activity (PA) or more broadly?

What do you understand a whole systems approach (WSA) (or system-wide/place-based approach) to mean?

What does systems leaders mean to you? What do you perceive systems leaders to mean to you?

Who are the local (and national) NHS systems leaders who should be engaged in WSA/system-wide/place-based approaches to PA? How are they defined?

How would you anticipate/should NHS systems leaders be engaged in WSA/system-wide/place-based approaches to PA? At what level? In what way?

Do you have any examples of effective NHS systems leaders engagement in WSA to/system-wide/place-based approaches PA you can share?

What do you believe are the success criteria/what good looks like for a WSA to PA?

To what extent do you perceive these aspects to be present in local systems?

What are the local and national barriers and enablers that discourage/encourage collaboration across the system?

- engagement within the NHS?

- engagement between the NHS, local government and other stakeholders that is businesses, community and voluntary sector?

What is the role of NHS system leaders in local WSA to PA/PA initiatives and the wider system?

How can (or do) NHS systems leaders link population health management with WSA on PA?

What is required to (further) engage and integrate key NHS systems leaders in WSA to PA?

Have you heard or read of PHE's WSA to obesity? Do you have any thoughts/feedback on this? Are you aware of or using any other guidance on WSA to PA? What are your thoughts on best way to communicate guidance?

Local (non-NHS) stakeholders

What is your role in the system generally, and in WSA to PA/PA initiatives specifically?

What do you understand a whole systems approach (WSA) (or system-wide/place-based approach) to mean?

Can you describe the local PA initiatives and their location in the wider system?

To what extent would you describe this as a WSA to PA?

What does systems leaders mean to you? What do you perceive systems leaders to mean to you?

Who are the NHS systems leaders who should be engaged in WSA to PA? How are they defined?

What is the role (if any) of NHS system leaders in local WSA to PA?

How should NHS systems leaders be engaged in WSA to PA? At what level? In what way?

What are the challenges for non-NHS stakeholders in engaging NHS systems leaders on WSA to PA

Do you have any examples of engaging NHS systems leaders in WSA to PA? How was this done?

What do you believe are the success criteria/what good looks like for a WSA to PA?

To what extent do you perceive these aspects to be present in local systems?

What are the local and national barriers and enablers that discourage/ encourage:

- collaboration across the system?
- engagement within the NHS?
- engagement between the NHS, local government and other stakeholders?

What is required to (further) engage and integrate key NHS systems leaders in WSA to PA?

Have you heard or read of PHE's WSA to obesity? Do you have any thoughts/feedback on this? Are you aware of or using any other guidance on WSA to PA? What are your thoughts on best way to communicate guidance?

Local NHS systems leaders

What is your role in the system generally, and in the local WSA to PA/PA initiatives specifically?

What do you understand a whole systems approach (WSA) (or system-wide/place-based approach) to mean?

Can you describe the local PA initiatives and their location in the wider system?

To what extent would you describe this as a WSA to PA?

What does systems leaders mean to you? What do you perceive systems leaders to mean to you?

How should you and other NHS systems leaders be engaged in WSA to PA? At what level? In what way? Do you recognise this as your role?

What do you believe are the success criteria/what good looks like for a WSA to PA?

To what extent do you perceive these aspects to be present in local systems?

What are the local and national barriers and enablers that discourage/encourage your engagement in collaboration on PA across the system?

How can (or do) NHS systems leaders link population health management (PHM) with WSA on PA? And what do you see as the opportunities with PHM being a core component of ICSs.

How would you see yourself and other key NHS systems leaders engaging in WSA (or system-wide/place-based approach) to PA? What would help?

Have you heard or read of PHE's WSA to obesity? Do you have any thoughts/feedback on this? Are you aware of or using any other guidance on WSA to PA? What are your thoughts on best way to communicate guidance?

Appendix 3: Making the case outline

A clear message from the interviews and webinar was the need for resources for local physical activity partnerships to help make the case to NHS stakeholders for engaging in whole systems approaches to physical activity. Key issues include:

- senior NHS stakeholders are very busy
- they do not necessarily know the evidence base on the benefits of physical activity
- guidance on engaging in whole systems approaches to physical activity may not be easily accessible to them

Therefore, participants suggested the need for some concise and accessible resources that help make the case and signpost NHS stakeholders to the evidence and actions they can take and further resources. However, different NHS stakeholders will be most likely to be influenced by different cases specific to their roles, thus there is a need to identify more specifically the target audiences for such 'making the case' resources, for example:

- ICS/STP programme leads
- CCG accountable officers and commissioning managers
- trust chief executives, directors and senior managers
- senior trust clinicians
- GPs

There could be a menu of options that, in different combinations, would influence different stakeholders to more or less degree, these could cover:

- CQUINs and other aspects of NHS performance management
- evidence-based guidance (for example NICE)
- research evidence (for example trust chief executives and directors are likely to be influenced by evidence that demonstrates how promoting physical activity to staff and patients will have short to medium term financial benefits and reduce bed days)
- impacts of changing active travel behaviour in staff, visitors and patients
- guidance to trust clinicians on how including physical activity in clinical pathways improves patient outcomes
- stories, examples and case studies they can learn from
- patient and public involvement

The format of each 'making the case' document should be concise, preferably one page, with plain English and attractive design, and signposting and hyperlinks to key resources. For example, the resource for ICS/STP programme leads might be a case study drawn from another ICS/STP which has integrated a whole systems approach to physical activity into their population health management strategy.

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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