

Submission of Evidence Form – National Development Framework

Name Jeremy Callard

Contact details [REDACTED]

Date 7th March 2017

Title of evidence Need for institutional reform and improved management of public realm to deliver greater active mode behaviour and so improved health outcomes.

Summary of evidence - attached.

Achieving-safety-sustainability-and-health-goals-in-transport-
Everybody Active Every Day evidence based approach
Turning the Tide of Inactivity
Ukactive and SRA Public Health Landscape in England

Summary of key issues/conclusions:

Welsh Government policy and its delivery, which is aimed at improving public health outcomes and reducing the burden on the Welsh NHS, has conspicuously failed to keep pace with that in England. Of particular concern is the failure to integrate public health professionals into local authorities to ensure the planning, design and delivery of transport schemes reflect the needs of the public health sector.

Why have you submitted this evidence?

To raise the profile of the need for this institutional change and supporting infrastructure delivery to deliver improved life chances for the Welsh population and to reduce the burden on the Welsh NHS.

How should this evidence inform the development of the NDF?

The NDF should support this reform of Welsh Local Government by including policies that encourage the health and transport joint working arrangements and by highlighting the need for more walking and cycling interventions, including reducing pavement parking, which is endemic in Wales.

How does this evidence and any actions it recommends help achieve the 7 well-being goals?

A prosperous Wales – reducing mortality due to inactivity would reduce call on health budgets.

A resilient Wales – a healthier population is a more resilient population

A healthier Wales – more walking and cycling would make the population healthier.

A more equal Wales – investment in walking and cycling would reduce health inequalities in the population.

A Wales of cohesive communities – healthy communities are more cohesive

A Wales of vibrant culture and thriving Welsh language – this well-being goal is more likely to be achieved with a healthy population

A globally responsible Wales - Wales can demonstrate global responsibility by improving the health of its citizens.

Why is the evidence of national significance? – see evidence attached.

Do you agree for your evidence to be made public? – Yes.

(Only evidence that can be made public will inform the development of the NDF)

The Public Health Landscape in England

A guide for the activity, sport and recreation sector

**SPORT+
RECREATION
ALLIANCE**



Abbreviations

CCG	Clinical Commissioning Group
DPH	Director of Public Health
GP	General Practitioner
GPPAQ	General Practice Physical Activity Questionnaire
JSNA	Joint Strategic Needs Assessment
JHWS	Joint Health and Wellbeing Strategy
LGA	Local Government Association
NHS	National Health Service
NHSCB	NHS Commissioning Board
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
QOF	Quality and Outcomes Framework

Contents

Foreword	02
Public health structure	04
Local authorities	06
Joint Strategic Needs Assessments	08
Joint Health and Wellbeing Strategies	10
Public Health Outcomes Framework	12
Physical activity outcomes	14
Health and Wellbeing Boards	15
Public Health England	16
Directors of Public Health	18
Clinical Commissioning Groups	20
CCG Outcomes Indicator Set	22
NHS Commissioning Board (NHSCB)	24
NHS Outcomes Framework	26
NHS England	27
Other key bodies	28
National regulators	30
National research bodies	31
The commissioning structure	32
The Quality and Outcomes Framework	35
QOF indicators for physical activity (2013-14)	36
Personal health budgets	38
Case study – the ‘Let’s Get Moving’ model	40

Foreword

On 1 April 2013 the statutory reforms outlined in the Health and Social Care Bill finally came into full effect. Six months on, it is clear that these changes have fundamentally altered the way in which the healthcare system operates and for the first time guaranteed that public health funding will be ring-fenced.

A strong focus on prevention, early intervention and behavioural change is necessary to stem the growing financial and societal costs associated with the increase in lifestyle-related chronic conditions. It is critical that we adopt a preventative strategy in order to ensure that the NHS remains free at the point of use for future generations.

The evidence for the effectiveness of physical activity in tackling some of the nation's most pressing health concerns is well established. Exercise, sport and day-to-day physical activity can be instrumental in the prevention and management of a wide range of increasingly prevalent conditions including diabetes, cancer, coronary heart disease, obesity, stroke, musculoskeletal conditions and mental health.

Foreword

We know that over two-thirds of the population are not currently meeting the recommended levels of physical activity.



The Chief Medical Officers in all four home countries have made it clear that physical activity can reduce the prevalence of such conditions by up to 50%, yet we know that over two-thirds of the population are not currently meeting the recommended levels of physical activity. The Lancet refers to an “inactivity pandemic” with physical inactivity being the fourth leading cause of death worldwide.

The sport and activity sectors have a crucial role to play in increasing levels of activity and, in doing so, alleviating the burden associated with lifestyle-related chronic conditions. Our presence in local communities is vital to redressing this rise in chronic disease and the increasing health inequalities associated with inactivity and sedentary behaviour. The facilities, resources and expertise of our sectors, as well as the passion and dedication of our coaches, trainers and exercise professionals to improve the health and wellbeing of millions of people every day is unquestionable.

At times our methods will have to adapt and our approach will need to be tailored to the needs of previously inactive and sedentary populations. This may require counselling interventions and tying into the work of primary care physicians, allied healthcare professionals and various patients groups. We must continue to support people and communities to help them to become more active.

This paper has been jointly published by ukactive and the Sport and Recreation Alliance to ensure that all of our respective members are fully informed about the structures which form the new public health landscape. It should be supplemented by additional support and guidance and needs to be read in conjunction with other useful resources produced by the Department of Health, Public Health England, the Local Government Association, the National Institute for Health and Care Excellence and others, as well as the guidance and direction of local officials, directors of public health and Health and Wellbeing Boards.

Such additional documents might include the Chartered Society of Physiotherapist guidelines, the Royal College of Physicians reports, the ukactive Research Institute’s publications, the Sport and Recreation Alliance’s *Game of Life* report and the Joint Consultative Forum’s new set of *Professional and Operational Standards for Exercise Referral*.

The paper marks the beginning of a broad partnership between our two organisations which we hope will help us achieve our shared objective of increasing participation in physical activity and sport, with the ultimate aim of improving the health and wellbeing of communities across the country.

David Stalker

CEO, ukactive

Tim Lamb

Chief Executive, Sport and Recreation Alliance

Handwritten signatures of David Stalker and Tim Lamb.

1

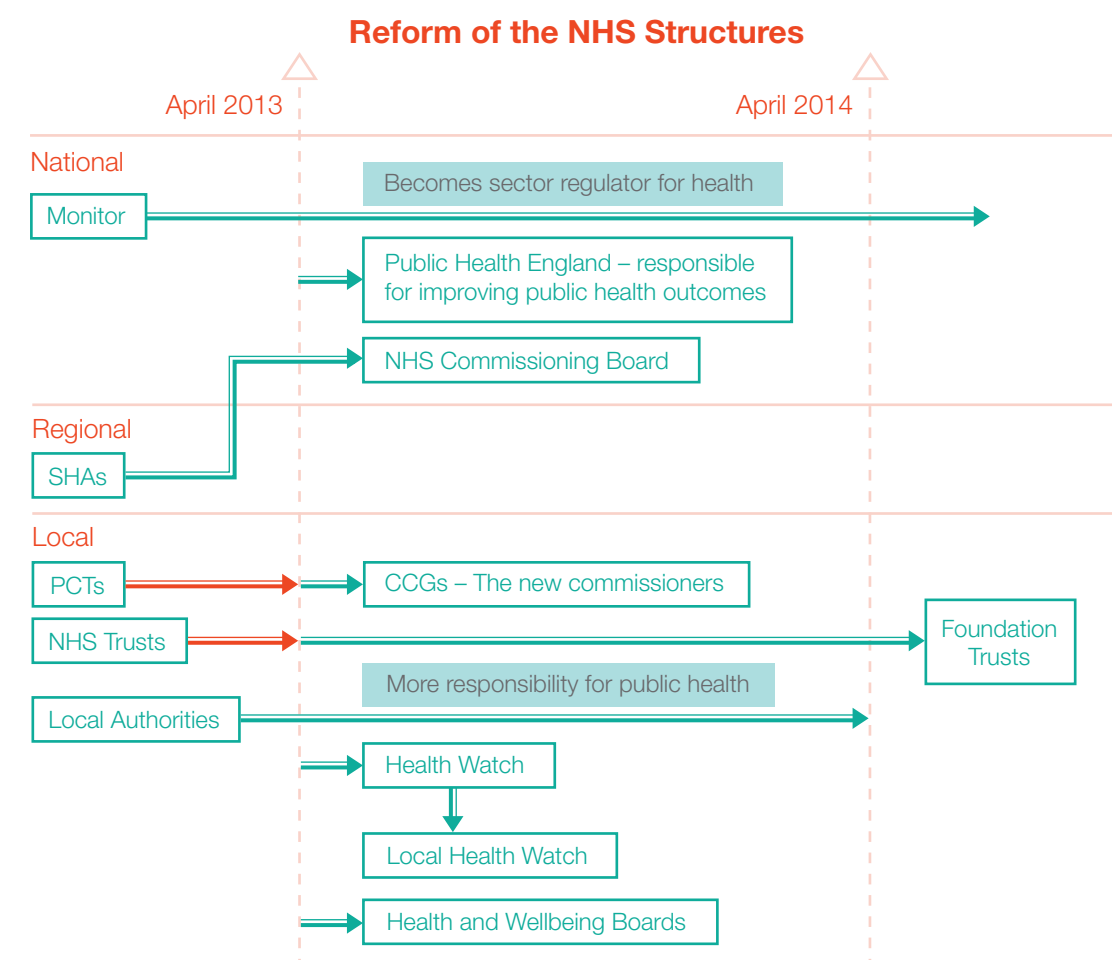
Public health structure

The Health and Social Care Act 2012 represents one of the most radical shake-ups of the NHS ever seen, setting out a major programme of reforms to restructure healthcare services and reallocate public health responsibilities.

1. Public health structure

The new system, which became fully operational on 1 April 2013, focuses more on prevention and on empowering local communities to plan services according to their local priorities. This will be led by local authorities who are now directly responsible for the health of their local populations and receive ring-fenced funding accordingly. Changes will be led by doctors, nurses and other health and care professionals working with local authorities, local directors of public health and local service providers. The diagram below sketches out these reforms in short.

When the reforms took effect around 4,500 people transferred to local authorities including public health consultants, public health commissioners, health promotion specialists, public health knowledge and intelligence staff and others. This paper summarises the wide-ranging NHS reforms and outlines the function and structure of the relevant bodies within the public health landscape.



2

Local authorities

Upper tier and unitary local authorities in England have a responsibility to improve the health of their populations and have each received a share of a two-year ring-fenced budget of £5.45bn to spend on public health services.

This constitutes £2.66bn (2013-14) and £2.79bn (2014-15). Through this funding they will drive local commissioning of healthcare, social care and public health and are expected to create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as education provision will also be addressed.

The level of funding that local authorities receive will be dependent on their performance to produce improvements in local health and wellbeing.



2. Local authorities

Local authorities are expected to champion health and wellbeing by promoting healthier lifestyles and scrutinising and challenging the NHS and other partners to drive improved health outcomes. They play a central role across the three domains of public health (health improvement, health protection and health services) and, in addition, have functions to ensure that NHS commissioners are provided with public health advice.

Local authorities have legal power to review and scrutinise any matter relating to the planning, provision and operation of the health service (including public health) in its area. This enables scrutiny of the quality of services provided locally (and proposals put forward for significant changes to those services) such as reorganising stroke care in an area and other linked services such as education, housing, social care, transport and leisure.

They are also supported by an executive agency, Public Health England, and will be guided by the Public Health Outcomes Framework. The level of funding that local authorities receive will be dependent on their performance to produce improvements in local health and wellbeing. This will be measured by the current Public Health Outcomes Framework of which physical activity is one of 66 measurements.

Each local authority has a Director of Public Health who is responsible for exercising public health functions and will be expected to publish an annual report that evaluates overall performance. They will contribute to revising the local annual Joint Strategic Needs Assessment (JSNA or Assessment) and develop the annual Joint Health and Wellbeing Strategy (JHWS or Strategy) with local partners including GP practices and Clinical Commissioning Groups (CCGs) with a jointly-agreed and locally determined set of priorities on which to base their commissioning plans. They will work with CCGs and other healthcare providers through statutory Health and Wellbeing Boards (HWBs or Boards).

Each local authority is required by statute to:

- appoint a Director of Public Health
- establish a local health and wellbeing board
- undertake a review of their commissioning intentions for the upcoming year
- develop a JSNA based on the needs of their local population
- develop a JHWS through a performance management framework.

The Local Government Association will support local authorities to secure improvement and address poor performance. Public Health England will not performance manage local authorities but will partner the LGA in taking forward effective sector-led improvement.

The main priorities for public health improvement include smoking cessation, reducing alcohol consumption, healthy eating and importantly increasing physical activity levels.

3

Joint Strategic Needs Assessments

Joint Strategic Needs Assessments are assessments of the current and future health and social care needs of a local community. They are produced annually by HWBs and are unique to each local area.

The core aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. Their outputs, in the form of evidence and the analysis of local needs and agreed priorities, will be used to help to determine what actions local authorities, the local NHS and other partners need to take

to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing in that locality.

The policy intention is for HWBs to consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes

3. Joint Strategic Needs Assessments



The responsibility falls on the board as a whole and so success will depend upon all members working together throughout the process.

and reduce inequalities. Local areas are free to undertake JSNAs in a way best suited to their local circumstances – there is no template or format that must be used and no mandatory data set to be included.

Nevertheless a range of quantitative and qualitative evidence should be used in JSNAs. There are a number of data sources and tools that HWBs may find useful for obtaining quantitative data. Qualitative information can be gained via a number of avenues, including views collected by the local Healthwatch organisation – which represents the interests of patients – or by local voluntary sector organisations, feedback given to local providers by service users and views fed in as part of community participation within the JSNA and JHWS process.

JSNAs can also be informed by more detailed local needs assessments such as at a district or ward level; looking at specific groups (such as those likely to have poor health outcomes); or on wider issues that affect health such as employment, crime, community safety, transport, planning or housing. Evidence of service outcomes collected where possible from local commissioners, providers or service users could also inform JSNAs.

Local authorities and CCGs have equal and joint duties to prepare JSNAs and JHWSs through the Boards of which they are part. The responsibility falls on the board as a whole and so success will depend upon all members working together throughout the process. Two or more HWBs could choose to work together to produce Assessments and Strategies, covering their combined geographical area. Some Boards may find it helpful to collaborate with neighbouring areas where they share common problems as this can prove to be more cost effective than working in isolation.

Local authorities and HWBs can decide to include additional members on the board beyond the required members including experts from charity and voluntary sectors. Membership of the board is not the only way to be involved in or influence JSNAs and JHWSs – HWBs will need to work with a wide range of local partners and the community beyond their small membership.

Working with local partners will allow Boards to undertake a thorough and broad assessment of local needs by using the evidence and expertise that these partners can provide and allow an opportunity to influence the work of these partners to support addressing the identified needs.

4

Joint Health and Wellbeing Strategies

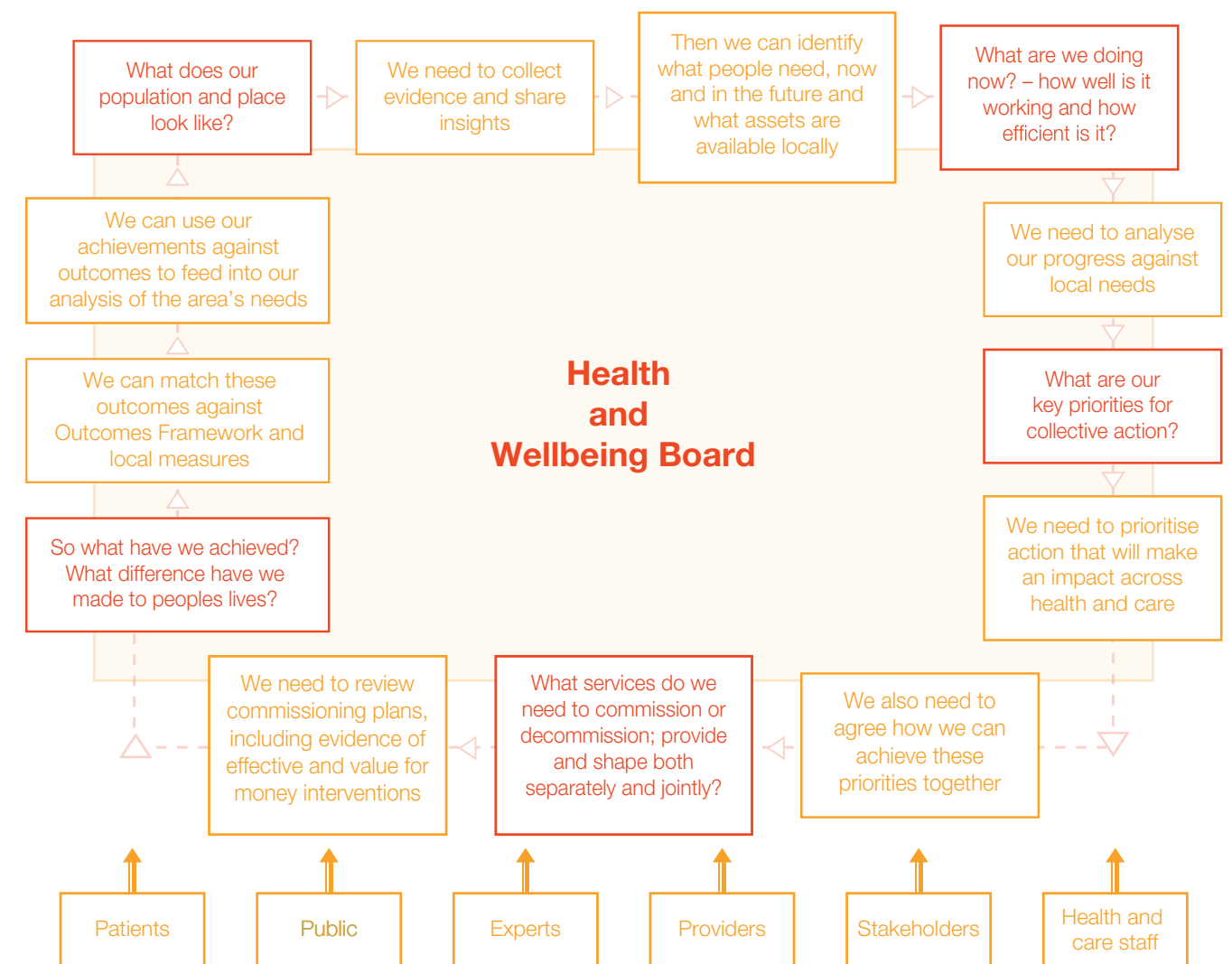
The Joint Health and Wellbeing Strategy is the mechanism for local authorities and CCGs to address the needs identified in Joint Strategic Needs Assessments.

4. Joint Health and Wellbeing Strategies

It aims to jointly agree what the greatest issues are for the local community based on evidence collated for Assessments, outline what can be done to address them and form what outcomes are intended to be achieved. By agreeing joint local priorities in JHWSs to inform joint action to tackle these

needs, HWBs will be able to lead action to improving people's lives, integrate services and reduce inequalities. To support HWBs in undertaking Assessments and developing Strategies, supportive resources have been published on the LGA Knowledge Hub.

JSNA and JHWS: explicit link from evidence to service planning



Involving partners and the community ensures transparency and accountability

5

Public Health Outcomes Framework

All local authorities have received a ring-fenced budget that will be spent exclusively on public health services and are able to choose how they spend it according to the needs of their population.

To make sure that progress is made on issues like childhood obesity and physical inactivity, Public Health England has set a series of outcomes to measure whether people's health actually improves.

The performance of each local authority and HWB will be measured against the Public Health Outcomes Framework which comprises 66 indicators including physical activity.

5. Public Health Outcomes Framework

Key facts

- The 353 councils in England will share a ring-fenced budget of around £5.45bn over two years.
- There are 66 indicators on the Public Health Outcomes Framework which includes physical activity.
- Other indicators include:
 - sickness absence rate
 - excess weight in 4-5 and 10-11 year olds
 - excess weight in adults
 - recorded diabetes
 - falls and fall injuries in the over 65s, mortality from causes considered preventable (cardiovascular diseases, stroke, cancer etc.)
 - health-related quality of life for older people.
- Local authorities will be paid a new health premium for the progress they make against the public health indicators. The framework concentrates on two high-level outcomes to be achieved across the public health system. These are:
 - increased healthy life expectancy
 - reduced differences in life expectancy and healthy life expectancy between communities.
- The outcomes reflect a focus on both how long people live and on how well they live at all stages of life. The second outcome particularly focuses attention on reducing health inequalities between people, communities and areas.

6

Physical activity outcomes

The indicator definition of physical activity as defined in the Public Health Outcomes Framework is the:

- Proportion of adults (16+) achieving at least 150 minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more.
- Proportion of adults (16+) classified as “inactive” that do less than 30 minutes of moderate intensity physical activity per week in bouts of 10 minutes or more.

They are based on the Chief Medical Officers' recommendations and report “Start Active, Stay Active” (2011).



7

Health and Wellbeing Boards

Health and Wellbeing Boards have been established by local authorities to bring locally elected councillors together with key healthcare commissioners including representatives from Clinical Commissioning Groups, directors of public health and local providers.

Each top tier and unitary authority has its own board with board members collaborating to understand their local community's needs, agreeing priorities and encouraging commissioners to work in a more joined-up way. This may include the pooling of funds and integrated provision.

HWBs assess the current and future health and social care needs of the local community through Joint Strategic Needs Assessments. Each Assessment is based on a principle of analysing the available evidence on the local community's health and social care needs. This includes engaging and working with a wide range of local stakeholders such as patient groups, voluntary organisations and the public.

Using the JSNA, Boards will then jointly agree strategic priorities for local health and social care services through the publication of their annual Joint Health and Wellbeing Strategies. Taken together, JSNAs and JHWSs are intended to form the basis of commissioning plans across local health and care services (including public health and children's services) for CCGs, NHS England and local authorities.

Key facts

- Local authorities are legally required to establish a HWB.
- There are a total of 152 HWBs which at the very least comprise:
 - one locally elected representative
 - the director of adult social services and children's services for the local authority
 - the Director of Public Health for the local authority
 - representative of the local Healthwatch organisation
 - representative from the local clinical commissioning group.
- HWBs are free to expand membership to include a wider range of expertise such as representatives from charity and voluntary sectors and have a statutory duty to involve local people.
- Sub-committee structures and political proportionality will be a matter for local determination, and papers and minutes must be made publicly available.
- The core functions of the HWB remains within the collective ownership of the board.

8

Public Health England

Public Health England has been established as the operationally independent executive agency of the Department of Health.

Public Health England (PHE) allocate ring-fenced budgets to local authorities for them to commission public health services, build a local evidence base and coordinate the integration of local services.

It provides national leadership and expert services to support public health and works with local government, the NHS and other key partners to respond to health protection emergencies.

There are 15 local centres with 5,500 people working within Public Health England in total.

Key roles

- Supporting local government in its leadership of public health.
- Supporting local authority directors of public health across the range of their responsibilities enabling them to access specialised advice and support when required.
- Working with NHS England to support it in its role as a direct commissioner of key services, including specialist services and national public health programmes.
- Making comparative data available to help drive improvements and reports annually on progress against the public health outcomes set out in the Public Health Outcomes Framework.
- Providing leadership in responding to emergencies where specialist public health expertise is necessary.

8. Public Health England

Key aims

- Help people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with high blood pressure, obesity, poor mental health and insufficient exercise.
- Reduce the burden of disease and disability in life by focusing on preventing and recovering from the conditions with the greatest impact including dementia, anxiety, depression and drug dependency.
- Improve health in the workplace by encouraging employers to support their staff and those moving into and out of the workforce to lead healthier lives.

PHE is ultimately responsible for protecting and improving the health and wellbeing of the population and reducing inequalities in health and wellbeing outcomes.

It works with a range of delivery partners including local government and private health providers. Part of the ring-fenced public health budget will be used by Public Health England for population-wide issues.

Regions and Centres

Public Health England will operate through four regions and 15 centres. These are shown on the map.

North of England

- 1 North East
- 2 Cumbria and Lancashire
- 3 Yorkshire and Humber
- 4 Greater Manchester
- 5 Cheshire and Merseyside

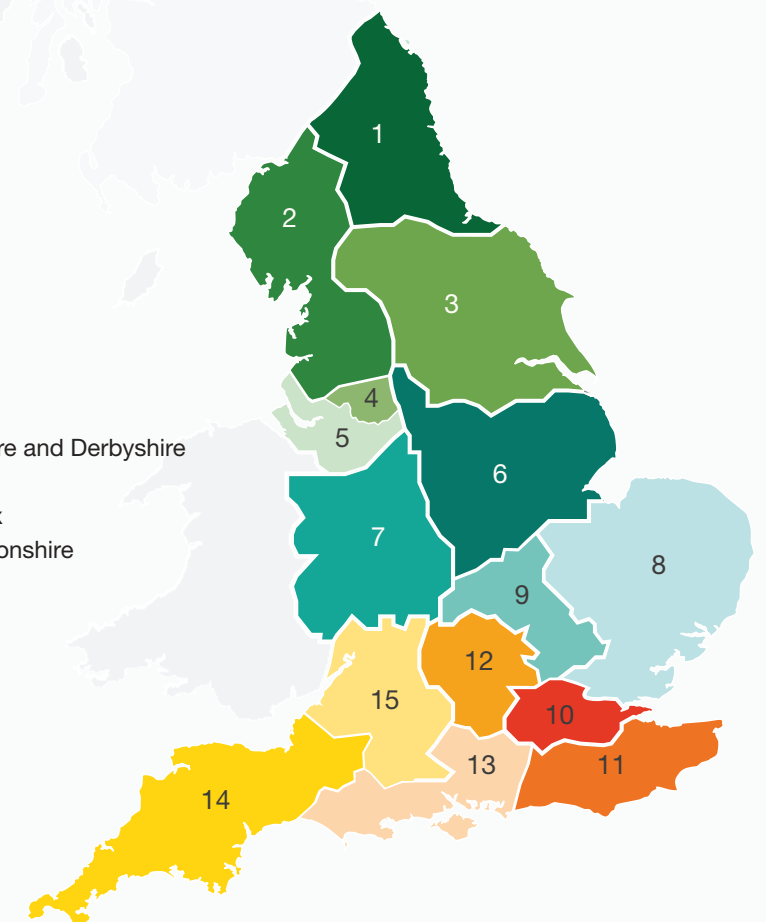
Midlands and East of England

- 6 Lincolnshire, Leicestershire, Nottinghamshire and Derbyshire
- 7 West Midlands
- 8 Norfolk, Suffolk, Cambridgeshire and Essex
- 9 Bedfordshire, Hertfordshire and Northamptonshire

London Integrated region and Centre

South of England

- 11 Sussex, Surrey and Kent
- 12 Thames Valley
- 13 Hampshire, Isle of Wight and Dorset
- 14 Devon, Cornwall and Somerset
- 15 Avon, Gloucestershire and Wiltshire



9

Directors of Public Health

Each local authority has, together with fellow NHS representatives, appointed a Director of Public Health (DPH) to act as the ambassador of health issues for the local population.

In practice, this means that they will lead discussions about how the ring-fenced money is spent to improve health. This will include influencing investment decisions right across the local authority with the goal of enhancing health and wellbeing. Crucially, they will be able to make sure that public health outcomes are always considered when local authorities, GP consortia and the NHS make decisions.

DPH will be a statutory member of the HWB and will contribute to the preparation of JSNA and the development of JHWS within the framework of the national Public Health Outcomes Framework.

They will ensure a focus on local priorities and action across the life course to ensure a preventive approach is embedded in the local system.

9. Directors of Public Health

Key roles

- To be the person who elected members and senior officers look to for leadership, expertise and advice on a range of issues such as local people's health and concerns around access to health.
- Know how to improve the population's health by understanding the factors which determine health and ill health, how to change behaviour and promote health and wellbeing to reduce inequalities.
- Statutory chief officer of the authority, providing the public with expert, objective advice on health matters.

Additionally, they will:

- Be an active member of the HWB, advising on and contributing to the development of JSNAs and JHWSs.
- Commission appropriate public health services accordingly.
- Take responsibility for the management of the local council's public health services, with professional responsibility and accountability for their effectiveness, availability and value for money.
- Contribute to and influence the work of NHS commissioners, including CCGs, ensuring a whole system approach across the public sector.

...public health outcomes are always considered when local authorities, GP consortia and the NHS make decisions.



10

Clinical Commissioning Groups

Clinical Commissioning Groups are made up of a range of healthcare professionals including GPs, nurses, hospital doctors and others medical professionals including physiotherapists and patient representatives.

This range of professionals use their knowledge of local health needs to plan and buy services for their local community from any service provider that meets NHS standards and costs – these could be NHS hospitals, social enterprises, voluntary organisations or private sector providers.

Healthcare professionals within GP practices aim to resolve problems locally including

through services provided by the practice. If a condition requires more specialised treatment, or further investigation, patients may be referred to another healthcare provider. These could be based in a hospital or in the community. Patients are entitled (where possible) to choose between different types of care and providers of their care, and should be supported to make the choice that is best for them.

10. Clinical Commissioning Groups

CCGs will commission the majority of health services including emergency care, elective hospital care and community and mental health services, and will work closely with HWBs to ensure that services are integrated and deliver the best quality health and care outcomes for their population.

They hold providers of NHS services to account through contracts but are ultimately accountable for the way that the majority of local NHS services are planned and paid. CCGs are also accountable to NHS England for how well they meet their population's needs.

Key facts

- A full national system of 211 authorised CCGs have taken on budgetary responsibility.
- They will be commissioning care for an average of 226,000 people each.
- All 8,300 GP practices in England are part of a CCG.
- CCGs are responsible for an annual budget of around £65 billion (around 60% of the total NHS budget).
- There are over 36,000 GPs in England, working in over 8,300 practices.
- Together these services deal with over 1 million patients every 36 hours.

CCGs have drafted and published their plans and priorities for 2013/2014 which will be available online. These broad plans will then be aligned with the priorities outlined by local HWBs and incorporated into the broader JHWS.

These might include:


- improving the health status of local populations
- making sure local children and young people have a better start in life
- tackling the challenges of an ageing and growing population
- making services more accessible and responsive to the needs of communities
- managing resources more effectively and responsibly
- addressing the holistic needs of the changing age profile of the population
- commissioning clinically effective, better quality services closer to home
- making the best use of public funds to ensure healthcare meets the needs of local patients.

11

CCG Outcomes Indicator Set

The CCG Outcomes Indicator Set (formerly known as the Commissioning Outcomes Framework) is part of the NHS Commissioning Board's (NHSCB) systematic approach to promoting an improvement in quality.

11. CCG Outcomes Indicator Set



Improving health outcomes by providing comparative information on the quality of health services commissioned by CCGs and the associated health outcomes.

Its aim is to support CCGs and HWBs in improving health outcomes by providing comparative information on the quality of health services commissioned by CCGs and the associated health outcomes – and to support transparency and accountability by making this information available to patients and the public.

It will cover each of the five domains of the NHS Outcomes Framework taking clinical effectiveness, patient experience and patient safety into account.

Examples include premature deaths from cardiovascular disease, health and quality of life for people with long term conditions and patient reported outcomes for operations. It will also contain measures developed by NICE from Quality Standards (e.g. prescribing rates of anti-psychotic medication for people with dementia) and measures developed from other data collections.

12

NHS Commissioning Board (NHSCB)

The NHS Commissioning Board is an independent board that has been established to allocate resources to CCGs and provide commissioning guidance for predominantly primary care services.

The board is organised into nine national directorates, four slim sub-national regions and a national network of local offices, led by local area teams, in which the bulk of its staff will fulfil NHS-facing functions.

Key functions

- Delivering improved health outcomes
- Supporting quality improvements
- Developing commissioning guidance
- Championing patient interests
- Overseeing the commissioning budget
- Supervising the development and overall outcomes of CCGs.

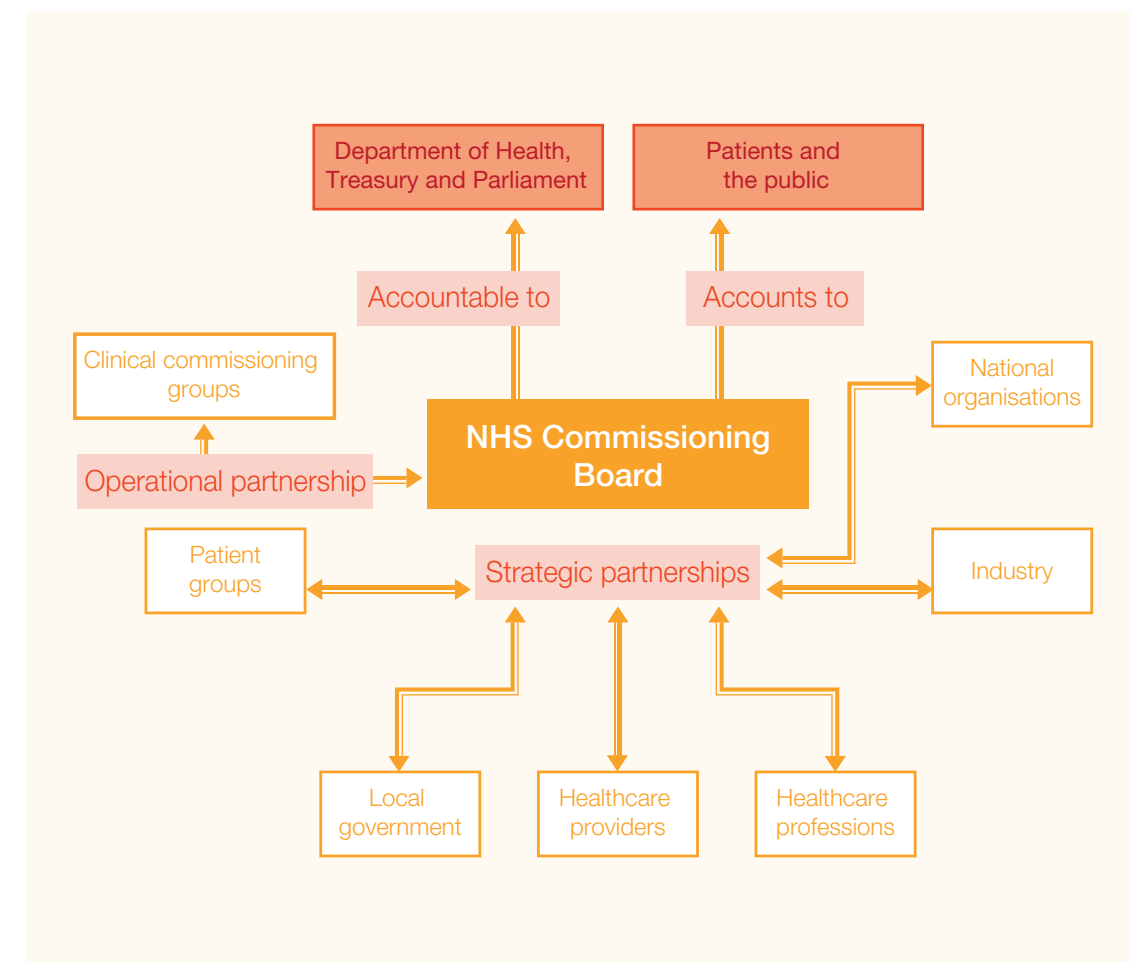
12. NHS Commissioning Board

The NHSCB will be held into account by Ministers and will have to regularly make a progress report to parliament.

The board will also be accountable to the Department of Health and HM Treasury for keeping within its annual commissioning budget and achieving value for money.

The broader strategic objectives of the NHSCB will be to:

- transfer power to local organisations
- establish the commissioning landscape
- develop specific commissioning and financial management capabilities
- develop 'excellent' relationships.



13

NHS Outcomes Framework

The NHS Outcomes Framework sets out the outcomes and corresponding indicators used to hold NHS England to account for improvements in quality.

It has been published to provide a national overview of how well the NHS is performing, wherever possible in an international context.

The aim is to provide an accountability mechanism between the secretary of state for health and the proposed NHSCB and to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a stronger focus on tackling health inequalities.

The NHS Outcomes Framework is structured around five domains (see right), which set out the high-level national outcomes that the NHS should be aiming to improve. The five domains were derived from the three-part definition of quality. Domains one to three include outcomes that relate to the

effectiveness of care, domain four includes outcomes that relate to the quality of the patient experience and domain five includes outcomes that relate to patient safety.

Domain One	Preventing people from dying prematurely
Domain Two	Enhancing quality of life for people with long-term conditions
Domain Three	Helping people to recover from episodes of ill health or following injury
Domain Four	Ensuring that people have a positive experience of care; and
Domain Five	Treating and caring for people in a safe environment; and protecting them from avoidable harm

14

NHS England

NHS England supports NHS services nationally and ensures that money spent on NHS services provides the best possible care for patients.

It funds local CCGs to commission services for their communities and ensures that they do this effectively, and further works with leading health specialists to ensure national standards are consistently in place across the country. Throughout its work it promotes the values and commitments enshrined in the NHS Constitution.

NHS England is operationally independent from the Department of Health but is given a specific mandate that highlights the areas of health and care where the Government expects to see improvements in the NHS and contains a number of objectives which NHS England must seek to achieve.

The mandate is intended to provide the NHS with the stability to plan ahead. It is therefore set for a number of years at a time, with the secretary of state refreshing it on an annual basis, yet not during the year without the agreement of NHS England (except in exceptional circumstances or after a general election).

It is the main way in which the secretary of state holds NHS England to account for the commissioning system, as Ministers do not have a day-to-day role in the running of the NHS.

15

Other key bodies

The Department of Health will continue to set objectives, budgets and hold the system to account on behalf of the Secretary of State.

The department will enable health and social care bodies to deliver services according to national priorities and work with other parts of government to achieve this. The secretary of state for health has ultimate responsibility for ensuring the whole system works together to meet the needs of patients.

Health Education England has taken over strategic health authorities' responsibilities for local education and training and operates to ensure that the healthcare workforce has the right skills and training to improve the care patients receive. It supports a network of local education and training Boards that plan education and training of the workforce to meet local and national needs.

15. Other key bodies

The view and experiences of patients, carers and others service users are taken into account when local needs assessment and strategies are prepared.



Healthwatch England is a national independent body that enables the collective views of the people who use NHS and adult social care services to influence national policy, advice and guidance. It will advise the NHSCB, Monitor, the Secretary of State and local authorities. It will also have the power to recommend that action is taken by the Care Quality Commission when there are concerns about health and social care services.

Every upper tier and unitary local authority area in England has arrangements with a local Healthwatch organisation to support patient and public involvement activities in its area. The activities include promoting and supporting the involvement of local people in the commissioning, provision and scrutiny of local health and care services. Local Healthwatch organisations are able to enter and view certain health and social care premises and produce reports and make recommendations that influence the way services are designed and delivered.

Local Healthwatch gives citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their

locality. It is an evolution from the existing Local Involvement (LINKs) and will form the local level mechanism of the national body Healthwatch England. If a local Healthwatch organisation sends a report or recommendation to a specified provider or commissioner of a local health or social care service, the provider or commissioner is legally obliged to respond to the local Healthwatch organisation in writing. Local Healthwatch organisations provide information and advice to the public about local services and pass on views to Healthwatch England.

Local Healthwatch bodies have a seat on HWBs, ensuring that the view and experiences of patients, carers and others service users are taken into account when local needs assessment and strategies are prepared, such as JSNA and authorisation of CCGs. It will be funded by local authorities and held to account by them for their efficiency and effectiveness. Local authorities have responsibility for commissioning NHS complaints advocacy and the intention is that the local Healthwatch will either provide the service or be able to signpost people to the provider of the service.

16

National regulators

Changes to the public health landscape have changed the way that NHS service providers will be regulated through the introduction of a licence for NHS providers. Monitor will have responsibility for issuing this licence and setting the conditions that all providers would have to meet.

Monitor is the economic regulator for all providers of health and adult social care services. It protects and promotes the interests of people using health services by making sure that NHS services are effective and offer value for money. All providers of NHS services are expected to hold a Monitor licence.

In addition to Monitor, the Care Quality Commission measures whether services meet national standards of quality and safety. It should be noted that most health and social care professionals must be registered with one of the independent regulators, such as the General Medical Council, who ensure that professional standards are met.

17

National research bodies

National Institute for Health and Care Excellence

NICE provides guidance to help health and social care professionals deliver the best possible care for patients based on latest available evidence. It involves patients, carers and the public in the development of its guidance and other products.

National Institute for Health Research

The National Institute for Health Research's clinical research networks form a health research system in which the NHS supports individuals, working in world-class facilities, conducting leading edge research focused on the needs of patients and the public.

Health and Social Care Information Centre

This body supports the health and care system by collecting, analysing and publishing national data and statistical information and will deliver national IT systems and services to support health and care providers.



The National Institute for Health Research's clinical research networks form a health research system in which the NHS supports individuals, working in world-class facilities, conducting leading edge research focused on the needs of patients and the public.

18

The commissioning structure

The planning and purchasing of NHS services is undertaken by organisations (or individuals) known as commissioners. They are responsible for assessing the reasonable needs of their populations as purchasers aim to secure services that are affordable and of the highest quality.

They can buy services from any provider that meets NHS standards of care and prices. Local authorities and CCGs hold the responsibility and resources to commission public health services. Local authorities are responsible for services such as smoking

cessation, locally-led nutrition initiatives, public mental health services and increasing levels of physical activity in the local population and will work with CCGs to provide as much integration across clinical pathways as possible.

18. The commissioning structure

CCGs provide the organisational infrastructure to enable GPs (working with other health professionals) to commission services for their local communities. CCGs' governing bodies have GP, nurse and secondary care representatives, as well as at least two 'lay' members who are not NHS professionals.

The services that CCGs commission include rehabilitative care, urgent and emergency care (including out-of-hours and accident and emergency services), most community health services, maternity services and mental health and learning disability services.

Because of the complexity and scale of the healthcare system, it is more efficient to plan and commission healthcare at a population level, such as a town and its surroundings or a metropolitan borough.

This is one of the reasons why all GP practices are required to be a member of a CCG. In order to plan their commissioning decisions, local authorities and CCGs (coming together through Health and Wellbeing Boards) use Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies to agree local priorities for local health and care commissioning.

Once a CCG or other commissioning organisation has made a decision to buy a service from a provider of care, a contract must be drawn up which clearly sets out the detailed specification of what the provider must deliver.

Commissioners must review the performance of providers through the contract and monitor the outcomes achieved by the service. This ensures that they can manage and check the quality of services and make an informed decision when they choose providers in the future.

Although GPs and other local health professionals commission most NHS services, some services are not appropriate to be commissioned locally, for example some specialised mental health services. NHS England commissions services which are more appropriate to commission at a national level.

Commissioning happens on an individual level every day in a GP practice. For example, when a GP refers a patient to a particular hospital for further investigation or treatment, the GP is effectively buying care for that patient from the hospital through that referral.

This 'secondary' provider is paid to treat the patient through the NHS payment system. What care the GP can buy for their patient is determined by the commissioning organisation.




18. The commissioning structure

In addition to commissioning services itself, NHS England also has responsibility for ensuring the overall system of commissioning NHS-funded services works well. This involves working on plans to improve commissioning for specific conditions (e.g. dementia) or patient groups (e.g. children's services).

NHS England provides information and resources for CCGs, and holds them to account for how they carry out their commissioning activities and improve the healthcare outcomes that matter locally. NHS England also looks at how well CCGs operate within their budgets, engage with their local populations and deliver the pledges, rights and values expressed in the NHS Constitution.

Commissioning support units can support CCGs to fulfil their commissioning duties, for example by helping with service redesign, giving advice when CCGs negotiate contract terms with providers or by assisting with information analysis. As part of their role, commissioners should work together with providers to determine the services needed for local areas.

NHS England is responsible for working with CCGs to encourage them to collaborate (where appropriate) to plan the structure of services. For services commissioned nationally, NHS England takes the lead role in coordinating key bodies in the local areas.



NHS England provides information and resources for CCGs, and holds them to account for how they carry out their commissioning activities and improve the healthcare outcomes that matter locally.

This can involve discussions over large changes to how services are organised, often called reconfigurations. NHS England has been set the objective of ensuring that any proposals for major service change meet four tests:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear clinical evidence base.
- Support for proposals from clinical commissioners.

If the relevant local authority does not consider the proposed changes to be in the best interests of the local population, they can refer the matter to the secretary of state for health.

19

The Quality and Outcomes Framework

The Quality and Outcomes Framework is a voluntary annual reward and incentive programme for all GP surgeries in England. It is not about performance management but resourcing and then rewarding good practice.

The QOF contains groups of indicators (including physical activity for the treatment of hypertension as of April 2013) against which practices score points according to their level of achievement. It gives an indication of the overall achievement of a practice through this points system. Put simply, the higher the score, the higher the financial reward for the practice. The final payment is adjusted to take into account the surgery's workload and the prevalence of chronic conditions in the practice's local area with results published annually.

The QOF contains four main components (known as domains) with each consisting of a set of achievement measures, known as indicators, against which practices score points according to their level of achievement. The 2010/11 QOF measured achievement against 134 indicators; practices scored points on the basis of achievement against each indicator, up to a maximum of 1,000 points.

The four domains are:

- **Clinical:** Consists of 86 indicators across 20 clinical areas (e.g. coronary heart disease, heart failure, hypertension) worth up to a maximum of 697 points.
- **Organisational:** Consists of 36 indicators (worth up to 167.5 points) across five organisational areas – records and information, information for patients, education and training, practice management and medicines management.
- **Patient experience:** Consists of three indicators (worth up to 91.5 points) that relate to length of consultations and to patient experience of access to GPs.
- **Additional services:** Consists of nine indicators across four service areas – cervical screening, child health surveillance, maternity service and contraceptive services.

20

QOF indicators for physical activity (2013-14)

The QOF currently rewards GPs in England for screening hypertensive patients for physical activity and delivering a brief intervention.

Although this incentive is currently only limited to hypertension, this is a large patient group (7.3 million) and sets an important precedent for incentivising GPs to prescribe physical activity for the prevention and management of a broader range of chronic diseases. GPs in Scotland and Wales will not face the indicators.

The QOF will award practices up to three QOF points to offer the General Practice Physical Activity Questionnaire (GPPAQ) each year to the 7.3m patients with hypertension in England. A further three points are available if they provide brief advice to those deemed 'less than active'.

20. QOF indicators for physical activity (2013-14)

GP practices receive nothing if they achieve up to 40% of patients receiving the intervention. Above 40% they get an increasing proportion of the points, and if they reach 80% (or above) they get all the points.

The average 'price' of one point is £152.96 but this varies between practices depending on list size and prevalence. The points allocations set out in the table below have been in place since 1 April 2013.

Indicator	Points	Threshold (13/14)
HYP003. The percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less	50	40-80%
HYP004. The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 in whom there is an annual assessment of physical activity, using GPPAQ, in the preceding 12 months	5	40-80%
HYP005. The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 who score 'less than active' on GPPAQ in the preceding 12 months, who also have a record of a brief intervention in the preceding 12 months	6	40-80%

21

Personal health budgets

A personal health budget is an agreed amount of money provided to an individual by their local NHS team to support their healthcare and wellbeing needs.

21. Personal health budgets

It has been designed to help people become more involved in discussions and decisions about their care and enable those with long-term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive.

Everyone with a personal health budget can get support to think through how they would like to use their budget to meet their health and wellbeing needs. Local NHS teams provide advice and make recommendations. This is often described as brokerage. Personal budgets could be spent on any care or services set out in an agreed care plan – such as therapies, personal care and equipment – and are part of a broader care plan designed to enable individuals to meet their specific health and wellbeing objectives.

There are a few obvious things that a personal health budget cannot be spent on such as alcohol, tobacco, gambling or debt repayment, or anything that is illegal. It cannot also be used to buy emergency care or buy services that the GP already provides – for instance seeing the doctor to discuss health issues or get a prescription. However, it can also be used for acquiring other recommended services such as physiotherapy. Those receiving a personal health budget and a personal budget for social care can join the two budgets together.

Following a three year pilot programme in the NHS, the Minister of State for Care Services announced the national roll out of personal health budgets on 30 November 2012. They will initially be aimed at people who are already receiving NHS Continuing Care but clinicians can also offer them to others that they feel may benefit from the additional flexibility and control. Patients will have a right to ask for a personal health budgets from April 2014.

Personal budgets could be spent on any care or services set out in an agreed care plan – such as therapies, personal care and equipment.



22

Case Study – the ‘Let’s Get Moving’ model

The *Let’s Get Moving* programme is a physical activity pathway involving GP surgeries, national governing bodies, leisure centres and activity providers.

It uses motivational counselling to engage and support the most inactive members of local communities to improve their activity levels. It was initially founded by the Department of Health and has since been developed by ukactive to incorporate a partnership model.

The project is currently being delivered in Bedfordshire and Luton with Bedford Borough Council, Luton Borough Council and Central Bedford Borough Council with additional support from the County Sports Partnership, Team BEDS&LUTON.

21. Case study – the ‘Let’s Get Moving’ model

Let’s Get Moving ...

Helps the most inactive members of the local community improve their activity levels through a motivational interviewing programme. The project follows the successful testing of the *Let’s Get Moving* model by ukactive and a consortium of partners with five Primary Care Trusts in Essex.

This saw 504 previously inactive participants amass a total of 164 million steps, accounting to 48,000 active hours, 11.2 million kcal and 69,000 miles walked. For previously inactive people in danger of developing chronic diseases related to their lifestyle choices, this was a significant outcome.

The model was originally developed by the Department of Health, validated by Loughborough University and recommended by the National Institute for Health and Care Excellence.

Is the provision of professional expertise (ideally) within a GP surgery with a view to supporting inactive people to understand what stops them from living a more active lifestyle and why it might be beneficial to change their habits. Participants are supported to explore ways that they might become more active, utilising evidence-based behaviour change techniques.

Group settings are used to provide peer-to-peer support and motivation. At the appropriate time, individuals are signposted to local sporting activities and services that provide previously inactive people with a friendly, welcoming and supportive environment in which they can try new activities. It then aims to retain participants who have completed the pathway within the service, so as to provide on-going peer-to-peer support at group sessions.

Has been backed by Sport England, who have provided the necessary resources to not only deliver both sporting and health outcomes for inactive people in Bedfordshire, but to also further systemise the concept in order to support its continued expansion into other areas of the country in a cost effective and proven manner.



Simon Butler
Policy Officer
Sport and Recreation Alliance

Burwood House
14-16 Caxton Street
London SW1H 0QT

sbutler@sportandrecreation.org.uk
www.sportandrecreation.org.uk

Constantinos Skinitis
Public Affairs and Policy Officer
ukactive

3rd Floor Castlewood House
77-91 New Oxford St
London WC1A 1PX

ConstantinosSkinitis@ukactive.org.uk
www.ukactive.com

For more information, please contact:

Turning the tide of inactivity



More people
More active
More often

#turnthetide

Acknowledgments

We would like to thank all of the public health and active lifestyles staff from local authorities across the UK and the wide range of stakeholders who provided us with the support and information for this report.

Visit the website

The information is constantly changing and ukactive will continuously update the website with new insights, evolutions and developments in turning the tide.

ukactive has developed an interactive website. To find out more details on physical inactivity visit:

www.ukactive.com/turningthetide

Connect

We encourage anyone with a role to play in turning the tide of physical inactivity to engage with us.

Facebook: [Get ukactive](#)

Twitter: [@_ukactive](#)

LinkedIn: [ukactive](#)

Email: turnthetide@ukactive.org.uk

Support us: [#turnthetide](#)

Contents

Foreword by David Stalker, Chief Executive, ukactive	4
Comment by Lord Sebastian Coe CH KBE	5
Introduction	6–7
Key findings	8
Recommendations	9
National picture	
Inactivity	11
Premature mortality	12
Cost and spend	13
Leisure facilities	14
Green spaces	15
Regional analysis	
North West	17
North East	18
West Midlands	19
Yorkshire and the Humber	20
East Midlands	21
East of England	22
South East	23
London	24–25
South West	26
UK and EU	
Scotland, Wales and Northern Ireland	28
European Union	29
Annexes	
Annex A – methodology	31–33
Annex B – references	34–35
Annex C – tables of socio-economic deprivation	
Most deprived	36
More deprived	37
Average	38
Less deprived	39
Least deprived	40
Annex D – full national rankings data table	41–46
Support and further information	47

Foreword



This report clearly shows the rising issue of physical inactivity across the UK. It is the first time that the scale and impact of inactivity has been established in this way and provides compelling evidence for establishing it as a public health concern in its own right.

The debate on inactivity has in the past focused primarily on its contribution to reducing obesity, but this direction is changing. With new evidence has come a change of emphasis, a change of direction and, above all, a need for a change of approach.

Incontrovertible evidence shows inactivity significantly heightens the risk of developing chronic illnesses. A study in *The Lancet*, published in 2012, highlighted how inactivity is responsible for 17 per cent of premature deaths in the UK every year and shortens the lifespan by three to five years.

Building on these shocking facts, this report raises further significant causes for concern. We can reveal that in some parts of the UK more than 40 per cent of the adult population is classed as inactive and 12.5 million people in England are currently failing to raise their heart level for more than half an hour per week over a 28-day period. This is the case even though people can achieve that 30 minutes in three ten-minute bites.

We found that approximately a quarter of all adults in England are failing to do enough physical activity to benefit their health. Similar concerns exist in Scotland, Wales and Northern Ireland, although a lack of available data prevented us from providing a comparable level of analysis across the rest of the UK.

The burden this is placing on already strained resources is unsustainable. Several local authorities have acknowledged this already and are championing collaborations between their leisure, open spaces and public health teams in order to promote active lifestyles. They are to be commended, but if we are to truly turn the tide of inactivity in the UK, urgent action is required that challenges central government, local authorities and the activity sector to get more people, more active, more often.

To gain the health, financial and social benefits turning the tide of inactivity will bring, it is vital that a national strategy is developed and a national ambition set. International examples show that this can be achieved effectively.

There are already a number of very positive examples of where action is being taken to turn the tide of inactivity, but we need to be doing so much more. I sincerely hope this report sparks the critically needed action and at every level to turn the tide of inactivity for good.



David Stalker, Chief Executive Officer, ukactive

"...urgent action is required that challenges central government, local authorities and the activity sector to get more people, more active, more often."

David Stalker, CEO,
ukactive

Lord Coe



The Olympic and Paralympic Games in London were an inspiration to people throughout the UK. We have since set out to deliver what no other host nation has done before; produce a lasting legacy that benefits future generations. Not just a legacy of stadia and medals but of a broader societal shift that supports communities to lead healthier and more active lives.

Legacy is a long-term programme and we have made an excellent start, including: over £11bn of economic benefits, eight out of eight retained Olympic Park venues with their future secured, and 1.5 million

more people playing sport once a week since we won the bid in 2005.

Turning the tide of inactivity would be a hugely important outcome for our legacy story, which would have a massive long-term impact on our nation's health and wellbeing.

Not many people are aware that physical inactivity currently accounts for nearly one-fifth of premature deaths in the UK. With projections showing that inactivity levels are due to increase by a further 15 per cent by 2030 there is no doubt that the issue requires immediate national attention and urgent action.

That is why I welcome this report by ukactive. Its analysis and recommendations have helped to establish the scale of the problem and provide an important step towards tackling the issue.

Supporting people that do little or no daily activity to become a bit more active is where the biggest public health gains can be made and the maximum financial returns on public investment attained. Turning the tide of physical inactivity must be viewed as a national priority and this report makes a persuasive case for action.

Lord Sebastian Coe CH KBE

"Turning the tide of physical inactivity must be viewed as a national priority."

Lord Sebastian Coe,
CH KBE

Introduction

Turning the tide of inactivity

What is physical inactivity?

The Chief Medical Officer defines physical inactivity as participation in less than 30 minutes of moderate intensity physical activity per week.

The Active People Survey classes someone as physically inactive when a respondent aged 16 and over, with valid responses to questions on physical activity, states that they are doing less than 30 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 16.

The activities included in this are walking, cycling, dance, gardening and sport, as well as regular physical activity and exercise.¹

12.5 million people in England fail to achieve 30 minutes of moderate intensity physical activity per week in a 28 day period even though they can do it in three ten-minute bites.

Inactivity levels

Turning the tide of inactivity establishes the scale of the physical inactivity epidemic in the UK.

In 2013, local authorities inherited the responsibility for improving public health from Primary Care Trusts (PCTs). Their first year has been one of transition and adaptation to the new system.

This report provides the first detailed analysis of physical inactivity, both at a national and local level. It examines the rate of inactivity in each top tier local authority and analyses its relationship with premature mortality, cost and spend, leisure facilities and green spaces.

In the past, promoting the benefits of physical activity has often been grouped with obesity, clouding the positive impact that getting active can have on health and wellbeing, independent of weight reduction.

This has prevented inactivity from being defined as a stand-alone public health issue that needs to be targeted and treated distinctly, despite this being called for by international health agencies such as the World Health Organisation (WHO).²

Turning the tide of inactivity seeks to support local authorities, public health professionals and the activity sector to better understand inactivity as a distinct risk to public health. It comes at a time when local authorities have the opportunity to shape how they begin to turn the tide of inactivity.

The scale of physical inactivity

Our analysis of the government's latest physical activity survey shows that 12.5 million people in England failed to achieve 30 minutes of moderate intensity physical activity per week within a 28-day period during 2013.³ This remains the case even though people could achieve that half an hour in three ten-minute bites.

In consequence, one in four of the adult population is classed as physically inactive falling into the Chief Medical Officer's (CMO) “high risk” health category. Those not achieving the CMO guidelines are at a much greater risk of up to twenty chronic diseases including heart disease, type 2 diabetes and high blood pressure.⁴

Evidence shows that the most significant health and clinical benefits are gained by an inactive person currently doing no physical activity starting to do even a little.⁵ The risk of a range of chronic conditions and associated financial costs are cut even when this new activity falls short of the CMO's guidelines.

Over the last 50 years, physical activity levels have declined by 20 per cent in the UK, with projections indicating a further 15 per cent drop by 2030.⁶ Experts predict that if trends continue, by 2030 the average British person will use only 25 per cent more energy than they would have done had they just spent the day in bed.⁷

A report by the Association of Public Health Directors showed that if everyone in England met CMO guidelines for activity nearly 37,000 deaths a year could be prevented.⁸

The financial case for turning the tide of inactivity is also apparent; inactive people spend 38 per cent more days in hospital than active people and visit the doctor almost six per cent more often.⁹ According to the National Institute for Health and Care Excellence (NICE), inactivity is costing the national economy in England £8.2 billion per year.¹⁰

Turning the tide of inactivity

This report analyses the most recent government surveys and publishes new information obtained from Freedom of Information (FOI) responses. The recommendations made are built on these and insights gained from first-hand interviews conducted by ukactive with local practitioners, commissioners and directors of public health.

Turning the tide of inactivity finds that inactivity levels are ten per cent higher in the most deprived areas in England compared to the least deprived. It reveals a general correlation between inactivity and premature mortality; areas with the highest levels of inactivity also have the highest levels of premature mortality.

Local authority responses to our FOI requests show that they spent an average of less than three per cent of their annual public health budgets on physical inactivity interventions last year. Five per cent of the local authorities who responded failed to apportion any of their public health budgets to physical inactivity in 2013/14.

Physical inactivity represents ten per cent of total societal costs when compared against other top-tier public health concerns including sexual health, smoking, obesity and drug and alcohol misuse. On average, it is costing the economy in each local authority in England £18 million per 100,000 people every year.

This is the first report that has evaluated the proportion of green space in each local authority with their levels of inactivity. We can reveal that there is no significant connection between the volume of green space in a local authority and its level of inactivity.

Our analysis explores the relationship between inactivity and other local factors. It examines the best available data and highlights trends that build our understanding. We acknowledge that further data is required. Turning the tide of inactivity is the first in a series of reports that aims to develop the knowledge base.

Our key recommendations

To turn the tide of inactivity it is critical for there to be a clearly-articulated national and local ambition. This report has found that reducing physical inactivity by just one per cent a year over a five-year period would save the UK economy just under £1.2bn.

If every local authority was able to reduce inactivity levels by one per cent year on year over this five-year period they would save local taxpayers £44 per household. More importantly, they would improve the health and wellbeing of their local communities.

To achieve this ambition, we call on government to develop and deliver a cross-party, cross-government and cross-sector national strategy in order to turn the tide of inactivity.

From ensuring that walking and cycling are the preferred modes of transport, to encouraging children to become physically literate from the earliest possible age, an industrial scale shift across society is needed to embed physical activity into people's daily lives.

This will require action across all relevant government departments including the Departments of Health; Transport; Communities and Local Government; Culture, Media and Sport; and the Cabinet Office among others.

Crucially it has to have strong leadership from government, coordinated action from local authorities and a concerted effort from the activity sector to engage and support inactive populations.

Reducing physical inactivity by just one per cent a year over a five year period would save local authorities £1.2bn.

Local ambition

We call on government to develop and deliver a cross-party, cross-government and cross-sector national strategy.

National strategy

Key findings

"Turning the tide of inactivity is essential to the health of our nation, I am delighted to support ukactive and its drive for making sure physical activity becomes part of the DNA of our country."

The Prime Minister
Rt Hon.
David Cameron MP

Inactivity

- » One in four people in England fail to achieve more than 30 minutes of moderate intensity physical activity per week over a 28-day period even though they can do it in three ten-minute bites.
- » There is a broad relationship between levels of physical inactivity and socio-economic status.
- » Highest deprivation areas are almost 10 per cent more physically inactive than lowest deprivation areas.

Premature mortality

- » There is a broad relationship between levels of physical inactivity and premature death.
- » Areas with the highest levels of physically inactivity have the highest levels of premature mortality.
- » Areas with the lowest levels of physically inactivity have the lowest levels of premature mortality.
- » This relationship becomes even stronger when put into the context of socio-economic deprivation.

Cost and spend

- » There is a disproportionately low spend on programmes to tackle physical inactivity by local authorities compared to other top tier public health concerns.
- » Reducing physical inactivity by just one per cent a year over a five year period would save local authorities £1.2 billion.

Leisure facilities

- » The most inactive local authorities have on average a third fewer facilities than the least inactive areas.

Green spaces

- » There is no significant relationship between the volume of green space in a local authority and its level of physical inactivity.
- » The utilisation of green space, rather than its volume, is the determining factor in reducing levels of physical inactivity.

Recommendations

Government should:

- » Develop and deliver a cross-party, cross-government and cross-sector national inactivity strategy.
- » Put greater investment into researching inactivity programmes that can be applied to everyday settings.
- » Improve the collation, coordination and breadth of physical inactivity data for adults and children within a single UK-wide framework.
- » Extend the National Child Measurement Programme to include the measurement of children's physical activity and fitness levels alongside weight and height.
- » Ensure that health care professionals receive comprehensive training on the specific physical, mental and social risks of physical inactivity.

Local authorities should:

- » Prioritise and resource physical inactivity programmes to the same level as other top tier public health risks.
- » Deliver physical inactivity strategies independently of obesity and weight management.
- » Invest in evidence-based programmes that engage inactive groups.
- » Partner with all local activity and sports providers to deliver a local ambition of a one per cent reduction in inactivity year-on-year for the next five years.
- » Ensure that their green spaces are developed to make them safe and accessible whilst integrating them into their leisure and physical inactivity strategies.
- » Extend the management and administration of their green spaces to include leisure and public health planning teams.
- » Be required to consider the impact of physical inactivity in regeneration and spacial plans.

The activity sector should:

- » Focus on engaging and supporting inactive people.
- » Deliver evidence-based programmes tailored towards inactive groups.
- » Better record, analyse and evaluate the users of their facilities and effectiveness of their programmes to improve the evidence base.

"These policy recommendations to government, local authorities and the activity sector are crucial to turning the tide of inactivity"

Fred Turok, Chairman of ukactive

National picture

National picture

Inactivity – levels of inactivity in England	11
Premature mortality – inactivity and premature mortality	12
Cost and spend – financial implications of inactivity	13
Leisure facilities – inactivity and leisure facilities	14
Green spaces – inactivity and green spaces	15

List of tables

Table 1 – Least inactive 15 local authorities	11
Table 2 – Most inactive 15 local authorities	11
Table 3 – Total annual cost and spend on top tier public health concerns by local authorities	13
Table 4 – The proportion of green spaces versus the proportion of inactive adults in eight of England's largest metropolitan cities	15

List of figures

Figure 1 – Inactivity and premature deaths when compared with socio-economic status	12
Figure 2 – Physical inactivity and premature mortalities	12
Figure 3 – The total societal cost of individual top tier public health concerns versus local authority spends in 2013/14	13
Figure 4 – Leisure facilities versus inactivity	14

Inactivity

Levels of inactivity in England

Table 1

Least inactive 15 local authorities

Lowest levels of inactivity	Percentage of inactive adults (%)
Wokingham	18.23
Richmond upon Thames	20.03
Islington	20.07
Windsor and Maidenhead	20.20
Bournemouth	20.41
Kensington and Chelsea	20.72
Hammersmith and Fulham	20.79
Lambeth	21.72
Oxfordshire CC	22.18
Bracknell Forest	22.66
Cambridgeshire CC	22.76
Wandsworth	22.76
Kingston upon Thames	22.77
South Gloucestershire	22.80
Bath & NE Somerset	22.91

Table 2

Most inactive 15 local authorities

Highest Levels of Inactivity	Percentage of Inactive Adults (%)
Stoke-on-Trent	35.07
Newham	35.11
Barking and Dagenham	35.14
Luton	35.88
Kingston upon Hull	36.07
Oldham	36.28
Coventry	36.81
Blackburn with Darwen	36.95
Sunderland	36.99
Slough	37.58
Dudley	37.67
Bradford	37.68
Salford	39.07
Sandwell	39.13
Manchester	40.24

Our recommendations

Government should develop and deliver a cross-party, cross-government and cross-sector national inactivity strategy.

Local authorities should invest in evidence-based interventions, such as Let's Get Moving, that target inactive groups at high risk of chronic illnesses.

Health care professionals should receive comprehensive training on the specific physical, mental and social risks of physical inactivity.

Findings

Our analysis shows there are 12.5 million adults classed as physically inactive in England. This means that one in four adults are failing to achieve 30 minutes of moderate intensity physical activity per week within a 28-day period. This is the case even though people can achieve that 30 minutes in three ten-minute bites.

There is a noticeable regional variance in inactivity levels across England. In the West Midlands, 32 per cent of adults are inactive compared to 26 per cent in the South East.

Evaluation of the data by local authority area shows Manchester City Council has the highest level of inactivity in England, with 40 per cent of its adult residents inactive. Wokingham Borough Council has the lowest with 18 per cent adults classed as inactive [Tables 1 and 2].

Review

Areas of high socio-economic deprivation are more likely to have higher levels of inactivity. The most deprived areas have on average 32 per cent adult inactivity compared to 24 per cent in the least deprived areas.

13 of the top 15 most inactive local authorities all sit in the "most deprived" or "more deprived" socio-economic quintile [Table 2].

An exception is the London Borough of Islington which, despite being amongst the most deprived areas, is the third most physically active local authority in England [Table 1].

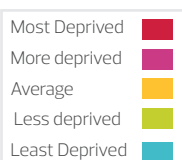
Implication

Our analysis shows a quarter of adults in England are classed as inactive, falling into the CMO's "high risk" health category. As a result they are more likely to develop chronic conditions including heart disease, high blood pressure and type 2 diabetes.

According to the CMO, supporting inactive people to become more active, even if falling short of the recommended levels of activity, is where the biggest public health gains lie.¹¹

Supporting inactive groups would provide the maximum financial returns on public investment and is the most effective means of narrowing health inequalities.

The Department of Health has developed Let's Get Moving, a behaviour change intervention designed to support inactive people at high risk of developing medical conditions become more active. This evidence-based intervention promotes physical activity by providing advice and motivational counselling in GP surgeries.



Premature mortality

Inactivity and mortality

Findings

Our analysis shows a relationship between high levels of inactivity and high numbers of premature adult death in local authorities [Figure 2]. This is in line with a separate study published in the health journal, The Lancet, which cited inactivity as the cause of 17 per cent of premature deaths in the UK.¹²

The average number of premature deaths per 100,000 people per year in the most inactive local authorities was 342. In the least inactive local authorities it was 242.

Our analysis also shows a relationship between levels of inactivity, premature deaths and socio-economic deprivation [Figure 1]. This is reflected in the findings of Public Health England's report on socio-economic inequalities published in 2013.

Review

Manchester City Council, which has the highest level of inactivity and is amongst the most deprived local authority areas, has the highest number of premature deaths per 100,000 adults with 455 per year.

Wokingham Borough Council has the lowest inactivity level and 200 premature deaths per 100,000 adults. It is among the least deprived local authorities.

The London Borough of Hammersmith and Fulham is an exception. It has both higher than average levels of deprivation and premature deaths per 100,000 adults but has the seventh lowest inactivity level in England.

Implication

There appears to be a relationship between inactivity, premature deaths and deprivation. However, to better understand any discrepancies and the impact of inactivity as one of many determinants of health, significant improvements need to be made to the collation, coordination and breadth of data.

Our analysis of existing data has scratched the surface of this issue, but in future, data collection methods need to improve significantly to reflect the scale of inactivity as a top-tier public health issue.

A number of local authorities reinforced this view. Dudley Borough Council told us: "As with all self-report studies and with such small sample sizes absolute accuracy is debatable and accurately plotting trends is also difficult due to anomalies in the data."

Also of concern, is the fact there is currently no adequate method of data collection for children and young people's inactivity levels. This data is essential if we are to improve local provision of children's services.

Key national bodies such as Public Health England should look at how to encourage the pooling of existing resources and create a single national framework for data collection. Following the findings of this report, we urge that inactivity is given due prominence.

Figure 1

Inactivity and premature deaths when compared with socio-economic status

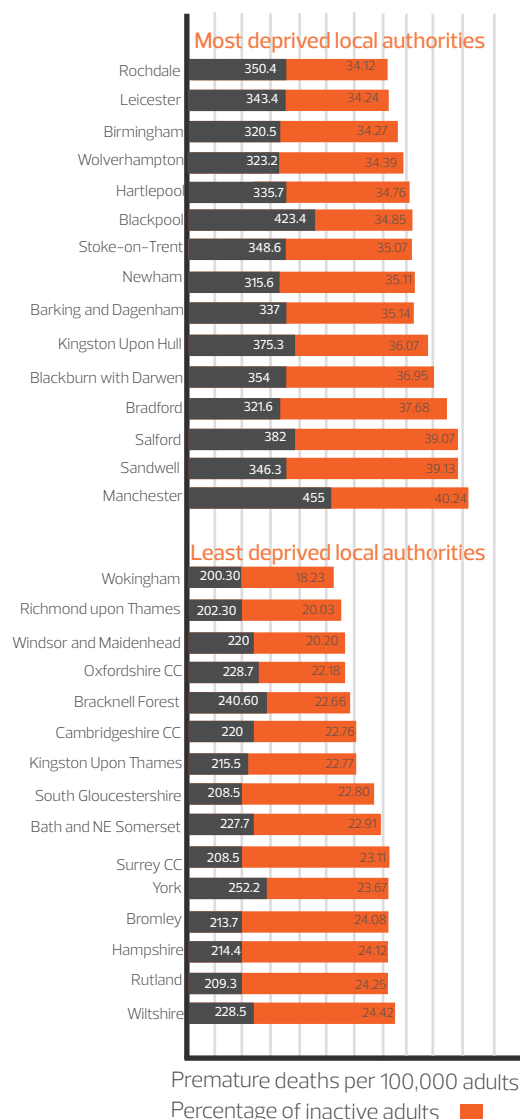
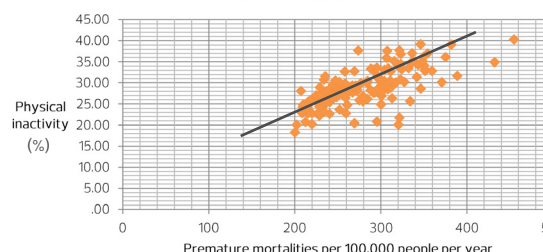


Figure 2

Physical inactivity and premature mortalities



Our recommendations

National bodies should improve the collation, coordination and breadth of data collection for within a single UK-wide framework.

The National Child Measurement Programme should be extended to include the measurement of children's physical activity and fitness levels alongside weight and height.

National bodies should put greater investment into researching inactivity interventions that can be applied to everyday settings.

Cost and spend

Financial implications of inactivity

Figure 3

The total societal cost of individual top tier public health concerns versus local authority spends in 2013/14

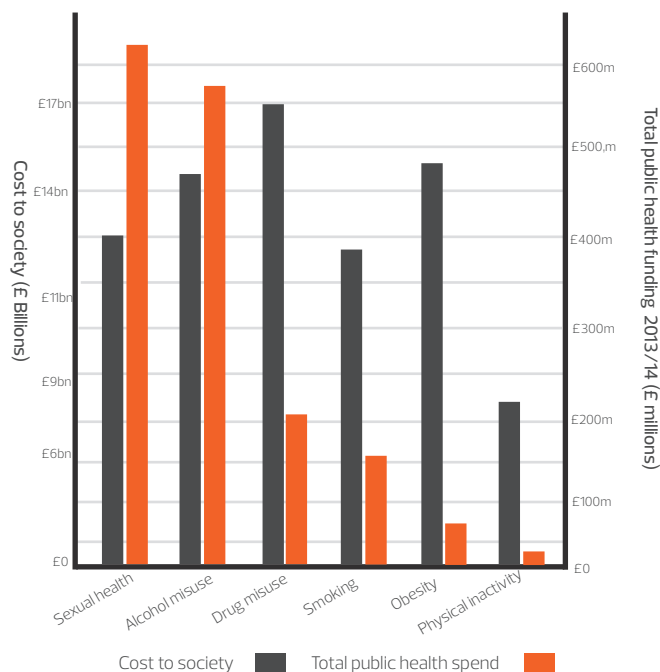


Table 3

Total annual cost and spend on top tier public health concerns by local authorities

Area of public health concern	Cost to society (£ billions)	Total public health spend 2013/14 (£ millions)
Sexual health	12.05	637
Alcohol misuse	15.4	569
Drug misuse	17	204
Smoking	13.7	158
Obesity	15.8	68
Physical inactivity	8.2	31

* See annexes A and B for methodology and references

Findings

For the first time, we are able to reveal the average spend by local authorities on adult physical inactivity is disproportionately low when compared to other top tier public health concerns. This information has been obtained by FOI responses.

We found that local authorities spent an average of 2.4 per cent of their public health budgets on programmes to tackle inactivity in 2013/14.

Central government estimates that local authority spending on inactivity is even lower than this; less than two per cent of public health budgets in 2013/14.¹³ This is compared to 38 per cent spending on sexual health services, 12 per cent on alcohol misuse services and four per cent on adult obesity [Figure 3 and Table 3].

The national cost of inactivity in England is £8.2 billion a year.¹⁴ This figure includes the direct costs of treating diseases linked to inactivity and the indirect costs caused by sickness absence.

Based on the best available data, we found that it represents ten per cent of total societal costs when compared against other top-tier public health concerns including sexual health¹⁵, smoking¹⁶, obesity¹⁷, drugs¹⁸ and alcohol misuse¹⁹ [Figure 3 and Table 3].

Review

Inactivity is costing Sunderland City Council £24 million per 100,000 adults every year. They attribute 0.3 per cent of their overall public health spend on programmes to tackle inactivity. Data shows that 37 per cent of its population is classed as inactive.

By comparison, its neighbour Newcastle City Council, which is also a "more deprived" local authority, spends five per cent of its public health budget on programmes to tackle inactivity. It has an adult inactivity level of 25 per cent. The cost of inactivity is £8 million lower per 100,000 people in Newcastle compared to Sunderland.

Some local authorities have not yet allocated a distinct budget for programmes to tackle inactivity at all. Derby City Council, Cornwall Council, Oldham Council and others include inactivity within their obesity programmes. Grouping inactivity with obesity was a common theme in interviews with directors of public health.

Implication

The extent to which local authorities commission programmes to tackle inactivity will be dependent on their Joint Strategic Needs Assessment. There is currently an imbalance on spending for programmes to tackle inactivity compared to other top-tier public health issues [Figure 3].

This will require activity providers to improve and expand their delivery of cost-effective and evidence-based programmes to tackle inactivity.

It should also be noted that councils only recently assumed the responsibility for public health and many inherited contracts from Primary Care Trusts. Outside of public health budgets, local authorities spend £925 million per year on leisure services.²⁰ This provides invaluable community services and facilities that widen physical activity participation.

Put together with active transport plans and programmes to tackle inactivity local authorities have an opportunity to shape how they turn the tide of inactivity.

Our recommendations

Local authorities should prioritise and resource physical inactivity services to the same level as other top tier public health risks.

Local authorities should deliver physical inactivity strategies independently of obesity and weight management.

Activity providers should deliver evidence-based programmes tailored towards inactive groups.

Leisure facilities

Inactivity and leisure facilities

Findings

Our analysis for the first time shows that local authorities with the highest levels of physical inactivity have a third fewer leisure facilities per 100,000 adults – 42 on average – compared to those with the lowest levels of adult inactivity which have an average of 64 leisure facilities [Figure 4]. However, no significant overall relationship was noted.

A relationship appears between the number of leisure facilities in a locality and its socio-economic status. Our findings show the most deprived areas have fewer than half the number of leisure facilities compared to the least deprived (37 and 77 facilities per 100,000 respectively). The national average is 60 leisure facilities.

This is revealed through our analysis of the Active Places Database which includes public, private and third sector facilities, as well as the facilities operated by more than 30 National Governing Bodies.²¹

Review

Sandwell Council, which is among the most deprived areas, has 78 leisure facilities for its 221,000 adults. South Gloucestershire Council has three times as many facilities (250) despite it having a smaller adult population.

Sandwell Council has an inactivity level of 39 per cent whereas South Gloucestershire Council has an inactivity level of 25 per cent.

It is too simplistic to conclude that the answer to the inactivity problem is opening more leisure facilities or preventing the closure of others. In a challenging economic climate, it is right that all public investment is scrutinised to ensure cost-effectiveness and value to the taxpayer. Our research and analysis offers food for thought on this issue.

In some cases, fewer but higher quality services are anticipated to lead to reductions in local levels of inactivity. Elmbridge Borough Council is projected to save an estimated £6 million over the next 15 years following the replacement of two ageing leisure facilities with one new, state-of-the-art centre, whilst at the same time increasing its total local usage.

Implication

Local authorities are currently making cutbacks and reviewing the value of their services. As a discretionary public service, leisure provision risks dropping down priority lists, but the messages in this report underline the fact any cut in funding now may lead to higher long-term costs.

It is now more important than ever for all leisure providers to focus their services on inactive population-groups, particularly public leisure services.

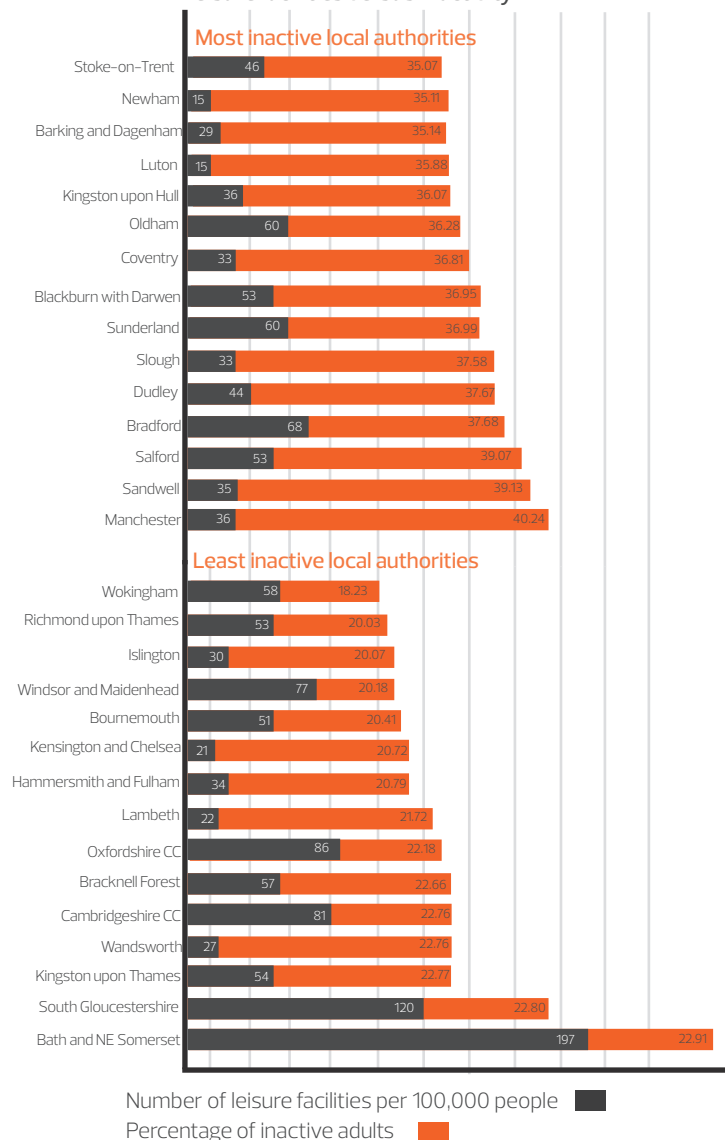
Supporting inactive groups to become more active is where the biggest public health gains can be made and where local authorities should be looking to obtain the maximum financial returns on their investment.

Attracting the hardest to reach groups is challenging and will require the delivery of tailored evidence-based provision.

Those providers which are able to demonstrate progress based on improved health outcomes will establish themselves as indispensable assets within their local community, thereby strengthening their case for investment.

Figure 4

Leisure facilities versus inactivity



Our recommendations

Activity and community sports providers should focus on engaging and supporting inactive people.

Local authorities should work in partnership with all local activity and sports providers to deliver a local ambition of a one per cent reduction in inactivity year-on-year for the next five years.

Activity providers should better record, analyse and evaluate the users of their facilities and effectiveness of their programmes to improve the evidence base.

Green spaces

Inactivity and green spaces

Table 4

The percentage of green spaces versus the proportion of inactive adults in eight of England's largest metropolitan cities

Eight of England's largest cities	Percentage of inactive adults (%)	Percentage of green spaces (%)
Newcastle	25.63	39
Leeds	26.85	53
Bristol	28.38	28
Sheffield	30.41	34
Liverpool	31.36	29
Nottingham	31.61	32
Birmingham	34.27	28
Manchester	40.24	33

Most Deprived
More deprived
Average
Less deprived
Least Deprived

Findings

We can show for the first time there is no significant connection between levels of physical inactivity and the amount of green space in a local authority. In the most inactive local authorities there is an average of 39 per cent green space compared to 36 per cent in the least inactive areas.

To ensure that the figures were not skewed by urban and rural disparities, we have included a table below [Table 4] which highlights the lack of correlation between green spaces and inactivity in eight of England's largest metropolitan cities.

Levels of inactivity are however linked to the safety and accessibility of outdoor areas and can be influenced by the way green space is utilised.

Review

Leeds City Council invested £3.7 million into the development of their parks and leisure, including the creation of West Leeds Country Park and Green Gateways trail. This transformed green space into a network of walking, running and cycling paths and has helped reduce local levels of inactivity by five per cent.

Birmingham City Council recently launched an Active Parks pilot programme offering free structured outdoor activities across six locations in the city. Initial results found that 71 per cent of participants had improved their fitness levels as a result of the activities and 76 per cent now spend more time in the park because of the Active Park sessions. The scheme is being rolled out across the city from spring 2014.

The development of Regents Park in London, including the provision of activity opportunities, is estimated to save the City of Westminster £3.1 million and NHS services £463,000 year on year through public use of the space.

Implication

A survey on the use of parks and open spaces in England found that 79 per cent of people thought that green spaces helped them keep fit and healthy and 60 per cent said more green spaces would help improve their physical health.²²

Open spaces help remove barriers to participation, reduce health inequalities and can lead to long-term savings if developed appropriately.

The provision of green space is too often rigidly managed around issues such as licensing. Whilst these are important, not enough cross-departmental coordination is carried out with equivalent planning, environment, transport, leisure and public health teams.

Leeds City Council's model works effectively. Their Parks and Leisure Service team operates alongside the Physical Activity Manager of their Active Lifestyles department, allowing a more effective utilisation of local green spaces.

Green spaces

The proportion of green space in each local authority is revealed for the first time through the coordination of over 6,000 census wards using information from the Office of National Statistics.

It is defined as all green spaces larger than five meters squared including parks, playing fields, woodlands, neighbourhood greens and transport verges and excludes domestic gardens.²³

Our recommendations

Local authorities should ensure that their green spaces are developed to make them safe and accessible whilst integrating them into their leisure and inactivity strategies.

Local authorities should extend the management and administration of their green spaces to include leisure and public health planning teams.

Local authorities should be required to consider the impact of physical inactivity in regeneration and spacial plans.

Regional analysis

North West	page 17
North East	page 18
West Midlands	page 19
Yorkshire and the Humber	page 20
East Midlands	page 21
East of England	page 22
South East	page 23
London	page 24–25
South West	page 26

North West

Out of nine regions the North West has the second highest percentage of adults who are physically inactive

Authority name		National rank	Proportion inactive	Premature deaths	Cost of inactivity
Trafford		23	24.75	228.5	£16,226,251
Cheshire East		28	25.45	228.5	£16,688,643
Stockport		34	25.87	218	£16,958,349
Warrington		39	26.15	220.2	£17,147,461
Cheshire West & Chester		44	26.43	280.1	£17,327,720
Bury		60	27.87	293.7	£18,273,957
Wirral		77	28.83	297.5	£18,902,698
Cumbria CC		95	29.94	250.3	£19,629,409
Lancashire CC		103	30.41	284.5	£19,938,307
St. Helens		105	30.49	299.9	£19,987,008
Bolton		108	30.76	233.9	£20,169,246
Sefton		110	31.20	297.8	£20,455,296
Halton		111	31.34	297.4	£20,544,755
Liverpool		113	31.63	235.5	£20,736,397
Tameside		118	32.81	351.7	£21,513,849
Knowsley		119	32.83	359.6	£21,523,050
Wigan		123	33.22	324.3	£21,779,819
Rochdale		130	34.12	350.4	£22,368,946
Blackpool		135	34.85	432.4	£22,851,824
Oldham		141	36.28	350.3	£23,786,780
Blackburn with Darwen		143	36.95	354.4	£24,225,029
Salford		148	39.07	382	£25,616,131
Manchester		150	40.24	455	£26,385,799

Most Deprived ■ | More deprived ■ | Average ■ | Less deprived ■ | Least Deprived ■

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The percentage of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Case Study

61 percent of participants said their physical health had improved

In Cheshire, AgeUK has been working with the local council and private businesses to ensure that elderly people are given

opportunities to become and to stay physically active. The programmes are particularly targeted at older people with long term conditions in hard to reach areas.

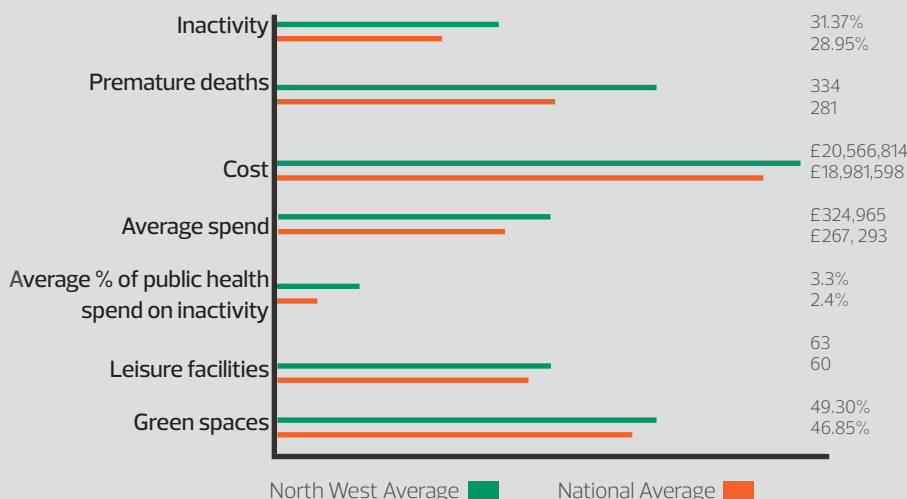
"We want to increase physical activity, confidence and self-esteem amongst participants, as well to empower communities in disadvantaged areas to take responsibility for their own health and wellbeing and support older people to actively engage," said Alison Read, Head of Charity Services, AgeUK Cheshire.

Based on an evaluation of nearly 200 attendees, 61% said their physical health had improved, and 66% said their mental health had improved due to the programme. – AgeUK Cheshire, Activity for older people

Key findings

- » 31 per cent of adults are classed as inactive
- » Manchester City Council stands out as having both a very high number of inactive adults and high levels of premature mortality

National Average: North West Region vs. Nationwide



Graph Key

Inactivity	The proportion of adults who are classed as physically inactive within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green space

North East

Out of nine regions the North East has the third highest percentage of adults who are physically inactive

Authority name	National rank	Proportion inactive	Premature deaths	Cost of inactivity
Newcastle Upon Tyne	32	25.63	279.2	£16,806,609
North Tyneside	54	27.30	229.8	£17,899,009
Northumberland	58	27.67	291.7	£18,143,977
Darlington	73	28.61	308	£18,755,034
Redcar and Cleveland	75	28.73	297.6	£18,835,079
County Durham	88	29.34	270.9	£19,238,873
Stockton-on-Tees	92	29.57	305.9	£19,386,703
Middlesbrough	99	30.12	252.4	£19,750,513
South Tyneside	126	33.50	332.3	£21,962,239
Gateshead	128	33.61	322	£22,032,893
Hartlepool	134	34.76	335.7	£22,791,547
Sunderland	144	36.99	336.5	£24,252,702

Most Deprived ■ | More deprived ■ | Average ■ | Less deprived ■ | Least Deprived ■

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The percentage of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Case Study

Data points to a return on investment of £3.20 for every £1 invested

County Durham Sport was commissioned to manage the Changing the Physical Activity Landscape (CPAL) programme 2010-13.

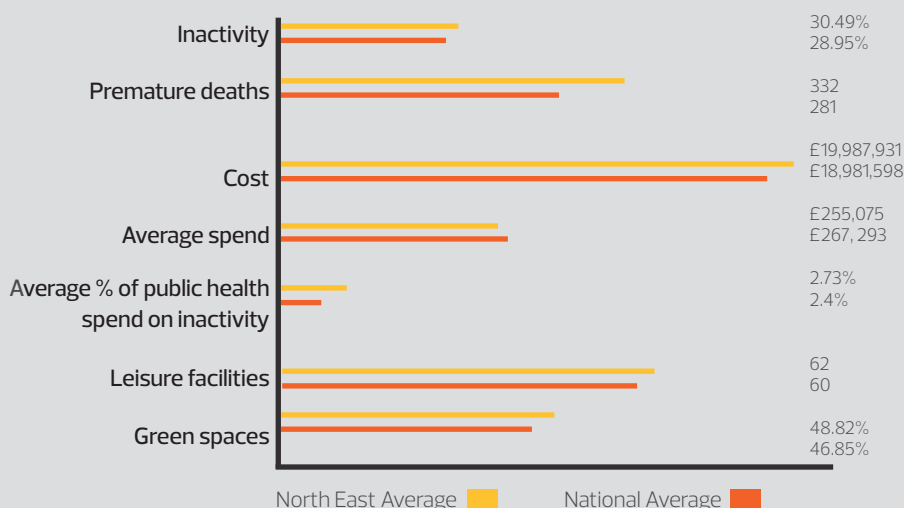
It represented not just a significant £4.5m investment, but also an evidence based strategy, supported by a partnership approach between commissioners and providers to coordinate efforts across the 23 providers.

After three years, data points to a return on investment of up to £3.20 for every £1 invested, in terms of savings to the NHS, the workplace and informal care costs. – Andrew Power, Strategic Manager (Physical Activity), County Durham Sport.

Key findings

- » 36 per cent of adults in Sunderland are inactive compared to 25 per cent in Newcastle
- » This is despite both having the same level of socio-economic deprivation
- » With 30.49 per cent of adults classed as physically inactive, the North East is just below the national average of 28.95 per cent
- » The North East spends slightly more (2.7 per cent) than the national average (2.4 per cent) on physical activity interventions as a proportion of its annual public health budget
- » For every 100,000 citizens in Sunderland, the annual financial burden of inactivity is £24 million
- » This is almost £8 million more than in Newcastle

National Average: North East Region vs. Nationwide



Graph Key

Inactivity	The proportion of adults who are classed as physically inactive within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space

West Midlands

Out of nine regions the West Midlands has the highest percentage of adults who are physically inactive

Authority name	National rank	Proportion inactive	Premature deaths	Cost of inactivity
Solihull	35	25.91	275	£16,990,472
Worcestershire CC	45	26.44	258.9	£17,333,227
Warwickshire CC	50	27.00	238.1	£17,702,331
Shropshire	69	28.44	272.8	£18,648,048
Herefordshire	85	29.22	248.9	£19,156,154
Staffordshire CC	97	30.01	277	£19,678,387
Telford and Wrekin	104	30.45	304.1	£19,965,492
Walsall	125	33.39	308.6	£21,888,945
Birmingham	132	34.27	320.5	£22,468,627
Wolverhampton	133	34.39	323.2	£22,548,412
Stoke-on-Trent	136	35.07	348.6	£22,995,395
Coventry	142	36.81	323.3	£24,135,384
Dudley	146	37.67	273.8	£24,696,234
Sandwell	149	39.13	346.3	£25,657,944

Most Deprived ■ | More deprived ■ | Average ■ | Less deprived ■ | Least Deprived ■

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The percentage of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Case Study

70 per cent of Worcestershire users said that they were more active due to the project

Worcestershire County Council teamed up with active transport charity Sustrans to increase the availability of active travel options in

the area. With a £900,000 Big Lottery Fund grant, a new cycling and walking bridge was established over the River Severn to supplement the existing cycle networks.

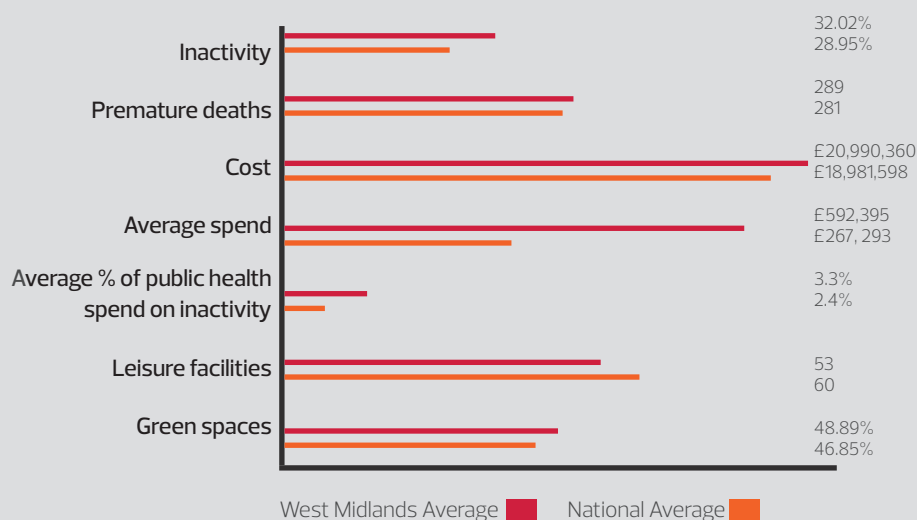
The scheme is estimated to facilitate over 3.3 million walking and cycling trips a year, which represents a 60 per cent increase.

If England were to match spending levels on cycling infrastructure to the Netherlands, the NHS could save £1.6 billion a year. - **Active Travel** - Sustrans and Worcestershire County Council

Key findings

- » The West Midlands has the highest proportion of adults who are physically inactive
- » The comparatively high spend (£592,395) on physical activity programmes in the region is almost three times more than the national average of £267,293
- » Much of this spend is apportioned to large individual councils including Birmingham City and Dudley who spend £3 million and £1 million respectively

National Average: West Midlands Region vs. Nationwide



Graph Key

Inactivity	The proportion of adults who are classed as physically inactive within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space

Yorkshire and the Humber

Out of nine regions Yorkshire and the Humber has the fourth highest percentage of adults who are physically inactive

Authority name	National rank	Proportion inactive	Premature deaths	Cost of inactivity
York	18	23.67	252.2	£15,515,622
East Riding of Yorkshire	42	26.36	313.2	£17,282,429
Leeds	48	26.85	279.5	£17,604,031
North Yorkshire CC	52	27.15	224.9	£17,798,171
North Lincolnshire	65	28.24	207.3	£18,517,852
Wakefield	71	28.46	240.2	£18,660,888
North East Lincolnshire	90	29.49	304.7	£19,334,218
Calderdale	98	30.02	284.1	£19,682,276
Sheffield	102	30.41	327.4	£19,937,814
Kirklees	114	31.65	389	£20,750,733
Doncaster	116	32.69	311.4	£21,434,207
Rotherham	127	33.57	295.6	£22,010,208
Barnsley	129	33.95	320.5	£22,260,523
Kingston upon Hull	140	36.07	375.3	£23,645,555
Bradford	147	37.68	321.6	£24,703,858

Most Deprived ■ | More deprived ■ | Average ■ | Less deprived ■ | Least Deprived ■

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The percentage of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Case Study

The programme was shown to develop activity habits in participants

20 sessions.

Goals are also set for each individual depending on their abilities, other co-morbidities and overall objectives. Between April 2012 – March 2013 the scheme had referred 926 people.

The results showed that:

- » 67% of participants lost weight
- » 62% reduced their BMI
- » 52% of participants reduced their blood pressure
- » 53% of participants reduced their resting heart rate

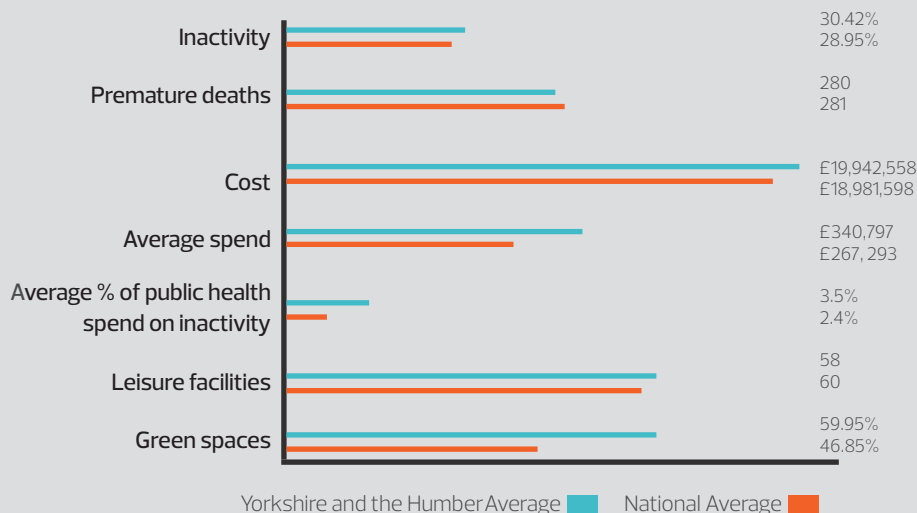
– Exercise Referral in East Riding

East Riding of Yorkshire's exercise referral scheme entitles the client to join any East Riding leisure centre for

Key findings

- » Yorkshire is characterised by large areas of open space (59 per cent) compared with the national average of 46 per cent
- » Despite this, Yorkshire's inactivity levels (30 per cent) are above the national average of 29 per cent
- » Yorkshire spends significantly more on physical activity programmes (3.5 per cent of its annual public health budget) than the national average of 2.4 per cent

National Average: Yorkshire and the Humber vs. Nationwide



Graph Key

Inactivity	The proportion of adults who are classed as physically inactive within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space

East Midlands

Out of nine regions the East Midlands has the fifth highest percentage of adults who are physically inactive

Authority name	National rank	Proportion inactive	Premature deaths	Cost of inactivity
Rutland	21	24.25	214.8	£15,902,041
Leicestershire CC	37	25.97	228	£17,026,038
Nottinghamshire CC	61	27.98	300.7	£18,343,978
Northamptonshire CC	64	28.08	296.3	£18,411,795
Derbyshire CC	66	28.27	272.5	£18,537,217
Derby	72	28.47	248	£18,666,081
Lincolnshire CC	80	29.00	229.3	£19,013,442
Nottingham	122	33.20	351.4	£21,766,638
Leicester	131	34.24	343.4	£22,451,172

Most Deprived ■ | More deprived ■ | Average ■ | Less deprived ■ | Least Deprived ■

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The percentage of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Case Study

"Walking for Health is vital for reducing inactivity, promoting activity, and improving social connections"

Ramblers and Macmillan Cancer Support delivers Walking for Health, helping more people – including those affected by cancer – discover the joys and health benefits of walking.

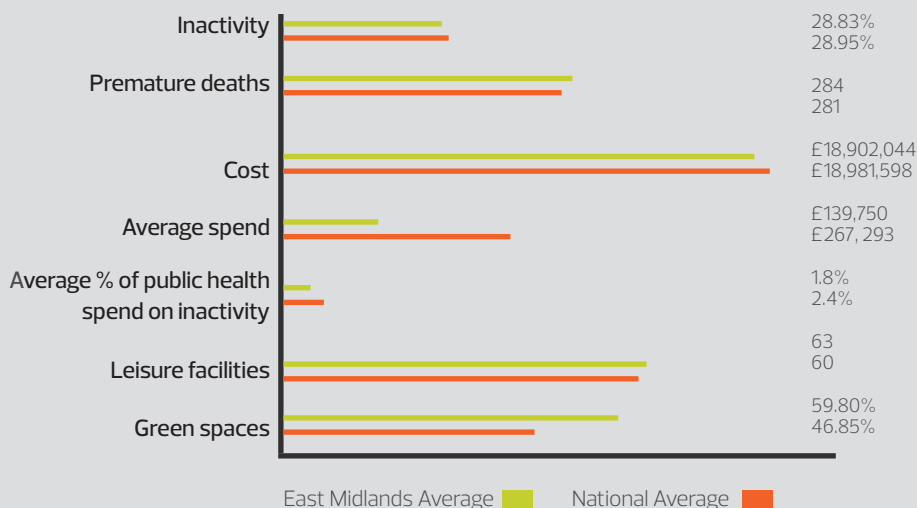
One such scheme is South Derbyshire which provides 20 weekly walks for over 250 regular walkers. Almost half of the walkers used to do less than half an hour of activity, three days a week until they started walking.

More than 70,000 people walk regularly at 3,400 weekly walks led by 10,000 volunteers – **Derbyshire – The Ramblers and Walking for Health**

Key findings

- » The East Midlands has one of the lowest proportional public health spends on physical inactivity (1.8 per cent) compared to the national average (2.4 per cent)
- » Four per cent more adults in the West Midlands are classed as inactive compared to the East Midlands
- » Large urban areas such as Leicester have a higher than average levels of adult inactivity (34 per cent)
- » This is less than densely populated areas such as Rutland where 24 per cent of adults are classed as inactive
- » The region has higher than average proportion of green spaces (60 per cent) compared with the national average (46 per cent)

National Average: East Midlands Region vs. Nationwide



Graph Key

Inactivity	The proportion of adults who are classed as physically inactive within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space

East of England

Out of nine regions East of England has the fourth lowest percentage of adults who are physically inactive

Authority name	National rank	Proportion inactive	Premature deaths	Cost of inactivity
Cambridgeshire CC	11	22.76	220	£14,919,159
Hertfordshire CC	27	25.38	236.5	£16,638,263
Bedford	31	25.62	228.9	£16,795,799
Essex CC	49	26.96	300.8	£17,678,012
Suffolk CC	51	27.03	244.6	£17,718,700
Norfolk CC	56	27.56	252.1	£18,068,159
Peterborough	59	27.74	267.1	£18,184,952
Central Bedfordshire	62	28.03	263.3	£18,378,029
Thurrock	81	29.08	265.3	£19,062,999
Southend-on-Sea	117	32.75	269.4	£21,472,753
Luton	139	35.88	306.7	£23,522,034

Most Deprived ■ | More deprived ■ | Average ■ | Less deprived ■ | Least Deprived ■

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The percentage of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Case Study

"It's important that all groups work with partners from key areas to encourage physical activity."

Less than two in ten of the estimated 11 million disabled people in England take part in sport.

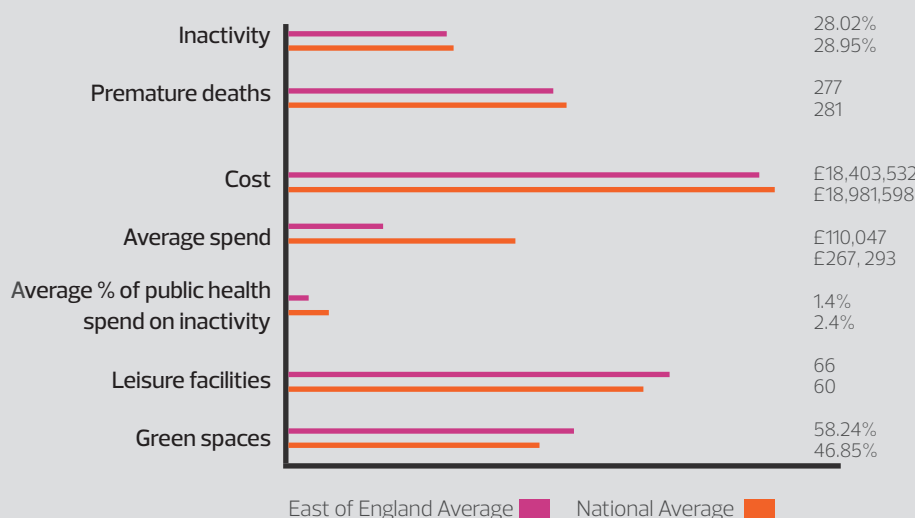
Inspire Peterborough is an award-winning disability sports programme that has over 400 regular users.

Brian Tyler, Disability Forum Manager at DIAL Peterborough said "We have had phenomenal support from every area of the community because organisations and individuals see the benefit in what we are trying to do—Make Sports and Leisure activities accessible and available to everyone. But most importantly, involve and include disabled people, their carers and family members in the decisions that affect them." - **Inspire Peterborough**

Key findings

- » The amount of spend attributed to physical activity within public health budgets is only two fifths (£110,047) of the national average (£267,293)
- » The East of England has a large number of leisure facilities per 100,000 people (66) when compared to the national average (60)
- » When compared to the national picture, the region scores better than average in terms of inactive adults, premature deaths, cost of inactivity, leisure facilities and amount of green and open spaces

National Average: East of England Region vs. Nationwide



Graph Key

Inactivity	The proportion of adults who are classed as physically inactive within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space

South East

Out of nine regions the South East has the lowest percentage of adults who are physically inactive

Authority name	National rank	Proportion inactive	Premature deaths	Cost of inactivity
Wokingham	1	18.23	200.3	£11,951,440
Windsor and Maidenhead	4	20.20	220	£13,242,832
Oxfordshire CC	9	22.18	228.7	£14,542,360
Bracknell Forest	10	22.66	240.6	£14,859,712
Surrey CC	16	23.11	208.5	£15,154,771
Hampshire CC	20	24.12	317.4	£15,811,966
Brighton and Hove	25	24.90	209.8	£16,328,295
West Berkshire	29	25.51	240.9	£16,723,746
West Sussex CC	30	25.60	215.7	£16,784,775
Buckinghamshire CC	33	25.79	334.2	£16,907,115
East Sussex CC	46	26.57	244.6	£17,420,909
Reading	47	26.83	248.5	£17,591,901
Kent CC	55	27.46	300.1	£18,005,909
Milton Keynes	79	28.97	311.4	£18,991,361
Isle of Wight	89	29.39	266.9	£19,268,125
Medway	96	29.98	258.5	£19,654,541
Southampton	109	30.87	322.9	£20,239,012
Portsmouth	120	33.05	304.5	£21,667,139
Slough	145	37.58	307.4	£24,640,771

Most Deprived ■ | More deprived ■ | Average ■ | Less deprived ■ | Least Deprived ■

Key findings

- » The South East has the lowest proportion of inactive adults in England (26 per cent)
- » Four of the ten least inactive local authorities in England are situated in the South East
- » These are Wokingham, Windsor and Maidenhead, Oxfordshire County Council and Bracknell Forest

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The percentage of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Case Study

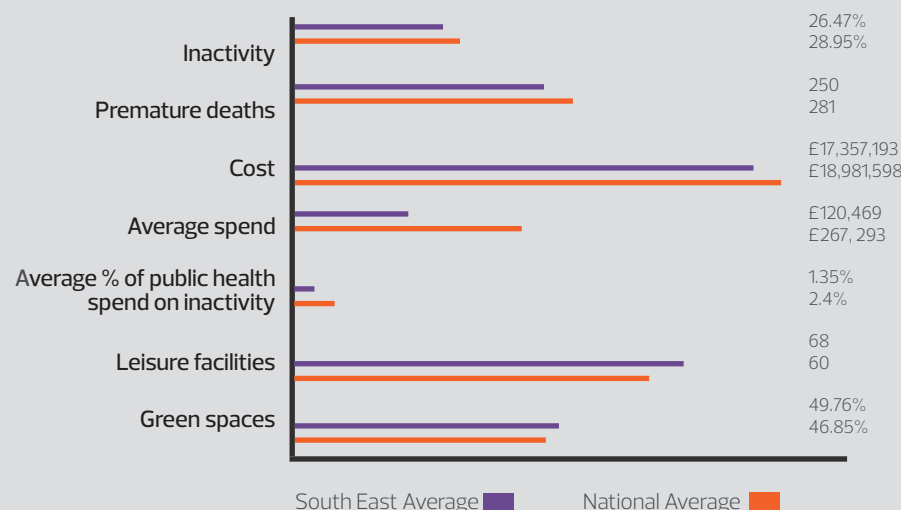
Ensuring low-activity groups are given opportunity to include activity in their daily routines is essential

In Brighton and Hove, the Sports Working Group identified Muslim women as a group that could become physically active.

Through strengthening the links between Muslim organisations and the Sports Development and Facilities teams, the Active for Life Project agreed to deliver two six-week swimming courses. The overall aim was to support Muslim women to sustain the swim sessions by developing their capacity to develop a women-only swim group in future.

Ensuring low-activity groups are given opportunity to include activity in their daily routines is essential. – Brighton and Hove – Targeting inactive groups

National Average: South East Region vs. Nationwide



Graph Key

Inactivity	The proportion of adults who are classed as physically inactive within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space

































London

Out of nine regions London has the third lowest percentage of adults who are physically inactive

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The percentage of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

"We're building a culture here that fosters a positive attitude to activity – The crucial element is partnerships."

Damien Swan,
General Manager
of Sobell Leisure
Centre, Islington

Authority name		National rank	Proportion inactive	Premature deaths	Cost of inactivity
Richmond upon Thames		2	20.03	202.3	£13,130,993
Islington		3	20.07	320.5	£13,157,874
Kensington and Chelsea		6	20.72	212.5	£13,583,305
Hammersmith and Fulham		7	20.79	295.6	£13,629,125
Lambeth		8	21.72	321.6	£14,242,276
Wandsworth		12	22.76	259.5	£14,919,361
Kingston upon Thames		13	22.77	215.5	£14,925,480
Sutton		17	23.15	234.4	£15,179,621
Bromley		19	24.08	213.8	£15,787,699
Harrow		24	24.76	261.1	£16,236,590
Barnet		38	26.11	235.6	£17,120,127
Enfield		40	26.26	284.6	£17,219,069
Southwark		41	26.32	236.5	£17,257,113
Haringey		43	26.40	245.2	£17,311,267
Waltham Forest		67	28.36	288.2	£18,592,625
Westminster		70	28.44	295.7	£18,648,227
Tower Hamlets		74	28.62	300.9	£18,763,499
Ealing		82	29.14	264.7	£19,102,686
Lewisham		84	29.18	270.7	£19,131,037
Hounslow		86	29.30	305.4	£19,208,292
Camden		87	29.32	246.1	£19,223,644
Redbridge		91	29.52	248.8	£19,354,909
Hillingdon		93	29.79	244.3	£19,531,766
Croydon		94	29.79	301.2	£19,533,387
Brent		100	30.15	370.9	£19,766,776
Hackney		101	30.20	251.8	£19,799,872
Havering		106	30.49	311.1	£19,987,520
Bexley		107	30.71	247.2	£20,135,710
Merton		112	31.55	342	£20,686,069
Greenwich		121	33.09	291.6	£21,696,268
Newham		137	35.11	315.6	£23,021,280
Barking and Dagenham		138	35.14	337.2	£23,040,174

Most Deprived  | More deprived  | Average  | Less deprived  | Least Deprived 

Key findings

- » The Borough of Islington, has the lowest percentage of green space nationally (eight per cent)
- » Despite this, it has one of the least inactive (20 per cent) adult populations in the country
- » London has almost half (35) the number of leisure facilities per 100,000 as the national average (60)
- » In London there is a wide variance of active and inactive populations – ranging from Barking and Dagenham (the 138th most inactive) to Richmond upon Thames (the second least inactive)

London

Islington

The project has encouraged more than 2000 young people in the borough to get active

In conjunction with local leisure providers, businesses and authority departments, the London Borough of Islington has succeeded in improving the level of general physical activity levels enormously.

Since its establishment in December 2012, after the awarding of more than £18,000 funding by a local bank, the Saturday Night Project has attracted more than 2000 young people in the Borough to enjoy a variety of activities in a safe and enjoyable environment.

Damien Swan, General Manager of Sobell Leisure Centre said: "We're building a culture here that fosters a positive attitude to activity – The crucial element is partnerships which is what Islington does very well. You can't put something like this on with one organisation and I don't think that anybody; councils, leisure organisations or businesses, can tackle inactivity on their own. It needs to be a partnered approach."

"Councils need to utilise these places more often, we can't rely on youth centres or external providers all the time when we have places like Sobell at our disposal"

– Aquaterra Leisure – Activity for young people

Tower Hamlets

The club linked with a local university to encourage growth

Bethnal Green Gardens, Tower Hamlets is located in one of the LTA/Tennis Foundation Community Pilot areas. In 2012 the courts were re-surfaced. They were previously managed by the Local

Authority who have now outsourced to a new tennis operator; Tower Hamlets Tennis Ltd. There are four floodlit courts in a densely populated cosmopolitan area.

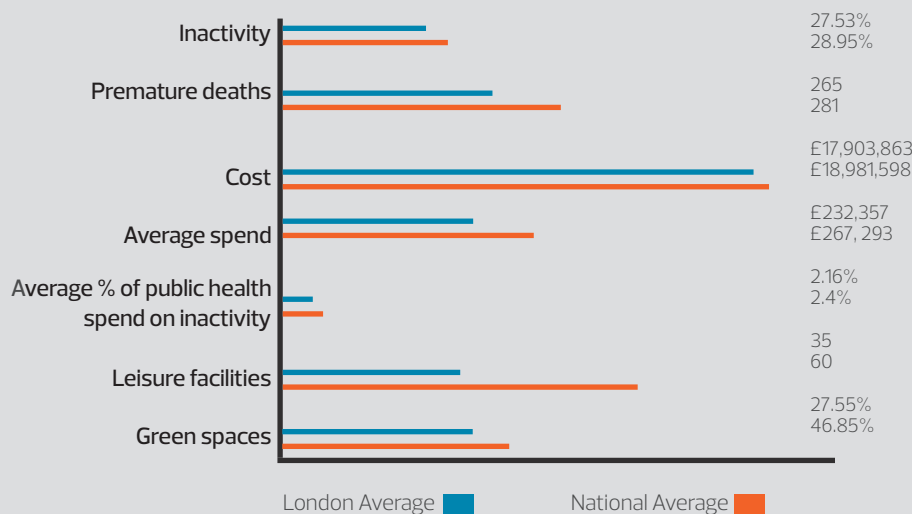
In January 2012 Tower Hamlets Tennis introduced Cardio Tennis sessions to help attract new players to the newly re-furnished courts, as well as those who had lapsed.

To encourage growth, the club linked with a local university and offered two free places per week to female students. This stemmed from a small amount of funding allocated via another partnership project (Us Girls) with the charity Access Sport.

Since January 2012, 67 unique players have booked on to a Cardio Tennis session at Bethnal Green and there have been a total of 44 sessions to date. Almost 50 per cent have attended four or more sessions. Around ten per cent of participants had no previous tennis experience and the majority of these were female.

– Cardio Tennis–Bethnal Green

National Average: London Region vs. Nationwide



Graph Key

Inactivity	The proportion of adults who are classed as physically inactive within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space

South West

Out of nine regions the South West has the second lowest percentage of adults who are physically inactive

Authority name	National rank	Proportion inactive	Premature deaths	Cost of inactivity
Bournemouth	5	20.41	269.3	£13,379,249
South Gloucestershire	14	22.80	208.5	£14,946,131
Bath & NE Somerset	15	22.91	227.7	£15,019,457
Wiltshire	22	24.42	209.3	£16,011,393
Gloucestershire CC	26	25.15	300.5	£16,490,895
Devon CC	36	25.97	229.5	£17,024,681
Somerset CC	53	27.30	236.9	£17,896,930
Plymouth	57	27.59	241.3	£18,089,425
Dorset CC	63	28.07	236.8	£18,400,365
Bristol, City of	68	28.38	256.3	£18,605,582
Cornwall	76	28.78	346.6	£18,869,527
Poole	78	28.90	248	£18,947,567
North Somerset	83	29.17	272.2	£19,124,425
Swindon	115	32.68	258.2	£21,424,838
Torbay	124	33.32	288.6	£21,846,333

Most Deprived ■ | More deprived ■ | Average ■ | Less deprived ■ | Least Deprived ■

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The percentage of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Case Study

Participants receive regular support and encouragement throughout the programme

Bournemouth's After Cancer Survivorship Programme (BACSUP) was set up to create a person centred, physical activity based living well programme.

Participants are supported throughout the programme, including a supportive phone call after three weeks, a motivational check-up after six weeks and a 12 week review. After six months, participants are contacted to establish activity levels and to offer support if needed.

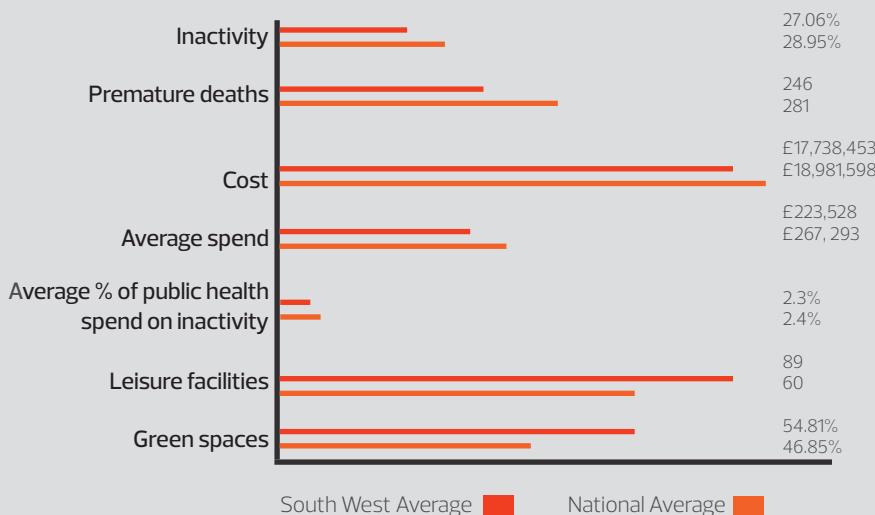
BACSUP has supported 457 people living with and beyond cancer to become more active.

—Bournemouth — Activity and Cancer Care

Key findings

- » The South West has an abundance of green space (54 per cent) and leisure facilities (89 per 100,000 people) compared to national average
- » Despite sharing a boundary, Gloucestershire has a significantly lower inactivity level (25 per cent) compared to neighbouring Herefordshire in the West Midlands (29 per cent)
- » Two thirds of local authorities in the South West are in the best performing half when ranked by adult physical inactivity levels

National Average: South West Region vs. Nationwide



Graph Key

Inactivity	The proportion of adults who are classed as physically inactive within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Average spend	The proportion of region made up of green and open space
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The average amount of funding attributed to physical activity within local authority public health budgets

UK and EU

United Kingdom

page 28

Scotland

Northern Ireland

Wales

European Union

page 29

United Kingdom



Shona Robison, Scottish Minister for the Commonwealth Games and Sport said:

"The Scottish government is committed to increasing physical activity. We want to make Scotland a more active country by encouraging people to make physical activity a part of their everyday lives."



John Griffiths, Welsh Minister for Culture and Sport said:

"The Welsh government is ambitious for Wales to be an active nation – we're clear that it has huge benefits. One of my priorities as Minister was to introduce something that would have a long-term positive effect on the health of the nation."

United Kingdom

Although Scotland²⁴, Wales²⁵ and Northern Ireland²⁶ have gathered data at a national level on physical inactivity, it has not been possible to carry out the same degree of regional analysis undertaken in England, as the data at a local level does not exist.

However, all three nations have at some point developed national physical activity strategies.

The Start Active, Stay Active report [Table 5] shows the percentage of adults across the Home Nations meeting CMO guidelines.²⁷ This allows for an element of top-level analysis but without sufficient depth or focus on inactivity.

Scotland

The Scottish government has committed to leaving a lasting physical activity legacy from the forthcoming 2014 Commonwealth Games. This year marks a new impetus to their national strategy with the launch of a cross-sector Physical Activity Implementation Plan and other initiatives, including a national walking strategy.

Northern Ireland

The government of Northern Ireland set a national target in 1998 to reduce the number of adult citizens classed as inactive from 20 per cent to 15 per cent. They published a report which recommended the establishment of regional training programmes and resources for physical activity.²⁸ This ended in 2002 with little indication of tangible progress made since then.

Wales

The Welsh government launched the Creating an Active Wales Physical Activity Action Plan in 2010.²⁹ This is central to the One Wales ambition for a healthier future for all and has been developed in partnership with local authorities, the NHS and the third sector.

In 2013, the Welsh Assembly passed the world's first 'active' travel legislation, which places a duty on local authorities to build and maintain a network of walking and cycle routes. They will be working with active travel charity Sustrans to deliver it.

Table 5

The proportion of adults completing CMO guidelines for exercise in the UK from Start Active, Stay Active, 2011³⁰

Country	Men	Women
England	40%	28%
Northern Ireland	33%	28%
Wales	36%	23%
Scotland	43%	32%

European Union

European Union

The European Union (EU) is actively aiming to promote sport and physical activity at policy level across member states.

It has sought to establish the level of physical activity across the EU through its Eurobarometer survey.³¹ The most recent survey interviewed 26,788 European citizens between 2009 and 2010. The results are now publicly available and show that over a third (34%) of respondents seldom, or never, do physical activity.

The Eurobarometer is designed to provide some supporting data for the evidence-based sports policies referred to above.

To accurately track and record physical activity throughout EU member states, the European Council also issued a new recommendation on 'health enhancing physical activity' (HEPA) in 2013.³² This supports the implementation of physical activity policies across EU governments for the first time.

At the heart of this new initiative is the proposed creation of a single monitoring framework to be used by member states. The framework has 23 indicators which are designed to support collating information on physical activity levels and from which governments can improve their policies.

It is not statutory but has been given cross-governmental support by member states including the UK government, which has accepted in full the Council's recommendations.

The use of a consistent methodology, under a single framework, would allow for a much greater depth of analysis of all the Home Nations, within a comparable format. This would improve the ability to produce evidence-based policy within the UK.

HEPA objectives

- » Promote a better understanding of health-enhancing physical activity and give a stronger voice to physical activity promotion in health policy and in other relevant sectors in Europe, including support for workforce development
- » Develop, support, and disseminate effective strategies and multi-sectoral approaches in the promotion of health-enhancing physical activity
- » Foster the preservation and creation of social and physical environments as well as values and lifestyles supportive of health-enhancing physical activity
- » Together with other relevant institutions and organisations, improve coordination in physical activity promotion across sectors and administrative structures.

HEPA guiding principles

- » Focus on population-based approaches for the promotion of health-enhancing physical activity using the best available scientific evidence
- » Emphasis on the importance of monitoring and evaluation; encouragement of the development of standardized measurement methods and systematic research
- » Encouragement of the ongoing exchange, dissemination and sharing of experience and knowledge
- » Support of cooperation, partnerships and collaboration with other related sectors, networks, and approaches.

Our recommendation

We welcome the EU's drive for a single comparable framework for data collection across Europe and urge the framework be implemented by health services throughout the UK in order to consistently and accurately establish levels of physical inactivity to better inform policy making and delivery.

Eurobarometer

Physical activity and sport became one of the European Union's supporting, coordinating and supplementing competencies with the ratification of the Lisbon Treaty in late 2009.

This set in motion a process whereby individual Member States will be encouraged to implement evidence-based policies designed to improve their provision of activity facilities and opportunities.

This means that for the first time the EU is actively aiming to promote physical activity and sport at the policy level – not only with a view to improving health and physical wellbeing across the EU, but also to enhance the role that activity can play in boosting social cohesion.

“Much more can be done through our policies to encourage people to get out of their chairs. We propose to Member States to take measures across all those policy sectors that can enable citizens to be or to become physically active.”

Androulla Vassiliou
European
Commission



Annexes

Annex A – methodology 31–33

Annex B – references 34–35

Annex C – tables of socio-economic deprivation

Most deprived	36
More deprived	37
Average	38
Less deprived	39
Least deprived	40

Annex D – full national rankings data table 41–46

Methodology Annex A

Inactivity

Percentage of physically active and inactive adults

Description:

Data on physical inactivity was provided for the first time in the 2013 Public Health Outcomes Framework Data Tool having been collated by the Sport England and Department of Health Active People Survey. It is the most up-to-date source, made up of responses from the period to January 2013.

The Chief Medical Officer defines physical inactivity as participation in less than 30 minutes of moderate intensity physical activity per week.

The Active People Survey classes someone as physically inactive when a respondent aged 16 and over, with valid responses to questions on physical activity, states that they are doing less than 30 "equivalent" minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 16.

The activities included in this are sport and active recreation (i.e leisure time fitness), recreational cycling and walking, cycling and walking for active travel purposes, dance and gardening.

Methodology: Bespoke telephone questionnaire collected data on frequency of participation in sport and active recreation during the previous 28 days.

Start date: 2005

Frequency of survey: Survey 1: 2005–6; Survey 2: 2007–8; Survey 3: 2008; Survey 4: 2009–10; Survey 5: 2010–11; Survey 6: 2011–12; Survey 7: 2012–13

Most recent full year results: January 2012 to January 2013

Commissioned by: Sport England

Coverage: Adult 16+ yrs in England

Sources: <http://www.phoutcomes.info/public-health-outcomesframework#gid/1000044/par/E12000004/ati/101/page/9>
http://www.noo.org.uk/data_sources/physical_activity/activepeople

Premature deaths

Premature deaths per 100,000

Description:

Sourced from Public Health England, the premature mortality data is based on directly standardised rates. This special measure of mortality makes allowances for the fact that death rates are higher in older populations and adjusts for differences in the age make up of different areas, enabling an accurate comparison.

Sources: <http://longerlives.phe.org.uk/>

Cost

Overall cost of inactivity

Description:

The national cost of physical inactivity in England is sourced from the National Institute for Health and Care Excellence paper "Costing Report: Four Commonly Used Methods to Increase Physical Activity" (2006) which references the Chief Medical Officer. It relates to the total cost of physical inactivity to the economy including treating diseases and sickness absence.

This figure may have increased further since this modelling was completed in line with inflation and other factors. The most recent estimate of the national cost was cited as £10 billion by Professor Kevin Fenton of Public Health England in his foreword for Walking for Health: Walking Works (http://www.walkingforhealth.org.uk/sites/default/files/Walking%20works_summary_AW_Web.pdf). As the modelling of this cost are unavailable to us we have based our calculations on the previously established figure of £8.2 billion.

The local figures presented in this report for the annual cost of physical inactivity per 100,000 adults in each local authority area has been calculated based on the number of physically inactive people in that local authority compared to the rest of the country.

The calculation is based on the size of the population and the proportion that is classed as physically

inactive divided by the 100,000s of the adult population to provide a comparable figure for local authorities, big or small.

Source: <http://www.nice.org.uk/nicemedia/live/11373/31847/31847.pdf>

Total cost of individual public health concerns to society

Due to lack of available national statistics in England, some of the costing data is UK-wide whilst others just account for England.

1. Alcohol – £17 billion (2011)

Description: Alcohol misuse is now estimated to cost the NHS £2.7 billion a year, almost twice the equivalent figure in 2001. But the cost of alcohol to society as a whole is even greater, estimated to stand at £17 – 22 billion, and by some estimates is as high as £55 billion.

Source: <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/virtuallibrary/Making%20alcohol%20a%20health%20priority.pdf>

2. Drugs – £15.4 billion (2003)

Description: The most recent estimate of the annual social and economic cost of Class A drug use in England was £15.4 billion, for the year 2003/04. Of this, problematic drug use (defined as use of heroin and/or crack cocaine) accounts for 99% of the total, and the costs of Class A drug-related crime is 90% (estimated £13.9 billion) of that total.

Source: <https://www.gov.uk/government/publications/financial-cost-of-acquisitive-crime-caused-by-class-a-drug-users-in-the-uk>

3. Smoking – £13.74 billion (2010)

Description: A report by the Policy Exchange in 2010 estimated the total cost to society of smoking to be £13.74 billion. This includes the £2.7bn cost to the NHS but also the loss in productivity from smoking breaks (£2.9bn) and increased absenteeism (£2.5bn). Other costs include: cleaning up cigarette butts (£342 million), the cost of fires (£507m), the loss of economic output from the death of smokers (£4.1bn) and passive smokers (£713m).

Source: <http://www.policyexchange.org.uk/images/publications/cough%20up%20-%20march%2010.pdf>

4. Obesity – £15.8 billion (2007)

Description: Estimates of the direct costs to the NHS for treating overweight and obesity, and related morbidity in England, have ranged from £479.3 million in 1998 to £4.2 billion in 2007. Estimates of the indirect costs (those costs arising from the impact of obesity on the wider economy such as loss of productivity) over the same time period ranged between £2.6 billion and £15.8 billion.

Source: http://www.noo.org.uk/NOO_about_obesity/economics

5. Inactivity – £8.2 billion (2006)

Description: The Chief Medical Officer (2004) estimated that the annual cost of physical inactivity was £8.2 billion, this includes diseases and sickness absence. The latest estimated from Public Health England was £10 billion referenced in Walking for Health: Walking Works (http://www.walkingforhealth.org.uk/sites/default/files/Walking%20works_summary_AW_Web.pdf)

Source: <http://www.nice.org.uk/nicemedia/live/11373/31847/31847.pdf>

6. Sexual Health – £12.05 billion (2013)

Description: Key findings based on maintaining current access levels of contraceptive and sexual health services show that, between 2013 and 2020, unintended pregnancy and STIs could cost the UK between £84.4 billion and £127 billion.

Source: <http://www.fpa.org.uk/sites/default/files/unprotected-nation-sexual-health-full-report.pdf>

Spend

Investment in programmes that tackle physical inactivity

Description:

This data has been obtained from original Freedom of Information responses received in December 2013 and January 2014. The responses cover the amount of spending attributed to programmes to increase physical activity in the year 2013/14 from local authority public health intervention budgets. 85 local authorities provided responses to our FOI requests; only 80 could be used for our analysis as the remaining 5 were not supplied in a comparable format.

To provide comparable figures, local authorities were also asked to supply their levels of spending on sexual health, smoking, alcohol misuse, drug misuse and obesity. When combined with their spending on physical activity, this provides total public health spending on interventions cited in this report. To work out the percentage, each of the above public health concerns were totalled and then divided into each spend category appropriately. Where local authorities gave details of additional public health concerns than the ones above, they were not included.

Source: <http://bit.ly/1f6iSmV>

Leisure facilities

Leisure facilities

Description: The number of facilities in each local authority, as well as the number of facilities per 100,000 people in each local authority, has been sourced from the Sport England Active Places database. This assessment is available under the open data licence. The Active Places Database includes public, private and third sector facilities as well as the facilities operated by over 30 National Governing Bodies including the Lawn Tennis Association, England Hockey and others.

Source: <https://spogo.co.uk/developer-area>

Green spaces

Green and open space

Description: The proportion of green space in each local authority was calculated through ukactive's coordination of the data for over 6,000 census wards into the local authority areas for which it was available. The original data was combined through the Office of National Statistics, land use database statistics for England from the Office of the Deputy Prime Minister and the land cover estimates from the European Environment Agency. It is defined as all green spaces larger than five meters squared including parks, playing fields, woodlands, neighbourhood greens and transport verges and excludes domestic gardens.

Source: <http://cresh.org.uk/cresh-themes/green-spaces-and-health/ward-level-green-space-estimates/>

Socio-economic deprivation

Deprivation status

Description: On the mortality rank tables, these five socio-economic groups are described as: 'least deprived', 'less deprived', 'average', 'more deprived' and 'most deprived'. These classifications are taken from Public Health England. Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial.

Source: <http://longerlives.phe.org.uk/mortality-rankings#are//par/E92000001>

Views and opinions of public health directors:

In order to properly understand the views and opinions of directors of public health when it comes to turning the tide of inactivity, ukactive interviewed over 30 directors from across the country in a series of telephone interviews dating between the 1st of November and 22nd of December 2013. Further to this, ukactive established a survey regarding physical inactivity, to which eight directors of public health responded.

Annex B References

Introduction

1. Department of Health, Start Active, Stay Active: A Report on Physical Activity from the Four Home Countries' Chief Medical Officers (2011). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf
2. World Health Organisation, Global Strategy on Diet, Physical Activity and Health (2014). <http://www.who.int/dietphysicalactivity/pa/en/>
3. Sport England, Active People Survey, Survey 7 (2013). http://www.sportengland.org/research/active_people_survey/active_people_survey_7.aspx
4. Department of Health, Start Active, Stay Active: A Report on Physical Activity from the Four Home Countries' Chief Medical Officers (2011). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf
5. Department of Health, Start Active, Stay Active: A Report on Physical Activity from the Four Home Countries' Chief Medical Officers (2011). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf
6. Nike, Designed to Move : A Physical Activity Action Agenda (2012). http://s3.nikecdn.com/dtm/live/en_US/DesignedToMove_FullReport.pdf
7. American College of Sports Medicine, International Council of Sport Science and Physical Recreation (2012). http://s3.nikecdn.com/dtm/live/en_US/DesignedToMove_FullReport.pdf
8. Network of Public Health Observatories, Health Impact of Physical Inactivity (2013). <http://www.apho.org.uk/resource/view.aspx?RID=123459>
9. NHS Sport and Exercise Medicine, A Fresh Approach (2011). http://www.fsem.co.uk/media/4165/sport_and_exercise_medicine_a_fresh_approach.pdf
10. National Institute of Health and Care Excellence, Costing Report: Four Commonly Used Methods to Increase Physical Activity (2006). <http://www.nice.org.uk/nicemedia/live/11373/31847/31847.pdf>

National picture

11. Department of Health, Start Active, Stay Active: A Report on Physical Activity from the Four Home Countries' Chief Medical Officers (2011). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf
12. The Lancet, Lee I-M, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk PT, Lancet Physical Activity Series Working Group, Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy (2012).
13. Department of Communities and Local Government, Local Authority Revenue Expenditure and Financing: 2013-14 Budget, England (2013). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/225884/RA_Budget_2013-14_Statistical_Release_-_FINAL_-_2_.pdf
14. National Institute of Health and Care Excellence, Costing Report: Four Commonly Used Methods to Increase Physical Activity (2006). <http://www.nice.org.uk/nicemedia/live/11373/31847/31847.pdf>
15. Family Planning Association, Unprotected Nation: The Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services (2013). <http://www.fpa.org.uk/sites/default/files/unprotected-nation-sexual-health-full-report.pdf>

16. Policy Exchange, Cough Up: Balancing Tobacco Income and Costs in Society (2010). <http://www.policyexchange.org.uk/images/publications/cough%20up%20-%20march%2010.pdf>
17. National Obesity Observatory, The Economic Burden of Obesity (2010). http://www.noo.org.uk/uploads/doc/vid_8575_Burdenofobesity151110MG.pdf
18. Home Office, Financial Cost of Acquisitive Crime Caused by Class A Crime Users in the UK (2013). <https://www.gov.uk/government/publications/financial-cost-of-acquisitive-crime-caused-by-class-a-drug-users-in-the-uk>
19. Alcohol Concern, Making Alcohol a Health Priority (2011). <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/virtuallibrary/Making%20alcohol%20a%20health%20priority.pdf>
20. Local Government Association, Media Release (2013). http://www.local.gov.uk/media-releases/-/journal_content/56/10180/3905304/NEWS
21. Spogo, Active Places Database. <https://spogo.co.uk/developer-area>
22. GreenSpace, GreenSTAT Visitor Survey System (2010). http://www.csd.org.uk/uploadedfiles/files/value_of_green_space_report.pdf
23. Centre for Research on Environment, Society and Health. <http://cresh.org.uk/cresh-themes/green-spaces-and-health/ward-level-green-space-estimates/>

UK and EU

24. Scottish Government, Scottish Health Survey (2012), <http://www.scotland.gov.uk/Topics/ArtsCultureSport/Sport/physicalactivity/palevels>
25. Lifestyle Change Branch, Welsh Government, Creating an Active Wales: Three Year Progress Report – Summary (2013), <http://wales.gov.uk/docs/phhs/publications/130807activewalesyear3reviewen.pdf>
26. Northern Ireland Physical Activity Strategy Group. The Northern Ireland Physical Activity Strategy Action Plan 1998–2002: an implementation plan for Be Active, Be Healthy – The Northern Ireland Physical Activity Strategy 1996–2002. Belfast: The Health Promotion Agency for Northern Ireland, 1996.
27. Department of Health, Start Active, Stay Active: A Report on Physical Activity from the Four Home Countries' Chief Medical Officers (2011). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf
28. Northern Ireland Physical Activity Strategy Group. The Northern Ireland Physical Activity Strategy Action Plan 1998–2002: an implementation plan for Be Active, Be Healthy – The Northern Ireland Physical Activity Strategy 1996–2002. Belfast: The Health Promotion Agency for Northern Ireland, 1996.
29. Sport Wales, Creating an Active Wales (2009), <http://www.sportwales.org.uk/media/144469/creating%20an%20active%20wales.pdf>
30. Department of Health, Start Active, Stay Active: A Report on Physical Activity from the Four Home Countries' Chief Medical Officers (2011). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf
31. European Commission, Sport and Physical Activity (2010), http://ec.europa.eu/public_opinion/archives/ebs/ebs_334_en.pdf
32. The Council of the European Union, Council Recommendation on Promoting Health-Enhancing Physical Activity Across Sectors (2013). http://ec.europa.eu/sport/library/news-documents/hepa_en.pdf

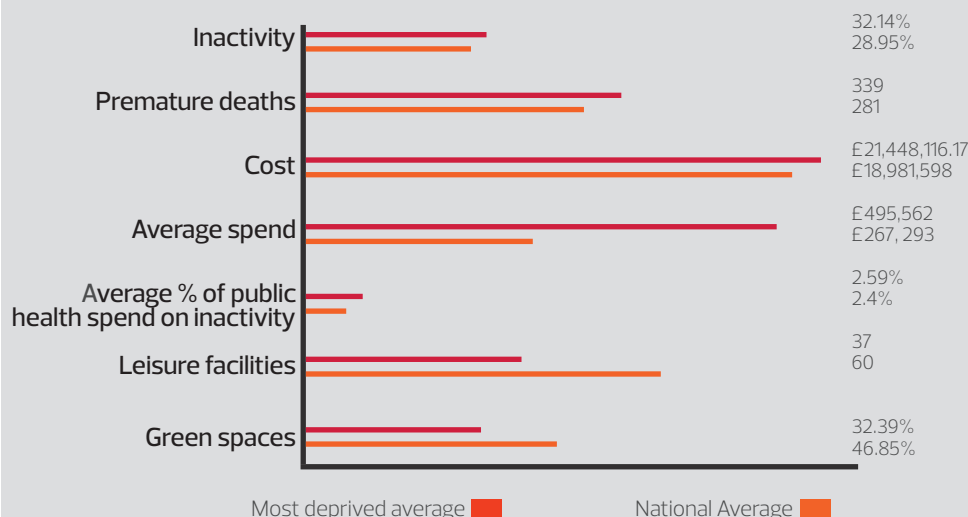
Annex C

Most deprived

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Proportion inactive	The proportion of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Authority name	Percentage inactive	Premature deaths	Cost of inactivity
Islington	20.07	320.5	£13,157,873.86
Lambeth	21.72	321.6	£14,242,276.38
Haringey	26.40	280.1	£17,311,267.19
Waltham Forest	28.36	272.8	£18,592,624.98
Tower Hamlets	28.62	346.6	£18,763,498.96
Lewisham	29.18	305.4	£19,131,037.10
Middlesbrough	30.12	370.9	£19,750,512.83
Brent	30.15	251.8	£19,766,775.99
Hackney	30.20	327.4	£19,799,872.06
Halton	31.34	342	£20,544,754.83
Liverpool	31.63	389	£20,736,396.71
Knowsley	32.83	359.6	£21,523,049.92
Greenwich	33.09	291.6	£21,696,267.61
Nottingham	33.20	351.4	£21,766,637.91
Walsall	33.39	308.6	£21,888,945.12
Rochdale	34.12	350.4	£22,368,946.49
Leicester	34.24	343.4	£22,451,172.23
Birmingham	34.27	320.5	£22,468,627.34
Wolverhampton	34.39	323.2	£22,548,411.59
Hartlepool	34.76	335.7	£22,791,546.59
Blackpool	34.85	432.4	£22,851,824.10
Stoke-on-Trent	35.07	348.6	£22,995,394.88
Newham	35.11	315.6	£23,021,280.37
Barking and Dagenham	35.14	337.2	£23,040,173.54
Kingston upon Hull	36.07	375.3	£23,645,555.12
Blackburn with Darwen	36.95	354.4	£24,225,029.08
Bradford	37.68	321.6	£24,703,858.34
Salford	39.07	382	£25,616,130.90
Sandwell	39.13	346.3	£25,657,944.14
Manchester	40.24	455	£26,385,799.05

National Average: Most deprived vs. Nationwide



Graph Key

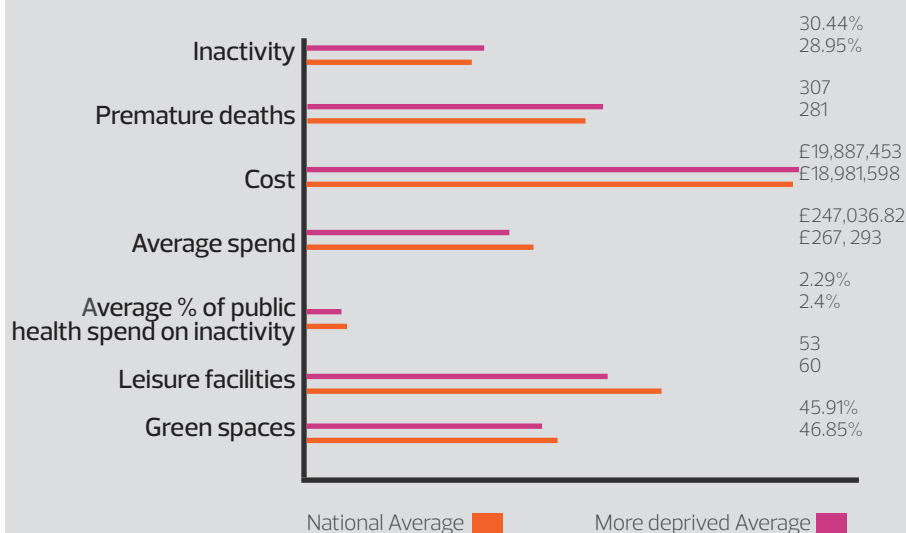
Inactivity	The proportion of adults who are classed as physically inactive within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space

More deprived

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The proportion of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Authority name	Percentage inactive	Premature deaths	Cost of inactivity
Hammersmith and Fulham	20.79	295.6	£13,629,124.62
Brighton and Hove	24.90	300.5	£16,328,294.75
Newcastle Upon Tyne	25.63	334.2	£16,806,609.34
Enfield	26.26	236.5	£17,219,068.55
Southwark	26.32	313.2	£17,257,112.91
Leeds	26.85	300.8	£17,604,030.61
Plymouth	27.59	291.7	£18,089,425.08
Peterborough	27.74	293.7	£18,184,951.97
Wakefield	28.46	308	£18,660,887.89
Darlington	28.61	297.6	£18,755,034.36
Redcar and Cleveland	28.73	297.5	£18,835,078.77
Wirral	28.83	311.4	£18,902,698.04
Camden	29.32	266.9	£19,223,644.41
County Durham	29.34	304.7	£19,238,873.41
North East Lincolnshire	29.49	305.9	£19,334,217.62
Sheffield	30.41	284.5	£19,937,814.13
St. Helens	30.49	311.1	£19,987,008.43
Bolton	30.76	322.9	£20,169,245.69
Doncaster	32.69	311.4	£21,434,206.62
Tameside	32.81	351.7	£21,513,848.78
Wigan	33.22	324.3	£21,779,819.15
Torbay	33.32	288.6	£21,846,333.40
South Tyneside	33.50	332.3	£21,962,239.45
Rotherham	33.57	295.6	£22,010,208.03
Gateshead	33.61	322	£22,032,893.38
Barnsley	33.95	320.5	£22,260,522.73
Luton	35.88	306.7	£23,522,033.74
Oldham	36.28	350.3	£23,786,779.60
Coventry	36.81	323.3	£24,135,384.36
Sunderland	36.99	336.5	£24,252,701.58

National Average: More deprived vs. Nationwide



Graph Key

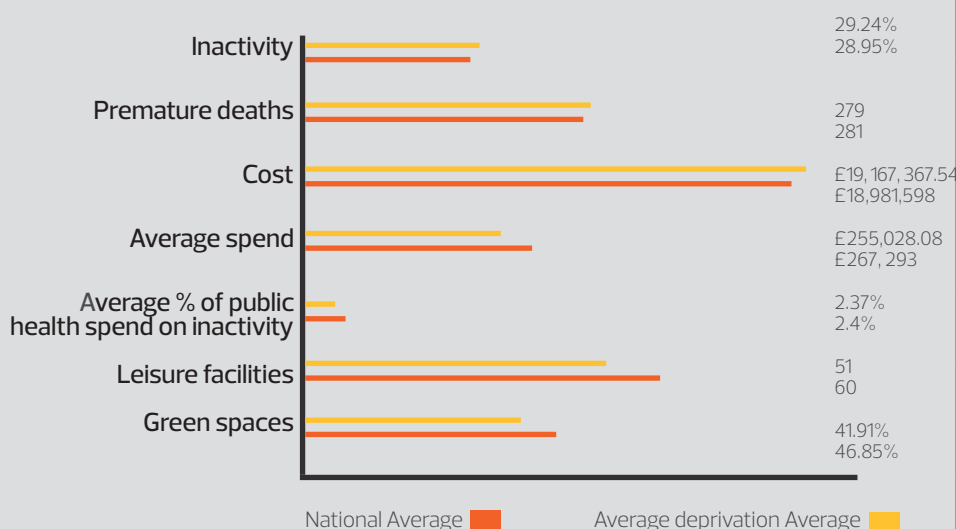
Inactivity	The proportion of adults who are classed as physically inactive within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Green spaces	The proportion of region made up of green and open space
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget

Average

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The percentage of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Authority name	Percentage inactive	Premature deaths	Cost of inactivity
Bournemouth	20.41	269.3	£13,379,249.32
Kensington and Chelsea	20.72	212.5	£13,583,305.29
Wandsworth	22.76	259.5	£14,919,360.86
East Sussex CC	26.57	248.5	£17,420,908.55
Reading	26.83	279.5	£17,591,901.05
North Tyneside	27.30	300.1	£17,899,008.69
Bury	27.87	300.7	£18,273,957.08
North Lincolnshire	28.24	288.2	£18,517,852.24
Bristol, City of	28.38	295.7	£18,605,582.27
Westminster	28.44	248	£18,648,226.88
Derby	28.47	300.9	£18,666,081.23
Cornwall	28.78	248	£18,869,526.99
Ealing	29.14	270.7	£19,102,686.46
Hounslow	29.30	270.9	£19,208,292.04
Isle of Wight	29.39	248.8	£19,268,124.65
Redbridge	29.52	244.3	£19,354,909.45
Stockton-on-Tees	29.57	301.2	£19,386,702.81
Croydon	29.79	258.5	£19,533,386.99
Cumbria CC	29.94	277	£19,629,409.37
Medway	29.98	284.1	£19,654,540.90
Calderdale	30.02	317.4	£19,682,276.15
Lancashire CC	30.41	304.1	£19,938,306.94
Telford and Wrekin	30.45	299.9	£19,965,492.46
Southampton	30.87	297.8	£20,239,012.02
Sefton	31.20	297.4	£20,455,295.53
Kirklees	31.65	296.3	£20,750,732.52
Southend-on-Sea	32.75	269.4	£21,472,753.03
Portsmouth	33.05	304.5	£21,667,139.12
Slough	37.58	307.4	£24,640,771.40
Dudley	37.67	273.8	£24,696,233.96

National Average: Average vs. Nationwide



Graph Key

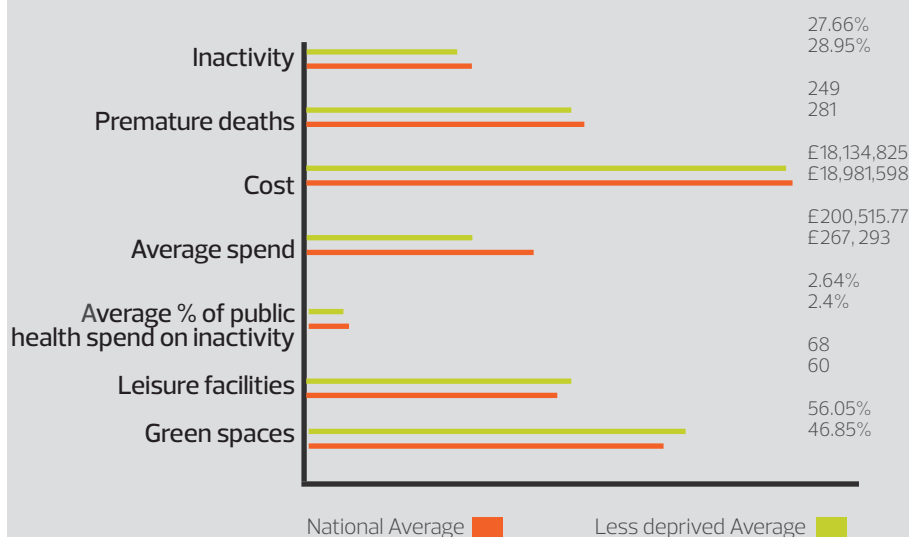
Inactivity	The proportion of adults who are classed as physically inactive within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Green spaces	The proportion of region made up of green and open space
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget

Less deprived

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The percentage of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Authority name	Percentage inactive	Premature deaths	Cost of inactivity
Sutton	23.15	234.4	£15,179,620.58
Trafford	24.75	261.1	£16,226,250.82
Harrow	24.76	209.8	£16,236,590.06
Bedford	25.62	279.2	£16,795,799.48
Stockport	25.87	275	£16,958,348.66
Solihull	25.91	229.5	£16,990,471.76
Devon CC	25.97	228	£17,024,681.04
Barnet	26.11	220.2	£17,120,127.41
Warrington	26.15	284.6	£17,147,461.42
Cheshire West & Chester	26.43	258.9	£17,327,720.30
Worcestershire CC	26.44	244.6	£17,333,226.91
Suffolk CC	27.03	224.9	£17,718,700.49
Somerset CC	27.30	229.8	£17,896,930.37
Kent CC	27.46	252.1	£18,005,908.62
Norfolk CC	27.56	241.3	£18,068,158.95
Northumberland	27.67	267.1	£18,143,977.17
Nottinghamshire CC	27.98	263.3	£18,343,978.07
Northamptonshire CC	28.08	272.5	£18,411,794.62
Derbyshire CC	28.27	256.3	£18,537,217.38
Shropshire	28.44	240.2	£18,648,048.32
Poole	28.90	229.3	£18,947,566.57
Milton Keynes	28.97	265.3	£18,991,361.36
Lincolnshire CC	29.00	264.7	£19,013,441.99
Thurrock	29.08	272.2	£19,062,998.51
Herefordshire	29.22	246.1	£19,156,153.90
Hillingdon	29.79	250.3	£19,531,765.93
Staffordshire CC	30.01	252.4	£19,678,386.74
Havering	30.49	247.2	£19,987,520.38
Bexley	30.71	233.9	£20,135,710.06
Swindon	32.68	258.2	£21,424,838.41

National Average: Less deprived vs. Nationwide



Graph Key

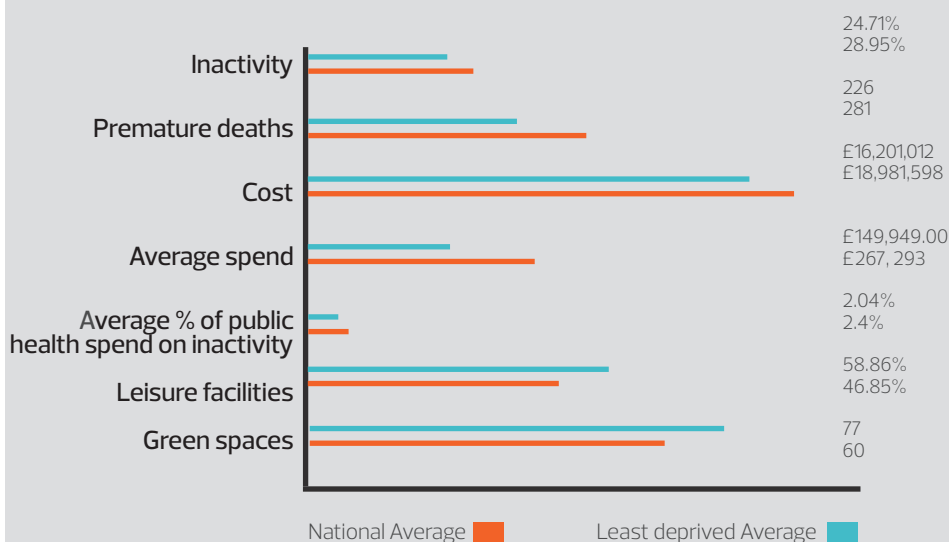
Inactivity	The proportion of adults who are classed as physically inactive within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Green spaces	The proportion of region made up of green and open space
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget

Least deprived

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Percentage inactive	The percentage of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year

Authority name	Percentage inactive	Premature deaths	Cost of inactivity
Wokingham	18.23	200.3	£11,951,440.07
Richmond upon Thames	20.03	202.3	£13,130,992.69
Windsor and Maidenhead	20.20	220	£13,242,832.27
Oxfordshire CC	22.18	228.7	£14,542,360.25
Bracknell Forest	22.66	240.6	£14,859,712.21
Cambridgeshire CC	22.76	220	£14,919,159.28
Kingston upon Thames	22.77	215.5	£14,925,480.29
South Gloucestershire	22.80	208.5	£14,946,131.47
Bath & NE Somerset	22.91	227.7	£15,019,456.94
Surrey CC	23.11	208.5	£15,154,771.00
York	23.67	252.2	£15,515,622.10
Bromley	24.08	213.8	£15,787,698.56
Hampshire CC	24.12	214.8	£15,811,965.60
Rutland	24.25	209.3	£15,902,040.79
Wiltshire	24.42	228.5	£16,011,392.57
Gloucestershire CC	25.15	236.5	£16,490,895.43
Hertfordshire CC	25.38	228.5	£16,638,262.61
Cheshire East	25.45	240.9	£16,688,642.53
West Berkshire	25.51	215.7	£16,723,746.18
West Sussex CC	25.60	228.9	£16,784,775.27
Buckinghamshire CC	25.79	218	£16,907,114.55
Leicestershire CC	25.97	235.6	£17,026,037.78
East Riding of Yorkshire	26.36	245.2	£17,282,429.04
Essex CC	26.96	238.1	£17,678,012.20
Warwickshire CC	27.00	244.6	£17,702,331.09
North Yorkshire CC	27.15	236.9	£17,798,171.03
Central Bedfordshire	28.03	236.8	£18,378,029.26
Dorset CC	28.07	207.3	£18,400,365.44
North Somerset	29.17	248.9	£19,124,425.46
Merton	31.55	235.5	£20,686,068.59

National Average: Least deprived vs. Nationwide



Graph Key

Inactivity	The proportion of adults who are classed as physically inactive within the region
Cost	The estimated cost of inactivity per 100,000 people within the region
Premature deaths	The average number of premature deaths per 100,000 people within the region
Green spaces	The proportion of region made up of green and open space
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget

Full national rankings Annex D

Table key		National averages	
Authority name	The name of the local authority	Physical inactivity	28.95 per cent
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)	Premature deaths	281 deaths
Proportion inactive	The proportion of adults who are inactive within each local authority	Leisure facilities	60
Premature deaths	The number of premature deaths per 100,000 people per year	Green spaces	46.85 per cent
Leisure facilities	The number of usable leisure facilities available per 100,000 people	Cost of inactivity	£18, 981, 598
Green spaces	The proportion of region made up of green and open space	Inactivity spend	£267, 293
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year	Average % of PH spend	2.4 per cent
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets		
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the public health budget		

Least inactive quartile ■ | Less inactive quartile ■ | More inactive quartile ■ | Most inactive quartile ■

Local authority name	National Rank	Physically inactive (%)	Premature deaths	Leisure facilities	Green spaces	Cost of inactivity	Inactivity spend (FOI data)	Average % of PH spend (FOI data)
Wokingham	1	18.23	200.3	77	26.84%	£11,951,440	£31,000	0.31
Richmond upon Thames	2	20.03	202.3	83	34.80%	£13,130,993	£139,100	3.2
Islington	3	20.07	320.5	51	8.00%	£13,157,874	£175,000	0.9
Windsor and Maidenhead	4	20.20	220	87	38.59%	£13,242,832	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Bournemouth	5	20.41	269.3	69	29.43%	£13,379,249	£427,300	3
Kensington and Chelsea	6	20.72	212.5	30	9.00%	£13,583,305	£84,000	0.65
Hammersmith and Fulham	7	20.79	295.6	48	13.20%	£13,629,125	£84,000	0.6
Lambeth	8	21.72	321.6	54	12.00%	£14,242,276	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Oxfordshire CC	9	22.18	228.7	430	69.12%	£14,542,360	£80,000	0.4
Bracknell Forest	10	22.66	240.6	51	49.10%	£14,859,712	£0	0
Cambridgeshire CC	11	22.76	220	387	78.16%	£14,919,159	£278,000	1.79
Wandsworth	12	22.76	259.5	65	20.41%	£14,919,361	£283,000	1
Kingston upon Thames	13	22.77	215.5	78	30.36%	£14,925,480	£330,000	5.9
South Gloucestershire	14	22.80	208.5	250	53.63%	£14,946,131	£192,196	4.9
Bath & NE Somerset	15	22.91	227.7	283	61.20%	£15,019,457	£40,900	0.8
Surrey CC	16	23.11	208.5	635	59.54%	£15,154,771	£0	0
Sutton	17	23.15	234.4	68	26.25%	£15,179,621	£80,000	1.51
York	18	23.67	252.2	85	62.00%	£15,515,622	£175,500	7
Bromley	19	24.08	213.8	138	44.00%	£15,787,699	£409,000	5.47
Hampshire CC	20	24.12	317.4	751	60.77%	£15,811,966	£173,000	0.8
Rutland	21	24.25	214.8	34	86.30%	£15,902,041	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Wiltshire	22	24.42	209.3	308	55.40%	£16,011,393	£19,000	1.2
Trafford	23	24.75	228.5	106	41.41%	£16,226,251	£262,438	4
Harrow	24	24.76	261.1	66	27.90%	£16,236,590	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Brighton and Hove	25	24.90	209.8	98	36.70%	£16,328,295	£348,932	2
Gloucestershire CC	26	25.15	300.5	406	69.35%	£16,490,895	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Hertfordshire CC	27	25.38	236.5	587	59.13%	£16,638,263	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Cheshire East	28	25.45	228.5	198	DATA NOT AVAILABLE	£16,688,643	£77,500	1.04
West Berkshire	29	25.51	240.9	112	68.81%	£16,723,746	£86,000	1.9
West Sussex CC	30	25.60	215.7	419	58.09%	£16,784,775	£84,000	0.65

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Proportion inactive	The proportion of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget

Least inactive quartile
Less inactive quartile
More inactive quartile
Most inactive quartile



Local authority name	National Rank	Physically inactive (%)	Premature deaths	Leisure facilities	Green spaces	Cost of inactivity	Inactivity spend (FOI data)	Average % of PH spend (FOI data)
Bedford	31	25.62	228.9	102	DATA NOT AVAILABLE	£16,795,799	£42,140	1.08
Newcastle Upon Tyne	32	25.63	279.2	108	39.12%	£16,806,609	£822,957	5.77
Buckinghamshire CC	33	25.79	334.2	360	70.09%	£16,907,115	£110,000	1.4
Stockport	34	25.87	218	135	45.23%	£16,958,349	£618,334	6.7
Solihull	35	25.91	275	93	43.24%	£16,990,472	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Devon CC	36	25.97	229.5	542	78.19%	£17,024,681	£169,000	1.2
Leicestershire CC	37	25.97	228	347	72.10%	£17,026,038	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Barnet	38	26.11	235.6	121	32.50%	£17,120,127	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Warrington	39	26.15	220.2	96	56.36%	£17,147,461	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Enfield	40	26.26	284.6	95	32.50%	£17,219,069	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Southwark	41	26.32	236.5	66	16.00%	£17,257,113	£331,000	1.8
East Riding of Yorkshire	42	26.36	313.2	184	76.86%	£17,282,429	£294,000	4.9
Haringey	43	26.40	245.2	63	23.40%	£17,311,267	£214,000	1.46
Cheshire West & Chester	44	26.43	280.1	161	DATA NOT AVAILABLE	£17,327,720	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Worcestershire CC	45	26.44	258.9	325	66.83%	£17,333,227	£320,000	2.69
East Sussex CC	46	26.57	244.6	282	65.78%	£17,420,909	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Reading	47	26.83	248.5	60	29.39%	£17,591,901	£49,000	0.9
Leeds	48	26.85	279.5	389	53.36%	£17,604,031	£266,000	1
Essex CC	49	26.96	300.8	745	68.19%	£17,678,012	£110,000	0.70
Warwickshire CC	50	27.00	238.1	298	56.36%	£17,702,331	£61,000	0.5
Suffolk CC	51	27.03	244.6	447	74.38%	£17,718,700	£131,000	0.6
North Yorkshire CC	52	27.15	224.9	499	82.32%	£17,798,171	£700,000	5.2
Somerset CC	53	27.30	236.9	406	73.96%	£17,896,930	DATA NOT AVAILABLE	DATA NOT AVAILABLE
North Tyneside	54	27.30	229.8	73	46.87%	£17,899,009	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Kent CC	55	27.46	300.1	760	64.47%	£18,005,909	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Norfolk CC	56	27.56	252.1	483	78.36%	£18,068,159	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Plymouth	57	27.59	241.3	99	54.16%	£18,089,425	£200,562	2.3
Northumberland	58	27.67	291.7	252	DATA NOT AVAILABLE	£18,143,977	£300,110	4.24

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Proportion inactive	The proportion of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget

Least inactive quartile	
Less inactive quartile	
More inactive quartile	
Most inactive quartile	

Local authority name	National Rank	Physically inactive (%)	Premature deaths	Leisure facilities	Green spaces	Cost of inactivity	Inactivity spend (FOI data)	Average % of PH spend (FOI data)
Peterborough	59	27.74	267.1	64	36.76%	£18,184,952	£93,146	1.72
Bury	60	27.87	293.7	91	59.88%	£18,273,957	£202,000	4.2
Nottinghamshire CC	61	27.98	300.7	381	63.60%	£18,343,978	£107,000	0.48
Central Bedfordshire	62	28.03	263.3	144	DATA NOT AVAILABLE	£18,378,029	£0	0
Dorset CC	63	28.07	236.8	259	71.18%	£18,400,365	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Northamptonshire CC	64	28.08	296.3	413	69.42%	£18,411,795	DATA NOT AVAILABLE	DATA NOT AVAILABLE
North Lincolnshire	65	28.24	207.3	84	72.54%	£18,517,852	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Derbyshire CC	66	28.27	272.5	473	70.49%	£18,537,217	£808,583	4.14
Waltham Forest	67	28.36	288.2	57	27.80%	£18,592,625	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Bristol, City of	68	28.38	256.3	226	28.00%	£18,605,582	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Shropshire	69	28.44	272.8	184	DATA NOT AVAILABLE	£18,648,048	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Westminster	70	28.44	295.7	91	13.90%	£18,648,227	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Wakefield	71	28.46	240.2	192	67.00%	£18,660,888	£400,080	3.5
Derby	72	28.47	248	81	38.02%	£18,666,081	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Darlington	73	28.61	308	42	43.35%	£18,755,034	£103,000	2
Tower Hamlets	74	28.62	300.9	62	14.00%	£18,763,499	£228,164	1.2
Redcar and Cleveland	75	28.73	297.6	57	68.26%	£18,835,079	£402,000	9.8
Cornwall	76	28.78	346.6	409	DATA NOT AVAILABLE	£18,869,527	£289,000	2.18
Wirral	77	28.83	297.5	129	58.00%	£18,902,698	£70,000	3.53
Poole	78	28.90	248	50	34.54%	£18,947,567	£427,300	3
Milton Keynes	79	28.97	311.4	99	55.00%	£18,991,361	£39,060	0.67
Lincolnshire CC	80	29.00	229.3	326	77.15%	£19,013,442	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Thurrock	81	29.08	265.3	51	58.11%	£19,062,999	£247,000	5.7
Ealing	82	29.14	264.7	79	26.90%	£19,102,686	£221,000	1.8
North Somerset	83	29.17	272.2	257	57.28%	£19,124,425	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Lewisham	84	29.18	270.7	52	27.83%	£19,131,037	£155,800	1.1
Herefordshire	85	29.22	248.9	102	83.49%	£19,156,154	£211,620	4.54
Hounslow	86	29.30	305.4	69	38.73%	£19,208,292	£117,500	1.4





Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Proportion inactive	The proportion of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget

Least inactive quartile
Less inactive quartile
More inactive quartile
Most inactive quartile



Local authority name	National Rank	Physically inactive (%)	Premature deaths	Leisure facilities	Green spaces	Cost of inactivity	Inactivity spend (FOI data)	Average % of PH spend (FOI data)
Camden	87	29.32	246.1	62	17.70%	£19,223,644	DATA NOT AVAILABLE	DATA NOT AVAILABLE
County Durham	88	29.34	270.9	293	DATA NOT AVAILABLE	£19,238,873	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Isle of Wight	89	29.39	266.9	87	DATA NOT AVAILABLE	£19,268,125	DATA NOT AVAILABLE	DATA NOT AVAILABLE
North East Lincolnshire	90	29.49	304.7	65	46.88%	£19,334,218	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Redbridge	91	29.52	248.8	72	68.26%	£19,354,909	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Stockton-on-Tees	92	29.57	305.9	62	51.12%	£19,386,703	£12,426	0.16
Hillingdon	93	29.79	244.3	98	43.73%	£19,531,766	£55,449	0.7
Croydon	94	29.79	301.2	103	34.02%	£19,533,387	£282,000	2
Cumbria CC	95	29.94	250.3	399	75.01%	£19,629,409	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Medway	96	29.98	258.5	82	43.92%	£19,654,541	£540,111	8
Staffordshire CC	97	30.01	277	417	66.53%	£19,678,387	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Calderdale	98	30.02	284.1			£19,682,276	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Middlesbrough	99	30.12	252.4	48	38.57%	£19,750,513	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Brent	100	30.15	370.9	62	22.00%	£19,766,776	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Hackney	101	30.20	251.8	37	15.00%	£19,799,872	£777,745	4.02
Sheffield	102	30.41	327.4	204	34.14%	£19,937,814	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Lancashire CC	103	30.41	284.5	594	65.35%	£19,938,307	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Telford and Wrekin	104	30.45	304.1	70	57.94%	£19,965,492	DATA NOT AVAILABLE	DATA NOT AVAILABLE
St. Helens	105	30.49	299.9	70	58.37%	£19,987,008	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Havering	106	30.49	311.1	56	47.46%	£19,987,520	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Bexley	107	30.71	247.2	62	32.40%	£20,135,710	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Bolton	108	30.76	233.9	124	53.17%	£20,169,246	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Southampton	109	30.87	322.9	67	27.14%	£20,239,012	DATA NOT AVAILABLE	DATA NOT AVAILABLE

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Proportion inactive	The proportion of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget

Least inactive quartile	
Less inactive quartile	
More inactive quartile	
Most inactive quartile	

Local authority name	National Rank	Physically inactive (%)	Premature deaths	Leisure facilities	Green spaces	Cost of inactivity	Inactivity spend (FOI data)	Average % of PH spend (FOI data)
Sefton	110	31.20	297.8	105	46.31%	£20,455,296	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Halton	111	31.34	297.4	57	44.89%	£20,544,755	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Merton	112	31.55	342	69	28.53%	£20,686,069	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Liverpool	113	31.63	235.5	125	28.65%	£20,736,397	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Kirklees	114	31.65	389		DATA NOT AVAILABLE	£20,750,733	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Swindon	115	32.68	258.2	89	46.36%	£21,424,838	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Doncaster	116	32.69	311.4	148	68.35%	£21,434,207	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Southend-on-Sea	117	32.75	269.4	58	38.36%	£21,472,753	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Tameside	118	32.81	351.7	101	49.35%	£21,513,849	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Knowsley	119	32.83	359.6	32	42.65%	£21,523,050	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Portsmouth	120	33.05	304.5	74	41.31%	£21,667,139	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Greenwich	121	33.09	291.6	70	32.10%	£21,696,268	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Nottingham	122	33.20	351.4	89	31.61%	£21,766,638	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Wigan	123	33.22	324.3	129	51.17%	£21,779,819	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Torbay	124	33.32	288.6	80	44.00%	£21,846,333	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Walsall	125	33.39	308.6	84	41.56%	£21,888,945	DATA NOT AVAILABLE	DATA NOT AVAILABLE
South Tyneside	126	33.50	332.3	60	39.16%	£21,962,239	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Rotherham	127	33.57	295.6	119	64.38%	£22,010,208	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Gateshead	128	33.61	322	97	48.65%	£22,032,893	£209,938	3.4
Barnsley	129	33.95	320.5	113	67.85%	£22,260,523	£91,000	0.97
Rochdale	130	34.12	350.4	61	52.50%	£22,368,946	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Leicester	131	34.24	343.4	96	29.48%	£22,451,172	£172,500	1
Birmingham	132	34.27	320.5	242	27.80%	£22,468,627	£2,464,778	4.8

Table key	
Authority name	The name of the local authority
National rank	150 local authorities ranked in order of inactivity (no. 1 is the least inactive, no. 150 is the most inactive)
Proportion inactive	The proportion of adults who are inactive within each local authority
Premature deaths	The number of premature deaths per 100,000 people per year
Leisure facilities	The number of usable leisure facilities available per 100,000 people
Green spaces	The proportion of region made up of green and open space
Cost of inactivity	The overall cost of inactivity per 100,000 people to each local authority per year
Average spend	The average amount of funding attributed to physical activity within local authority public health budgets
Proportion of spend on activity	The average amount of funding spent on physical activity as a proportion of the Public Health budget

Least inactive quartile
Less inactive quartile
More inactive quartile
Most inactive quartile



Local authority name	National Rank	Physically inactive (%)	Premature deaths	Leisure facilities	Green spaces	Cost of inactivity	Inactivity spend (FOI data)	Average % of PH spend (FOI data)
Wolverhampton	133	34.39	323.2	64	DATA NOT AVAILABLE	£22,548,412	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Hartlepool	134	34.76	335.7	48	45.02%	£22,791,547	£154,000	2.56
Blackpool	135	34.85	432.4	43	27.59%	£22,851,824	£250,000	2
Stoke-on-Trent	136	35.07	348.6	87	45.02%	£22,995,395	£464,000	3.48
Newham	137	35.11	315.6	26	29.04%	£23,021,280	£216,000	3.14
Barking and Dagenham	138	35.14	337.2	39	32.00%	£23,040,174	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Luton	139	35.88	306.7	54	32.68%	£23,522,034	£0	0
Kingston upon Hull	140	36.07	375.3	90	30.49%	£23,645,555	£459,000	2.5
Oldham	141	36.28	350.3	99	50.83%	£23,786,780	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Coventry	142	36.81	323.3	83	38.13%	£24,135,384	£379,178	3.1
Blackburn with Darwen	143	36.95	354.4	55	50.50%	£24,225,029	£794,485	6.1
Sunderland	144	36.99	336.5	135	48.12%	£24,252,702	£36,174	0.3
Slough	145	37.58	307.4	32	31.04%	£24,640,771	£25,000	0.55
Dudley	146	37.67	273.8	106	31.14%	£24,696,234	£730,000	6.8
Bradford	147	37.68	321.6	258	53.14%	£24,703,858	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Salford	148	39.07	382	96	44.81%	£25,616,131	DATA NOT AVAILABLE	DATA NOT AVAILABLE
Sandwell	149	39.13	346.3	78	28.58%	£25,657,944	£108,300	1.2
Manchester	150	40.24	455	146	33.20%	£26,385,799	DATA NOT AVAILABLE	DATA NOT AVAILABLE

Turning the tide

Visit: www.ukactive.com/turningthetide for further details of the scale and implications of physical inactivity across the UK.

On the road

Throughout 2014, ukactive will continue to engage with local authorities, leisure providers, public health professionals and anyone who has a role to play in turning the tide of physical inactivity through a series of regional events.

Contact turnthetide@ukactive.org.uk for more information on these upcoming events.

Next steps

The information and data is constantly moving and evolving, and ukactive will continuously update this website with new insights, evolutions and progress in turning the tide. We encourage anyone with a role to play in turning the tide of physical inactivity to engage with this facility and make use of it wherever possible.

Visit www.ukactive.com/turningthetide to keep informed.

For further information call 020 7420 8560 or [email: turnthetide@ukactive.org.uk](mailto:turnthetide@ukactive.org.uk)
ukactive, Castlewood House, 77–91 New Oxford St, London WC1A 1PX | www.ukactive.com



More people
More active
More often

Facebook: [Get ukactive](#)
Twitter: [@_ukactive](#)
LinkedIn: [ukactive](#)
[#turnthetide](#)



Achieving **Safety**, **Sustainability** and **Health** Goals in Transport

Naomi Baster, Lucy Amos and David Davies
Parliamentary Advisory Council for Transport Safety (PACTS)
March 2014

WITH SUPPORT FROM THE ASHDEN TRUST AND BRITISH CYCLING

ACKNOWLEDGEMENTS

This report was made possible due to the generous financial support of the Ashden Trust and British Cycling.

PACTS is grateful to the many individuals and organisations who contributed to this project. Particular thanks go to Dr Nicola Christie, Karen Creavin and Graham Lennard who helped organise the expert seminars in London and Birmingham, to all who attended them and to UCL's Centre for Transport Studies and Birmingham City Council for hosting these events. The speakers and delegates at the PACTS *Triple Whammy conference* on this topic in October 2013 provided valuable material, as did members of the PACTS road safety working parties and the ADEPT Transport Board. PACTS would particularly like to thank Sian Ferguson of the Ashden Trust for her support and comments and consultant Dr Adrian Davis who acted as special adviser throughout the project.

Responsibility for the contents and conclusions of this report lies with the authors and does not necessarily reflect the views of the Board of Directors of PACTS.

THE PARLIAMENTARY ADVISORY COUNCIL FOR TRANSPORT SAFETY (PACTS)

The Parliamentary Advisory Council for Transport Safety (PACTS) is an associate Parliamentary group and registered charity. Its charitable objective is: to protect human life through the promotion of transport safety for the public benefit.

FOREWORD

Scarcely a day goes by without a report on the growing levels of obesity, particularly in children, and the need for more physical activity to reduce physical and mental health problems. The serious health impacts of air pollution, partly due to transport emissions, are being increasingly well understood and are also feeding back into our transport system with the Highways Agency proposing 60mph limits on sections of the M1 and M3 to meet air quality standards.

This winter's storms and floods, bringing expense and misery to many people and chaos to our transport systems, have reignited debate over climate change. Regardless of the causes of these extreme weather events, it is evident that we need to make our transport systems more sustainable.

Despite the substantial recent falls in UK casualty numbers, road traffic collisions remain the biggest single source of death for young people aged 5-25 years and is of concern to people of all ages. Parliamentarians of all parties have made clear that our streets need to be safer for all to use. The *Get Britain Cycling* debate in the House of Commons Chamber in October last year, in which 100 MPs spoke, showed their interest and that of their constituents in road safety, particularly when linked to other agendas such as the environment and health. These issues have been pursued by our colleagues in the All Party Parliamentary Cycling Group and the Transport Select Committee as well as by PACTS.

1st April 2014 is the first anniversary of the transfer of responsibility for public health to local authorities, under the Health and Social Care Act 2012. "Green shoots..... healthier....but not yet fully sustainable." These could be the words of the Chancellor of the Exchequer last year about the economy. They apply equally to the degree to which the policies on road safety, sustainable transport and public health are being planned and delivered in a joined up way. This report shows that progress is being made but that there is still a long way to go. The UK is still in a period of austerity with further spending cuts on the way, particularly for local government. Joining up these three areas is essential to delivering more for less.

PACTS will be using this report to hold government to account. We hope you will find it useful in your efforts to deliver safety, sustainability and health goals in transport.

Signed by PACTS co-chairs



John Leech MP



Jim Fitzpatrick MP



Sir Peter Bottomley MP

March 2014

CONTENTS

2	ACKNOWLEDGEMENTS
3	FOREWORD
7	SUMMARY
8	CHAPTER 1: INTRODUCTION
8	New thinking on safety, sustainability and health
8	Report aims and methodology
10	CHAPTER 2: POLICY CONTEXT AND TRENDS
10	Road safety
16	Sustainable transport
21	Public health
24	Joined-up agendas
28	CHAPTER 3: CASE STUDIES
28	Selection of case studies:
	The Portsmouth 20mph speed limit scheme
	Sustainable Travel Demonstration Towns
	Barclays Cycle Superhighways
	Change4Life
37	Conclusion
38	CHAPTER 4: PULLING IN THE SAME DIRECTION?
39	Testing the policies in practice
40	To what extent is policy already aligned?
40	Does joined up work already exist and if so, to what extent?
41	What are the enablers and obstacles to joined-up working?
44	CHAPTER 5: SAFETY IN THE FUTURE
44	Addressing conflict
44	Getting the best out of links to other agendas
44	Ensuring that the safety agenda remains a priority
45	The road safety approach
47	CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS
50	UK road safety in the future
51	APPENDIX I : PARTICIPANTS IN THE EXPERT SEMINARS
52	APPENDIX II : ROAD SAFETY POWERS AND DEVOLUTION
55	GLOSSARY

SUMMARY

For some years now there have been calls for greater alignment of policy and practice across the road safety, sustainable transport and public health sectors. On 1st April 2013 responsibility for public health was transferred from the NHS to local authorities. This has presented an opportunity to deliver road safety, sustainable transport and public health initiatives in a more integrated and effective way. This report, drawing on the views of a cross section of experts and focusing on local transport, shows that, one year on, progress has been made but much more is needed.

Policy, necessity and public opinion are driving change at national and local level towards a more integrated approach. Concerns about obesity and poor air quality, the need to reduce carbon emissions and resurgence in interest in cycling have given a boost to investment in local sustainable transport. At the same time, road safety funding cuts and reductions in the number of people killed or injured on the roads have led many local authorities to merge a reduced road safety staff with sustainable travel teams.

Road safety needs to be pursued in a broad multi-sectoral context since it cuts across public health and sustainable transport (as well as occupational health and safety) agendas. Road traffic collisions are a major public health issue and the largest single source of death for people aged 5-25 years in the UK.¹ More needs to be done not only to prevent death and serious injuries, the vast majority of which are largely avoidable but also to make people feel safer so that the public health agenda and the public's aspirations for safer mobility can be fulfilled.

Despite the statements of common policy objectives, there is still insufficient alignment between these sectors in practice to realise the substantial co-benefits of coordinated action. Public health and sustainable transport emphasise the health and environmental benefits of walking and cycling while the road safety sector is concerned that insufficient effort and investment are being made to prevent death and serious injury and that increases in these vulnerable modes may lead to more casualties. Closer integration and synergy at national and local level is needed.

The long term decline in active travel, particularly walking, and the increases in obesity show that significant and structural change is needed.² Behavioural change initiatives are not enough. While cycling has become the poster-boy of sustainable transport, walking lags behind, despite its much wider potential appeal and benefits. It is also a higher priority for casualty reduction. Public transport also seems to be failing to capitalise on its safety and health advantages.

This report calls on the Government to show more leadership and joined-up working at national level and to recognise that the desired changes (healthier lifestyles, more active travel, safer road use) will require long-term planning and investment in physical infrastructure. It is imperative that the efforts to encourage walking and cycling are accompanied by safer infrastructure provision, effective speed management and improved road user training. The report also calls for the Departments of Transport and Health to jointly publish improved information about walking and cycling journeys and the health benefits and risks of the main travel modes. At local level it recommends a series of measures to improve cross-sector working and understanding.

1. IHME, *Global Burden of Disease: Generating Evidence, Guiding Policy*, Institute of Health Metrics and Evaluation, University of Washington, Seattle, USA, 2013

2. DfT, *National Travel Survey: 2012*, September 2013

Chapter 1: Introduction

A new vision is needed for road safety in Britain This should be underpinned by a strategy that explains how casualty reduction, danger reduction and the various other important policy objectives, such as a sustainable transport system, economic efficiency, climate change, social inclusion and physical health are integrated. House of Commons Transport Select Committee, 2008.³

New thinking on safety, sustainability and health

1. This decade has seen notable developments in attitudes to road safety, sustainable transport and public health on the part of the public, media and institutions. Cycling has often been the catalyst. Demands for safer conditions for walking and cycling and for lower speeds in residential areas have grown rapidly, despite the continued large falls in overall casualty numbers. The London cycling commuter boom and British successes at 2012 Olympics and in the Tour de France (2012 and 2013) have given a new confidence to those promoting sustainable transport. In the public health sector, institutional changes have been accompanied by growing concerns about obesity levels, particularly amongst children, and the long-term health consequences. The paradigm shift to *Safe System* in road safety thinking and practice has highlighted that the vast majority of death and serious injury is preventable, given current knowledge.
2. Road safety, sustainable transport and public health have often been thought of as three separate policy areas. Today, a combination of financial necessity, new challenges, policy decisions and the understanding that potential substantial co-benefits can be achieved are bringing them closer together – in some areas at least. Central government has cut funding for road safety and many local authorities have combined their remaining road safety and sustainable transport staff. Local authorities now have responsibility for public health and some are taking advantage of the opportunities to combine health and active travel agendas.
3. It has been evident for some time that road safety could not be treated in isolation. In the World Report on Road Traffic Injury Prevention, the World Health Organisation stated in 2004 that road safety is a public health issue.⁴ At national level, PACTS has consistently highlighted the linkages between safety and health. In 2007 PACTS held a conference *Road Safety and Health* and published *Beyond 2010 – a holistic approach to road safety in Great Britain*⁵ which stated that improving road safety had a key role to play in establishing a road environment conducive to active travel, with both health and environmental benefits. The 2008 report *Behave Yourself*⁶ covered behaviour change and modal shift for health and environmental reasons. *It's My Choice: safer mobility for an ageing population*, published in 2012, highlighted the health benefits of enabling and encouraging older people to use active travel. The recent series of *Tackling the deficit* reports⁷ pointed to the desirability of integrating road safety with other agendas but also the danger that the vital task of reducing casualties might be overlooked.

Report aims and methodology

4. This report attempts to describe the new landscape for road safety, sustainable transport and public health, to assess whether these policy areas are working effectively together to deliver key policy objectives and to highlight the opportunities and risks involved in joint working. It makes recommendations to government, local authorities and to stakeholders. Each of these

³ House of Commons Transport Committee, [Ending the Scandal of Complacency](#), HC 460 Session 2007-2008, 2008

⁴ WHO, *World Report on Road Traffic Injury Prevention*, 2004

⁵ PACTS, [Beyond 2010- a holistic approach to road safety in Great Britain](#), 2007

⁶ PACTS, [Behave Yourself- Road Safety Policy in the 21st Century](#), 2008

⁷ PACTS, [Tackling the Deficit: At what cost to road safety?](#), 2010 and PACTS, [Tackling the Deficit: Where next for road safety?](#), 2011

three policy areas is a major topic in its own right; the emphasis here is on delivery by local government, active travel and road safety.

5. The report reviews the policy, legislative and institutional frameworks for safety, sustainable transport and health. It summarises key trends in the three policy areas, including road casualties, sustainable transport and public health. Case studies are provided to illustrate the synergy (actual and potential) of transport-related safety, sustainability and health schemes. They are not necessarily good practice. Two expert seminars were held – one national and one regional – to obtain the views of those involved with policy making and service delivery under the Chatham House rule on confidentiality. (See Appendix I.) In addition, PACTS held a conference on this topic and the speakers' presentations and the delegates' contributions have been used to inform this report.⁸ Draft conclusions were discussed at a joint meeting of the PACTS road safety working parties and with the ADEPT Transport Board.⁹ The report is based on a synthesis of these sources.
6. The challenges of reducing casualties, promoting sustainable transport and improving public health are common across the UK. There are growing differences, however, in legislation, structures and approach in the devolved administrations. We have tried to reflect these differences in the report but the focus is on the UK Government. Appendix II sets out the main road safety powers in relation to devolution.
7. PACTS hopes that the conclusions and recommendations provided in this report will encourage government to align better these three crucial policy areas and assist practitioners at all levels to deliver safety, sustainability and public health goals in transport more effectively.

⁸ Pacts Conference, *Triple Whammy, Achieving safety, sustainability and health goals in transport*, 26.10.13, Royal College of Surgeons, London

⁹ ADEPT is the Association of Directors of Environment, Planning and Transport, a local government body.

Chapter 2: Policy context and trends

8. This chapter provides an outline of the key policy documents, issues, trends and legal frameworks for road safety, sustainable transport and public health. It highlights the extent to which policies demonstrate synergy across the three sectors.
9. There are increasingly different frameworks for these policy areas in the devolved administrations of the UK. The road safety powers are summarised in Appendix II and some differences in relation to sustainable transport and public health are included in this chapter. Despite the differences in frameworks, the administrations generally share common objectives: to reduce road traffic casualties, to promote active travel, and reduce obesity levels and CO₂ emissions. The UK government has committed to “work closely within the devolved administrations in an area of shared interest”.¹⁰

Road safety

Strategic Framework for Road Safety

10. Between 1987 and 2010, the UK had national road safety strategies which set out numerical casualty reduction targets and a broad range of engineering, education and enforcement measures by which the targets were to be delivered.¹¹ The 2010 Coalition Government made clear early on that it did not favour nationally-imposed targets (for road safety or other matters) and that, under its policy of localism, it would leave many aspects of road safety to local authorities.
11. There was, therefore, some doubt whether the Coalition Government would produce a road safety strategy of any type. On taking office, Secretary of State for Transport Philip Hammond announced that the Government would “*end the war on the motorist*” and stop funding for speed cameras.¹² Subsequently he proposed that the motorway speed limit be increased to 80mph.¹³ When the Strategic Framework for Road Safety was published in May 2011, there was disappointment among road safety groups at what the Framework omitted and how far it had strayed from identified international and previous national best practice and the promotion of evidence-based approaches.¹⁴
12. The Strategic Framework for Road Safety identified road safety as a “*priority for the government...to maintain its record and build upon it.*” It made clear, however, that it should be understood as working within the overarching priority of allowing the government to “*restore the public finances and return the economy to sustainable and secure economic growth.*” The Framework states that the Government’s “*long term vision is to ensure that Britain remains a world leader on road safety...our aim is [also] to reduce the relatively high risk of some groups more quickly, such as cyclists and children in deprived areas.*”¹⁵
13. The key themes of the Framework are education and enforcement – making it “*easier for road users to do the right thing*” and to “*crack down on antisocial...driving that still leads to far too many fatalities and serious injuries*”. The Framework also stated that there would be more local and community decision-making, assisted by the provision of local information to citizens to enable them to challenge priorities. The Government would also help build capability in the road safety community through better tools to support road safety professionals. “*wherever possible,*

¹⁰ DH, *Healthy Lives, Healthy People*, 2010, p.4

¹¹ DfT, *Road Safety: The next steps*, 1987 and DfT, *Tomorrow's Roads: Safer for everyone*, 2000.

¹² David Millward, *Coalition Government: Transport Secretary Phillip Hammond ends Labour's 'war on motorists'*, 2010

¹³ Melissa Kite, Deputy Political Editor, The Mail, ‘*Motorway Speed limit could be raised to 80mph*’, 2011

¹⁴ PACTS evidence to Transport Select Committee, *Submission to the Inquiry into the Road Safety Framework*, 2011

¹⁵ DfT, *Strategic Framework for Road Safety*, 2011, p.3-11

[the] local authority should have the freedom to make their own decisions on road safety” in order to provide the best solutions to suit both their environment and infrastructure.¹⁶

14. Specific measures proposed were changes to drink and drug drive legislation, tackling uninsured and unlicensed driving, and the introduction of a fixed penalty offence for careless driving. In addition, the Framework outlined plans to improve training for drivers and riders, develop a new post-test vocational qualification and develop more targeted and effective marketing of safety.

Measuring progress

15. Road safety is often measured in terms of the number of people killed or injured on the roads; and reductions in the number of casualties imply increased safety. Transport safety practitioners and others tend to prefer to measure safety by means of casualty rates – casualty numbers relative to exposure – rather than the absence of casualties alone. Exposure is usually measured by distance travelled (per million vehicle or passenger kilometres) or population. Where data allow, casualty rates may also be measured by the number of trips or hours of exposure. Progress can be measured against targets, trends or comparators.
16. Transport users have their own individual and subjective perceptions of the safety of the system. These do not necessarily correspond to population-based casualty numbers or rates. For example, most people appear to think that cycling is more dangerous than walking. Yet the fatality rates are very similar: in 2012 there were 38 pedestrian deaths and 38 cyclist deaths per billion miles walked or cycled.¹⁷ This does not mean that they are mistaken: different ages, traffic skills, routes, behaviours and other factors may explain these differences. It also shows the difficulties of measuring “safety” in terms of final casualty outcomes, although intermediate outcomes, such as mean speeds, are a relatively easy means of measuring road safety.
17. Strategic Framework for Road Safety recognised some of the complexity and established a set of indicators, an “Outcomes Framework”, to measure changes both in safety and in casualty numbers.¹⁸ These included six key indicators (casualty numbers and casualty rates for key road user groups). It was supplemented by a more comprehensive list of indicators, including proportions of drivers exceeding drink-drive limits or speed limits, and perceptions of road safety when walking or cycling. *“These are designed to help Government, local organisations and citizens to monitor progress towards improving road safety and decreasing the number of fatalities and serious injuries on Great British roads.”* These indicators (where available) are published annually in Reported Road Casualties Great Britain but Ministers seem to make very little use of the wider data set.
18. The Strategic Framework for Road Safety notes the linkages between road safety, sustainable transport and public health, and the potential for joined-up working: *“Making the links with other local agendas, such as public health and sustainable travel and helping to remove barriers to increasing walking and cycling, such as the use of a new indicator on perceptions of road safety.”* The Local Sustainable Transport Fund (LSTF) is highlighted as a source of funding and it also suggests that road safety schemes might be funded from the dedicated public health grant, noting that *“The number of casualties killed and seriously injured on English roads is included as an indicator in the public health outcomes framework.”* It also states that *“There can be benefits for those who choose to make cycling and walking journeys, as well as benefits for society – the annual cost to the NHS as a result of inactivity is estimated at between £1bn and £1.8bn.”* However, this comes with the somewhat opaque rider that *“Road safety is only one contributor to the health of the nation and needs to be considered in a wider perspective.”* In the Framework

¹⁶ Philip Hammond, MP, Secretary of State for Transport, *Strategic Framework for Road Safety*, 2011, p.3.

¹⁷ DfT, [Facts on Cycling Safety](#), December 2013

¹⁸ DfT, *Strategic Framework for Road Safety*, 2011, Annex B

the terms “sustainability” is also frequently used with reference to restoring government finances – an overriding consideration.¹⁹

Casualty trends

19. The headline measure of progress in road safety tends to be the reduction in the total number of people killed or seriously injured (KSI). The long-term reduction in KSI has continued with a steep decline in the number of deaths in recent years – 45% between 2006 and 2012 (see Tables and Figures 1 & 2). Similar trends have been observed in many other countries and the global financial crisis has been identified as a major contributory factor.²⁰
20. The decline in casualties has not been uniform for all road user groups. The number of cyclists sustaining serious injury has increased steadily since 2004 while serious injuries to pedestrians have declined far less than those to car occupants and have increased in 2011 and 2012. (See Table 2.) While the increase in cyclist casualties is broadly in line with the increase in cycle use,²¹ the increase in pedestrian casualties is harder to explain in terms of the available data. Motor cyclist casualties, particularly deaths, have declined since 2007 but the casualty rate (per distance travelled) remains very high. This is problematic in relation to promoting sustainable transport. In addition, young and older drivers are overrepresented in casualty statistics in relation to the amount that they drive.
21. By way of comparison with the safety of other transport modes, there has not been a passenger killed on board a train on GB railways since 2007 and the rail industry is focusing more resources on the safety of passengers at train-platform interface, level crossing safety, track worker safety and work-related driving (on the road) by railway staff.²²

The local authority’s statutory responsibility

22. Most roads in Great Britain fall under the responsibility of the local authorities. The Highways Agency is responsible for motorways and trunk roads in England which account for 2% of the road length in England. Much of the trunk road network in England was “de-trunked” and responsibility for it transferred to local authorities under the last Government. In Northern Ireland all roads are the responsibility of the Department of Environment Northern Ireland.
23. Under the Road Traffic Act 1988, local authorities have a statutory responsibility for road safety. Section 39 of the Act requires local authorities to undertake studies into the occurrence of accidents on their roads, to take appropriate remedial measures and to design new roads to reduce the possibility of accidents. They can employ education, training and engineering responses. However, the legal minimum level of activity is not specified in the Act and has not been tested in the courts. Road safety, like many public services, has been going through a period of change since the 2010 general election due to austerity measures. The PACTS report series “Tackling the Deficit” showed how the local road safety community was being depleted and aspirations for improving road safety were diminishing due to spending cuts and the ring-fencing of funding for other services with clearer statutory requirements, such as child protection and adult social care.²³

¹⁹ DfT, *Strategic Framework for Road Safety*, 2011, pp.9, 31 and 37

²⁰ Louise Lloyd, Caroline Reeves, Jeremy Broughton and Jennifer Scoons, TRL, [Published Project Report PPR663: Investigating the reduction in fatal accidents in Great Britain from 2007-2010](#), 2013

²¹ DfT, [Facts on Cycling Safety](#), December 2013,

²² Office of Rail Regulation, [Health and Safety Report 2013](#), 2013, p.36

²³ PACTS, [Tackling the Deficit 2: Where next for road safety?](#), 2011

The Local Authority's Statutory Duty for Road Safety

The Road Traffic Act 1988, Section 39, states:

(2) Each local authority must prepare and carry out a programme of measures designed to promote road safety and may make contributions towards the cost of measures for promoting road safety taken by other authorities or bodies.

Without prejudice to the generality of subsection (2) above, in pursuance of their duty under that subsection each local authority –

(3a) Must carry out studies into accidents arising out of the use of vehicles on roads.

(3b) Must, in the light of those studies, take such measures as appear to the authority to be appropriate to prevent such accidents, including the dissemination of information and advice relating to the use of roads, the giving of practical training to road users or any class or description of road users, the construction, improvement, maintenance or repair of roads for the maintenance of which they are responsible and other measures taken in the exercise of their powers for controlling, protecting or assisting the movement of traffic on roads, and

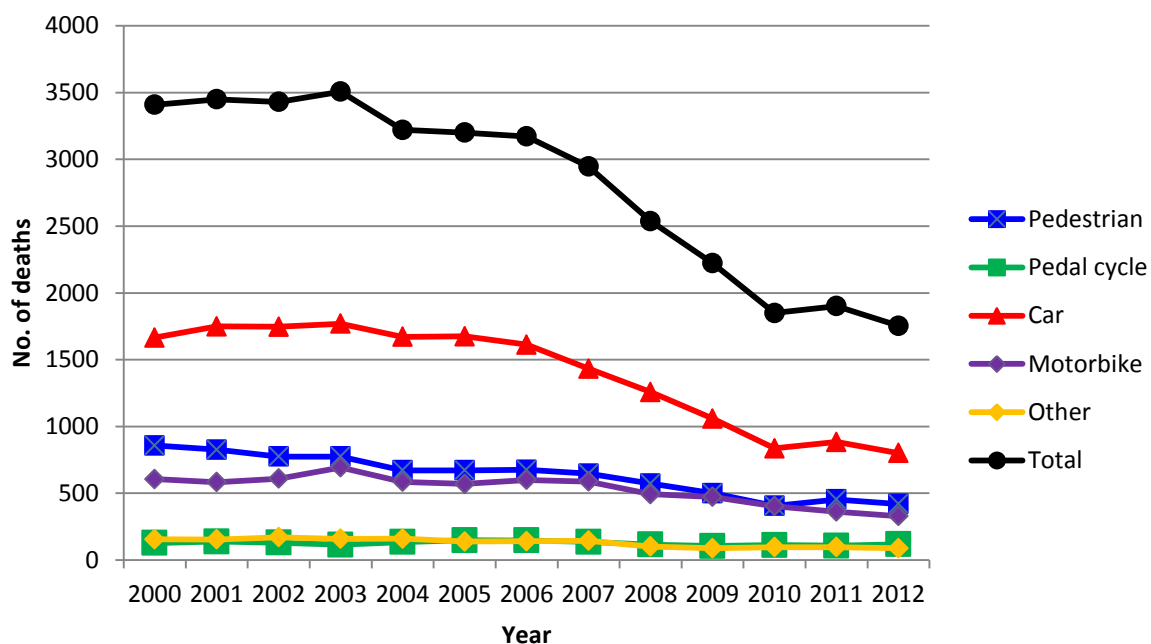
(3c) In constructing new roads, must take such measures as appear to the authority to be appropriate to reduce the possibilities of such accidents when the roads come into use.

Road user type	Table 1. Deaths by road user type (Great Britain, 2000-2012)												
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Pedestrian	857	826	775	774	671	671	675	646	572	500	405	453	420
Pedal cycle	127	138	130	114	134	148	146	136	115	104	111	107	118
Car	1,665	1,749	1,747	1,769	1,671	1,675	1,612	1,432	1,257	1,059	835	883	801
Motorbike	605	583	609	693	585	569	599	588	493	472	403	362	328
Bus	15	14	19	11	20	9	19	12	6	14	9	7	11
HGV	55	54	63	44	47	55	39	52	23	14	28	28	29
LGV	66	64	70	72	62	54	52	58	43	36	34	34	33
Other	19	22	18	31	31	20	30	22	29	23	25	27	14
Total	3,409	3,450	3,431	3,508	3,221	3,201	3,172	2,946	2,538	2,222	1,850	1,901	1,754

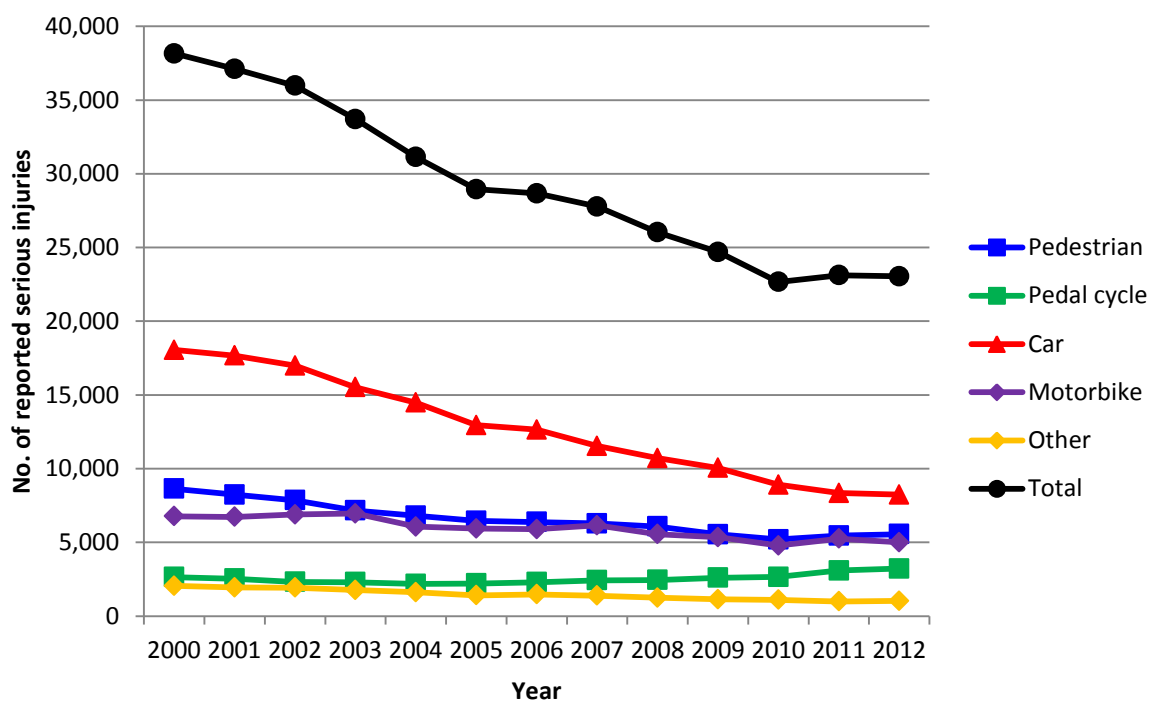
Road user type	Table 2. Reported serious injuries by road user type (GB, 2000-2012)												
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Pedestrian	8,641	8,238	7,856	7,159	6,807	6,458	6,376	6,278	6,070	5,545	5,200	5,454	5,559
Pedal cycle	2,643	2,540	2,320	2,297	2,174	2,212	2,296	2,428	2,450	2,606	2,660	3,085	3,222
Car	18,054	17,675	16,981	15,522	14,473	12,942	12,642	11,535	10,711	10,053	8,914	8,342	8,232
Motorbike	6,769	6,722	6,891	6,959	6,063	5,939	5,885	6,149	5,556	5,350	4,780	5,247	5,000
Bus	563	548	532	489	468	354	407	443	426	356	392	325	312
HGV	516	446	461	385	359	340	344	311	217	175	184	167	169
LGV	747	747	710	693	569	533	512	436	402	381	325	306	330
Other	222	194	225	203	217	176	211	196	202	224	205	196	215
Total	38,155	37,110	35,976	33,707	31,130	28,954	28,673	27,774	26,034	24,690	22,660	23,122	23,039

Source: Department for Transport, Reported Road Casualties Great Britain, [Tables RAS30064](#), [RAS30065](#), [RAS30069](#)

**Figure 1. Deaths by road user type
(Great Britain, 2000-2012)**



**Figure 2. Reported serious injuries by road user type
(Great Britain, 2000-2012)**



Source: Department for Transport, Reported Road Casualties Great Britain, [Tables RAS30064](#), [RAS30065](#), [RAS30069](#)

Sustainable transport

The local sustainable transport white paper

24. Within days of coming to power in 2010, the Prime Minister David Cameron announced that he wanted the Coalition Government to be the “greenest government ever”. In January 2011, the DfT published the white paper *Creating Growth, Cutting Carbon: Making Sustainable Local Transport Happen* and announced the associated Local Sustainable Transport Fund. Both focused on two “key government objectives: *“to help create growth in the economy, and to tackle climate change by cutting our carbon emissions”*. The white paper also stated that local action on sustainable travel choices would contribute to improvements in road safety and in public health. *Sustainable transport can also influence the quality of our lives, the air we breathe, how healthy and fit we are, the money in our pockets and how long we spend in traffic queues – as well as the pleasantness of our environment and public spaces....Encouraging sustainable travel choices does not just help create economic growth and cut carbon, but also contributes to improvements in road safety and in public health.*²⁴
25. Sustainable transport is a widely used term although it has no rigorous definition. It is generally used to describe transport which is less harmful in terms of carbon emissions, air quality and (sometimes) risk distribution among road users. It may also have health and social-justice aspects. This could include transport modes:
- with zero or negligible emissions, such as walking or cycling (active travel);
 - which offer an alternative to higher emission-modes, as does public transport;
 - modes which use technology to significantly reduce emissions, such as electric or hybrid vehicles.
26. The white paper *Creating Growth, Cutting Carbon* does not define sustainable transport but by implication sustainable transport is that which reduces carbon and generates economic growth and jobs, while providing long-term congestion and health benefits. In the white paper, local sustainable transport focuses on behaviour change – converting short car trips to walk, cycle or bus – rather than technology solutions such as low carbon vehicles.
27. Motorcycling could be considered a more sustainable mode than private car use: on average motorcycling has lower CO₂ emissions per mile travelled and requires less road space. It does not have the health benefits of walking or cycling but it may be more practical for longer journeys and more accessible than public transport in rural areas. Generally, however, motorcycling has not featured significantly in LSTF consideration of sustainable transport and successive governments have been reluctant to promote motorcycling for transport because of the high casualty rates.

Sustainability legislation

28. Sustainability, including sustainable transport, is covered by a number of pieces of legislation.
- The Climate Change Act 2008 imposes legal obligations on government to reduce emissions of greenhouse gases (carbon dioxide, nitrogen dioxide, methane, hydrofluorocarbons and perfluorocarbons);

²⁴ DfT, *Creating Growth, Cutting Carbon, Making Local Sustainable Transport Happen*, Cm 7996, 2011, p.5.

- EC Air Quality Framework Directive (96/62/EC) and subsequent daughter directives set legally binding air quality standards for the UK, addressed by the DEFRA 2007 *Air Quality Strategy*;²⁵
- The Education and Inspections Act 2006 places a duty on local authorities in England to promote sustainable travel modes for school travel;
- The Greater London Authority Acts 1999 and 2007 imposed various general environmental, social and economic sustainability duties on the Mayor and the GLA; in England, outside London, there is however no over-riding statutory duty for local authorities to promote sustainability;
- The Active Travel (Wales) Act 2013 requires local authorities in Wales to encourage and improve facilities for active travel.

Local authority duty to promote sustainable school travel

The Education and Inspections Act, 2006 (Section 508A) places a duty on local education authorities in England to promote the use of sustainable travel modes to and from school. The Act has four main requirements: an assessment of the travel and transport needs of children and young people in the authority area; an audit of the sustainable travel and transport infrastructure within the authority that may be used when travelling to and from, or between schools and institutions; a strategy to develop the sustainable travel and transport within the authority, so that the needs of children and young people are better cared for; and the promotion of sustainable travel and transport to, from and between schools and institutions. [tbc Adrian]

<http://www.legislation.gov.uk/ukpga/2006/40/section/76>

Local Sustainable Transport Fund

29. The white paper *Creating Growth: Cutting Carbon* was supported by the announcement of the Local Sustainable Transport Fund, which provided £560 million of revenue and capital funding between 2011 and 2015 (£350 million in revenue, £210 million in capital) to enable local authorities to support sustainable measures that boost economic growth and reduce carbon emissions. The white paper and related funding emphasised the importance of the localism agenda in promoting sustainable travel. The LSTF can be seen as building on the Sustainable Travel Demonstration Towns programme.²⁶ (See case studies.)

30. In this report we have focused on local sustainable transport schemes and policies - the types covered by *Creating Growth: Cutting Carbon* and the LSTF. We are aware however that other important initiatives are underway at national or international level, such as promotion of electric cars, the low carbon vehicle partnership (LCVP), rail electrification, support for greener buses, and a tightening of CO₂ emission standards by the EC for car sales in the EU. These are essentially aimed at reducing carbon emissions through technological improvements – with some success. The average new car sold in 2013 emitted 128.3g/km CO₂, almost 30% down on 2000.²⁷ These may also have important health benefits through reduced air pollutants but generally do not promote active travel.

²⁵ DEFRA, *The Air Quality Strategy for England, Scotland, Wales and Northern Ireland Vol.1*, p.7

²⁶ DfT, *Sustainable Travel Demonstration Towns, Part IV, Ch.18*, 2010

²⁷ Low Carbon Vehicle Partnership, *'Average UK new car CO₂ emissions down 3.6% in 2013; target for 2015 achieved early'*, 13th March 2014

Beyond LSTF

31. The LSTF has given a significant boost to walking and cycling schemes, particularly during a period of austerity and cuts in local government spending. The Cycle Safety and Cycle City Ambition grants have further boosted spending on cycling. However, it would be wrong to assume that all is well for sustainable transport. An analysis by the Campaign for Better Transport and CPRE of the spending plans of the recently established Local Transport Bodies found that while some were proposing packages of schemes to support sustainable development, others were not. On average, the 37 plans scored only 3.2 out of 10 for “sustainability” with 8 Local Transport Bodies scoring only 1. There was some allocation for walking and active travel (£65m for 6 schemes) but nothing for cycling. In total £442m was proposed for sustainable transport schemes (33% of the total).

Some [Local Transport Bodies] have made choices in a transparent way, seeking out local views and considering a full range of transport modes. This has led to balanced and imaginative packages of projects to support local economies and reduce car dependency, building on the good work of the Local Sustainable Transport Fund....Others have been less forward thinking. Several have adopted closed decision-making processes and there is a tendency to favour road building and widening over more cost effective options.²⁸

32. The government’s wider policies and spending priorities are not seeking to reduce car-dependency. The National Planning Policy Framework replaces previous policies which required or promoted travel plans and restrictive car parking standards. Town centre car parking, even on yellow lines, is being promoted by the Department for Communities and Local Government (DCLG). The Chancellor has suspended increases in VED and announced the largest ever road building programme (in financial terms) for twenty years. In the October 2013 ministerial reshuffle, roles were also amended: whereas outgoing Transport Minister Norman Baker MP had responsibility for “sustainable travel (including walking and cycling)” and “alternatives to travel”,²⁹ his successor Robert Goodwill has simply “walking and cycling”. As the recession ends, traffic growth and rising car sales have returned. While rail use continues to grow strongly, bus use continues to decline and there is little sign of reduced car dependency. The DfT’s national traffic model forecasts increased traffic growth of 40% by 2040. London is the exception where car dependency may be decreasing.³⁰
33. Recent planning guidance from the Department of Communities and Local Government has emphasised the duty of planning authorities to consider health and wellbeing in local and neighbourhood plans and in planning decision making and to work with public health organisations.³¹

²⁸ Campaign for Better Transport and CPRE, [Where’s the money going? Local Transport Body Plans](#), 2013

²⁹ [DfT website](#) 2013

³⁰ TfL, [Travel in London- Report 6](#), 2014

³¹ DCLG, Planning Practice Guidance, [Health and Wellbeing](#), Revision 6 March 2014

The European Commission Paper on Sustainable Travel

The 2009 European Commission (EC) Paper on *A Sustainable Future for Transport* maintained the importance of establishing a system that would meet “society’s social, economic and environmental needs” and be “conducive to an inclusive society”. Due to the increasing concerns surrounding sustainability and air quality, the EC argued that the priority remained “a better integration of the modes of transport” and “full interoperability” along with the development of technology to match the public need.³²

Brussels has identified sustainable travel as key to improvements in environmental quality and ultimately to the state of European connectivity.

Travel trends

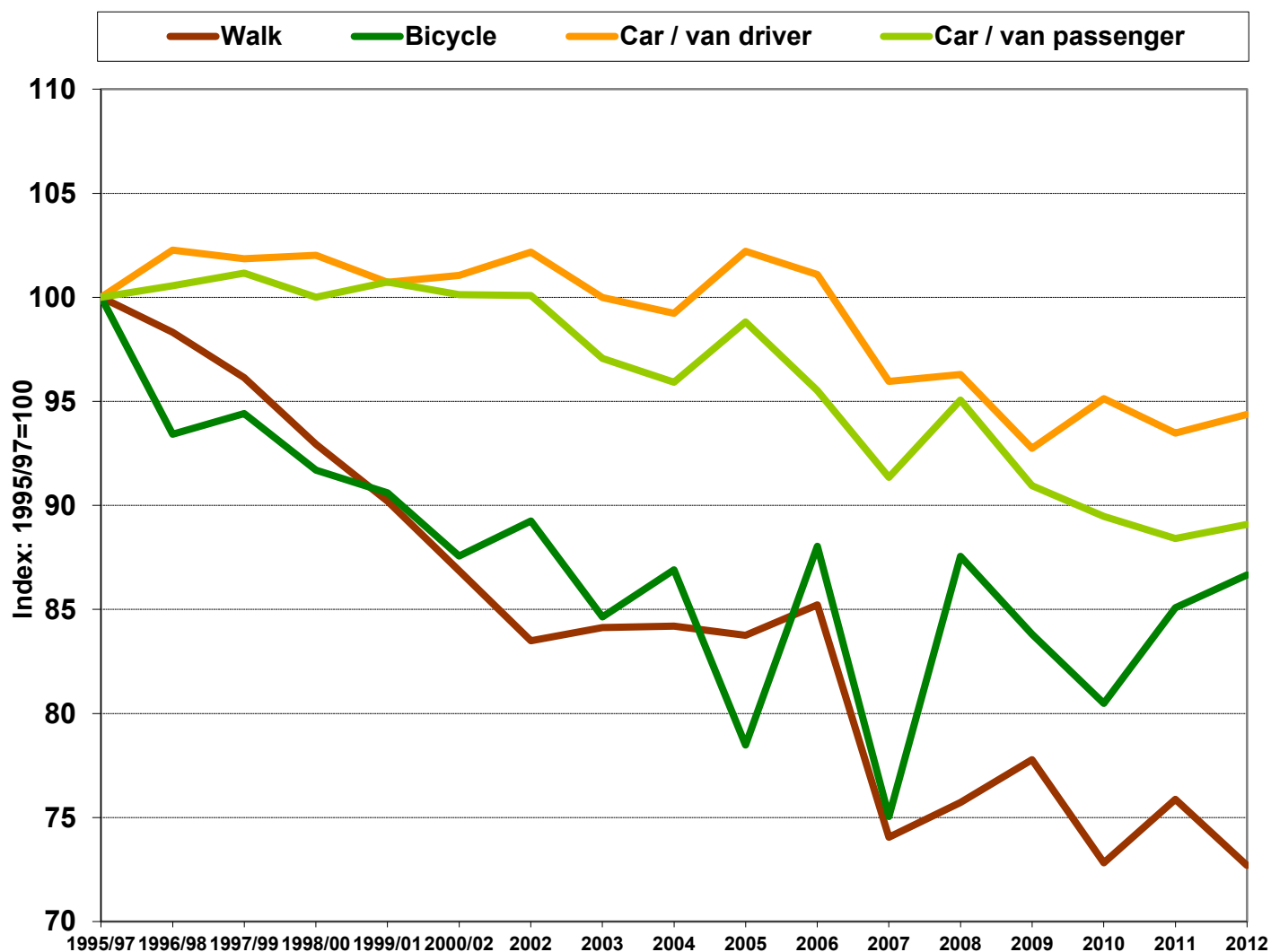
34. Despite the recent increases in cycling (mainly since 2006), the longer-term trends in active travel are not encouraging (see Figure 3).³³ The number of walk and cycle trips fell by a quarter between 1995/97 and 2012 (although cycle *mileage* rose by 23%). Travel to school by car has increased while walking to school has declined. Bus and rail trips often involve walking and so may have health benefits: outside London bus use declined by 17% while rail trips increased by 66%. Trends in London are different: cycling, bus and rail use have all increased and London is the only region in Great Britain where the percentage of households without a car has increased.
35. A separate study found that only 25% of primary school children in England are allowed to travel home from school alone, compared with 86% in 1971. Primary school children in Germany are allowed considerably more independence.³⁴

³² European Commission, [A Sustainable Future for Transport](#), 2009

³³ DfT, [National Travel Survey: 2012](#), September 2013

³⁴ Policy Studies Institute, [Children’s Independent Mobility in England and Germany, 1971-2010](#), 2013

**Figure 3: Average number of trips by selected private transport modes - index:
Great Britain, 1995/97 to 2012**



Source: DfT, National Travel Survey, 2013

Public health

36. Public health refers to policies and interventions to protect and promote good health and well-being, in some cases providing expert treatment and in others actively seeking to pre-empt health issues via strategic thinking. Public health policy revolves around prevention of illness, promotion of awareness of dangers to health and protection of the vulnerable. Healthcare services are estimated to contribute to one third of life-expectancy improvements whereas changing people's lifestyles and removing health inequalities contribute to two-thirds.

The health challenges and trends

37. The Government acknowledges the scale of the public health challenges, and highlights key issues, although road traffic casualties are not highlighted:

*We have to be bold because so many of the life-style driven health problems we see today are already at alarming levels. Britain is now the most obese nation in Europe. We have the worst rates of sexually transmitted infections recorded, a relatively large population of problem drug users and rising levels of harm from alcohol. Smoking alone claims over 80,000 lives every year. Experts estimate that tackling poor mental health could reduce our overall disease burden by nearly a quarter. Health inequalities between rich and poor have been getting progressively worse. We still live in a country where the wealthy can expect to live longer than the poor.*³⁵

38. In public health, the scale of a health problem is often measured in terms of disability adjusted life years (DALYs) lost. In the UK in 2010, 835,000 (5%) DALYs were attributable to physical inactivity and low physical activity while 311,000 (2%) were attributable to road transport injuries.³⁶ Childhood obesity is an increasing problem, as illustrated in Figure 4.
39. Some of these problems, particularly obesity and poor mental health, can be alleviated by active travel. A survey by the British Heart Foundation found that eight in ten thirteen year olds did not engage in the recommended levels of physical activity. One in three children were classed as overweight upon leaving primary school, with the prospect that children today might "die younger than their parents."³⁷
40. Poor air quality, often resulting from traffic emissions, is also a cause of serious health ill-health.

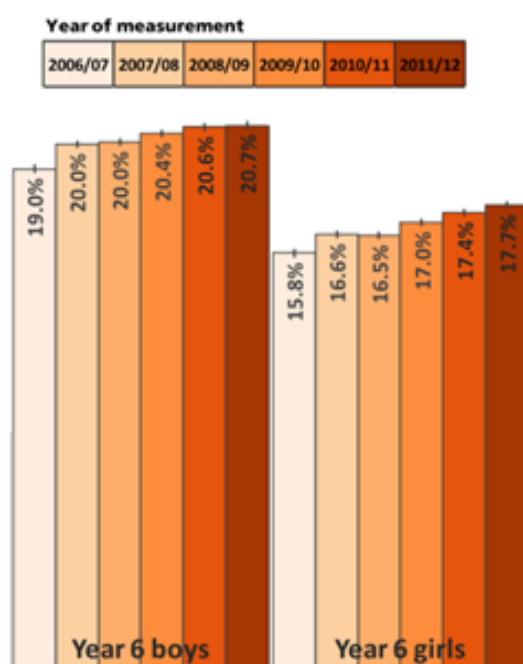
In Greater London it is estimated at in 2008 there were over 4,000 'death brought forward' attributable to long term exposure to small particles [PM10s].

³⁵ DH, *Healthy Lives, Healthy People: Public Health Strategy*, 2010, p.7

³⁶ UK health performance: findings of the Global Burden of Disease Study 2010, *The Lancet*, Vol 381 March 23, 2013, pp997-1020

³⁷ Chris Smythe, 'Obesity will send today's children into an early grave', *The Times*, 12 August 2013

Figure 4. Prevalence of childhood obesity in Year 6 boys and girls, 2006/07-2011/12



Source: National Obesity Observatory, *National Child Measurement Programme, [Changes in children's BMI between 2006/07 and 2011/12](#)*, February 2013

Policy framework

41. The Department of Health's 2010 Command paper *Healthy Lives: Healthy People: Public Health Strategy* set out the Coalition Government's key policy aims for public health:

- Protecting people from serious health threats;
- Helping people live longer, healthier and more fulfilling lives; and
- Strong development in the poorest areas.³⁸

42. Public health is, in the Government's view, a shared responsibility: it is "*simply not possible to encourage healthier lifestyles through Whitehall Diktat*" and promotes a more localised approach.³⁹ It is accompanied by significant institutional change (see below).

43. The strategy is the Government's response to Professor Sir Michael Marmot's *Fair Society, Healthy Lives* report⁴⁰ - the "Marmot review", often described as highlighting the "causes of causes". It points to local environments and income inequalities as the key determinants of public health and is sceptical about the potential to improve health for those most in need without tackling the more fundamental causes of ill-health.

Institutional framework

44. There has been significant institutional change in the NHS and public health under the present Government. From the 1st April 2013, the Health Protection Agency, Regional Public Health Groups and Health Observatories were merged into Public Health England, an executive agency

³⁸ DH, *Healthy Lives, Healthy People: Public Health Strategy*, 2010, p.7

³⁹ DH, *Healthy Lives, Healthy People: Public Health Strategy*, 2010, p.2

⁴⁰ Marmot, M. [Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010](#), 2010

of the Department of Health. Public health at a local level is now managed by local authorities, overseen by their newly-established Health and Wellbeing Boards which are required to consider priorities set locally (Joint Strategic Needs Assessment) and nationally (Public Health Outcome Framework) when deciding on their local public health actions.

45. Established under s194 of the *Health and Social Care Act 2012*, Health and Wellbeing Boards are designed to provide a forum within which key leaders from the health and care system are able to work together in order to improve the health and well-being within their districts whilst reducing health inequalities. A key aspect of broader plans to modernise public health, these boards will hold a strong influence over commissioning, localisation and joined-up working. They are designed to give communities a greater say in understanding and addressing local health care needs. The Health and Wellbeing Boards are required to consider priorities set locally (Joint Strategic Needs Assessment) and nationally (Public Health Outcome Framework) when deciding on their local public health actions.

PHOF and JSNAs

46. Two key documents in the new arrangements for public health are the Public Health Outcomes Framework (PHOF) and Joint Strategic Needs Assessments (JSNAs).
47. The Public Health Outcomes Framework (PHOF) sets out the desired outcomes for public health and how they will be measured. The PHOF for 2013-2016, updated in November 2013, reiterates the Government's philosophy to public health that the *"The responsibility to improve and protect our health lies with us all – government, local communities and with ourselves as individuals."*⁴¹ It highlights the importance of two factors: increasing healthy life expectancy and removing the inequalities in healthy life expectancy. The framework specifies annual indicators for public health nationally and regionally. Rather than setting "top-down targets" it emphasises achieving locally-determined priorities, guided by the PHOF. This contains indicators relating to transport, including the number of people killed and seriously injured on roads, older people's perception of safety and physical inactivity as well as obesity and self-reported well-being.
48. Joint Strategic Needs Assessments (JSNAs) are documents that analyse the health needs of local populations, to inform and guide the commissioning of health, well-being and social services within the local authority area. The JSNAs are designed to underpin the health and well-being strategies and commissioning plans. The main purpose of a JSNA is to assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities. The NHS and upper-tier local authorities have had a statutory duty to produce an annual JSNA since 2007.⁴²
49. An analysis of 40 JSNAs by the Royal Society for the Prevention of Accidents (RoSPA) found that the coverage of road safety was mixed. Half had no explicit section on road safety and, while some were "excellent" others were short and contained very little detail. RoSPA concludes that:
- Road safety activities can be integrated with wider public health work by considering it alongside healthy transport and efforts to increase physical activity. Joint Strategic Needs Assessments should include road safety.*⁴³

⁴¹ DH, [Improving outcomes and supporting transparency. A public health outcomes framework for England, 2013-2016](#), November 2013

⁴² NHS Confederation, [The Joint Strategic Needs Assessment](#), 2011

⁴³ RoSPA, [Road safety and public health](#), 2014

Public health arrangements in the devolved administrations

Public Health Wales is an NHS Trust and provides specialist public health advice and services in support of many organisations across Wales. Its principal stakeholders includes the:

- Welsh Government
- Seven Health Boards in Wales
- Two other NHS Trusts in Wales
- 22 Local Authorities in Wales

The Public Health Wales board published a five year strategy in 2010 setting out strategic objectives including:

- *Improve health and reduce health inequalities by addressing the social, economic and environmental factors which determine people's health*
- *Promote healthy behaviour.*⁴⁴

In 2011, the Public Health Strategic Framework was published, setting out priorities for public health in Wales for the next 18 – 24 months.⁴⁵

NHS Health Scotland is Scotland's national agency for reducing health inequalities and improving health. A central part of its work lies in supporting Health Boards to achieve their health improvement targets, as set by the Scottish Government and laid out in their local delivery plans.

A Fairer Healthier Scotland, the strategy from 2012 to 2017, sets out the role, direction and priorities of NHS Health Scotland for the next five years.⁴⁶

Joined-up agendas?

50. In this chapter we have set out the current policy frameworks and highlighted some areas where there are synergies between the three sectors. We summarise our findings in Table 3.

51. It is evident that transport and public health bodies locally and centrally are growing increasingly concerned about obesity and this is driving sustainable transport initiatives. Though it is not a new concern, there have been a number of recent publications from the health sector recognising the impact that the transport sector has on public health, and urging changes to be made. For example:

- BMA: *"...transport's impact on health has become unnecessarily harmful, to the point where it is a significant cause of morbidity and mortality."*⁴⁷ This harmful impact refers not only to direct impacts such as casualties and pollution, but also indirectly to health problems relating to air pollution and physical activity deficiency.
- TfL: if physical inactivity trends continue, 90% of the adults in London will be obese by 2050, as the children grow-up in a city "where it is normal to be obese."⁴⁸

52. A major driver for public health is the priority to reduce health inequalities. This has clear linkages to the priority in the road safety Framework to prioritise casualty reduction for children in deprived areas. Children from deprived households suffer greater levels of ill-health and higher pedestrian casualty rates than children from wealthier households.

⁴⁴ NHS Wales, [Public Health Wales: Five year Strategy](#), 2010

⁴⁵ NHS Wales, [Delivering a Five-Year Service, Workforce and Financial Strategic Framework for NHS Wales](#), 2010

⁴⁶ NHS Health Scotland, [A Fairer, Healthier Scotland: Our Strategy 2012-2017](#), 2012

⁴⁷ BMA, [Healthy transport = healthy lives](#), 2012

⁴⁸ TfL, [Roads Task Force - Tactical Note 20: What are the main health impacts of roads in London?](#), 2012, pp.2-3

53. The road safety sector is also increasingly aware of public health and sustainable transport issues. Links between road safety, sustainability and public health are increasingly recognised at international level. An “integrated approach to road safety” is one of the three top principles in the European Commission’s Road Safety Policy Orientations 2011-2020. The European Commission states that:

*The future road safety policy should be taken into account in other policy fields of the EU, and it should take the objectives of these other policies into account. Road safety has close links with policies on energy, environment, employment, education, youth, public health, research, innovation and technology, justice, insurance, trade and foreign affairs, among others.*⁴⁹

54. On the other hand, the public health sector seems to be less focused on road safety than the casualty numbers might suggest. This contrasts with the international situation. At the UN Rio+20 Summit in 2012, governments agreed that safe and sustainable transport needed to be an essential component of development strategy. Road traffic deaths and injuries represent a worsening global public health epidemic. There is an opportunity to include road safety in the Sustainable Development Goals which replace the Millennium Development Goals in 2015.”⁵⁰

London – an example of joined up delivery.

London is unique and has many attributes that do not apply to other cities or devolved administrations in the UK. However, it is instructive to see how it is tackling the issues of road safety, sustainable transport and public health, both separately and jointly.

Road safety. The London road safety action plan Safe Streets for London contains an ambitious target to reduce KSIs by 40% by 2020 from a 2005-2009 baseline. The plan is focused on outcomes and based on a Safe System approach. It prioritises safety for vulnerable road users as they account for 77% (in 2011) of KSIs but warns against a “victim blaming approach”. It states that “*Casualty reduction needs to be considered within the wider context of health policy, including public health.*”

Sustainable transport. Within a context of support for an extensive public transport system, the Mayor has set a target to increase cycle use by 400% between 2001 and 2026. Many initiatives and funding streams are underway to support this including expansion of the public Bike Hire scheme, safety improvements to the Cycle Superhighways, new “mini-Hollands” and “Quietways” and free “Bikeability” cycle training for all school children. Walking is being encouraged through improved information, including Legible London, improvements to the public realm and countdown facilities at pedestrian crossings.

Public health. The statutory responsibility for public health in London lies with London Boroughs. However, the Mayor of London has also taken a pro-active approach. Transport for London (TfL) has published what it claims to be the world's first transport health action plan. This seeks to increase physical activity, reduce the impacts of road traffic collisions and traffic noise and improve air quality. It notes that “*Road traffic injuries account for a very small proportion of all poor health and deaths in London....However, fear of road traffic injury is the leading reason people give for not walking or cycling...*”⁵¹

⁴⁹ EC, [Towards a European road safety area: policy orientations on road safety 2011-2020](#), 2010

⁵⁰ Kevin Watkins, [Safe and Sustainable Roads: The Case for a Sustainable Development Goal](#), 2011

⁵¹ TfL, [Improving the health of Londoners. Transport Action Plan](#), February 2014

Table 3. Summary of existing national policy frameworks for road safety, sustainable transport and public health					
	Long term vision and main aims	Motivations	Strategy	Indicators	Sources
Safety	<p>Ensure that Britain remains a world leader in road safety.</p> <p>Continue to reduce the number of people killed and seriously injured on Britain's roads.</p> <p>Take into account the modal shifts occurring in order to reduce the increasing number of cyclist collisions on the roads.</p>	<p>Personal loss</p> <p>Social impact</p> <p>Perception of failure</p> <p>Public calls for response</p> <p>Economic impact</p> <ul style="list-style-type: none"> - emergency and health costs - insurance pay outs - impact of collisions and incidents on congestion, reliability and resilience 	<p>Improving road safety together: empowering local citizens and local service providers away from centralised policy and catering for regional differences.</p> <p>Education: developing skills and attitudes, advice to road users, educational interventions for offenders</p> <p>Targeted enforcement and sanctions: drink and drug driving, careless driving, etc.</p> <p>Make it "easier for road users to do the right thing".</p>	<p><u>Key indicators:</u></p> <p>Number of road deaths (& rate per billion vehicle miles (pbvm))</p> <p>Rate of motorcyclist deaths pbvm</p> <p>Rate of car occupant deaths pbvm</p> <p>Rate of pedal cyclist deaths pbvm</p> <p>Rate of pedestrian deaths pbvm</p> <p>Number of deaths resulting from collisions involving drivers under 25</p> <p><u>Others include:</u></p> <p>Perceptions of road safety, feeling safe walking and cycling</p> <p>Ensure deprived living areas do not experience a deprivation of safety.</p>	<p>DfT, <i>Strategic Framework for Road Safety</i> (2011)</p> <p>Additional strategies in devolved administrations</p>

Sustainable travel	<p>Living within environmental limits Ensuring a strong, healthy & just society (Sustainable Development Strategy, 2005)</p> <p>“Our vision is for a transport system that is an engine of economic growth, but one that is also greener and safer and improves quality of life in our communities.” (Creating Growth, Cutting Carbon 2011)</p> <p>80% reduction in CO₂ by 2050 (Climate Change Act 2008)</p> <p>“Outdoor Air Without Risk To Health” (Air Quality Strategy for England, Scotland, Wales and N. Ireland 2007)</p>	<p>Legal requirements:</p> <ul style="list-style-type: none"> • To reduce carbon • To comply with air quality standards • sustainable development duties (London) <p>Policies:</p> <ul style="list-style-type: none"> • Provide travel choice • Reduce car use for short journeys • Economic growth • Climate change • Protect the natural environment • Public health: increasing incidence of cardiovascular and respiratory diseases. 	<p>Focus on short trips, smaller-scale local schemes (LSTF).</p> <p>Make travelling on foot, by bike or on public transport more attractive.</p> <p>Make car travel greener by supporting the development of the low carbon vehicle market</p> <p>Increase the availability and accessibility of active transport through planning and infrastructure improvements.</p> <p>Improve education and awareness of sustainability and encourage journey planning amongst younger generations.</p> <p>Traffic management in areas experiencing extreme levels of congestion.</p>	<p>Levels of cycling Creating Growth, Cutting Carbon 2011</p> <p>Public transport use. Creating Growth, Cutting Carbon 2011</p> <p>Monitoring & evaluation of LSTF projects (eg. Travel patterns) LSTF Monitoring & Evaluation Framework 2012</p> <p>CO₂ emissions Climate Change Act 2008</p> <p>Levels of air pollutants, including:-</p> <ul style="list-style-type: none"> - Nitrous Oxide - Particulates - Sulphur Dioxide <p>Air Quality Strategy 2007</p>	<p><i>LSTF Monitoring and Evaluation Framework (2012); Creating Growth, Cutting Carbon: making Sustainable Local Transport Happen (2011); Climate Change Act (2008); Air Quality Strategy (2007).</i></p>
Public Health	<p>Improve healthy life expectancy Decrease health inequalities</p> <p>Improve the population’s lifestyles increasing health and well-being as a result</p>	<p>Recognition that causes of death are dominated by “diseases of lifestyle”</p> <p>Overweight and obesity</p> <ul style="list-style-type: none"> • 1 in 5 children • 2 in 3 adults 	<p>Improve local environment to make physical activity part of everyday life.</p> <p>Encourage a modal shift towards active transport or public transport.</p> <p>Protect the population from health threats</p> <p>Empower local leadership and local communities</p>	<ul style="list-style-type: none"> - Individuals killed and seriously injured on roads - Injuries in under 18s - Adult/childhood obesity - Physical inactivity - Air pollution - Population affected by noise - Social connectedness - Use of green space for exercise - Self-reported well-being - Falls & falls injuries – over 65s - Quality of life for older people - Number of cycle paths and the use they receive. 	<p>DoH, <i>Healthy Lives, Healthy People: Our strategy for public health in England</i> (2010)</p>

Chapter 3: Case Studies

Selection of case studies

55. In order to illustrate the policy intersections and possible synergies between transport safety, sustainability and health, four case studies were selected from the three policy areas (see Table 4).
56. The case studies are intended to show the degree to which schemes focused on one policy areas have delivered synergies or co-benefits for others. They were not chosen to (necessarily) illustrate good practice. They are all partly or mainly behaviour-change schemes. Two involve a significant degree of infrastructure provision.

Table 4. Principle objectives for the case study schemes

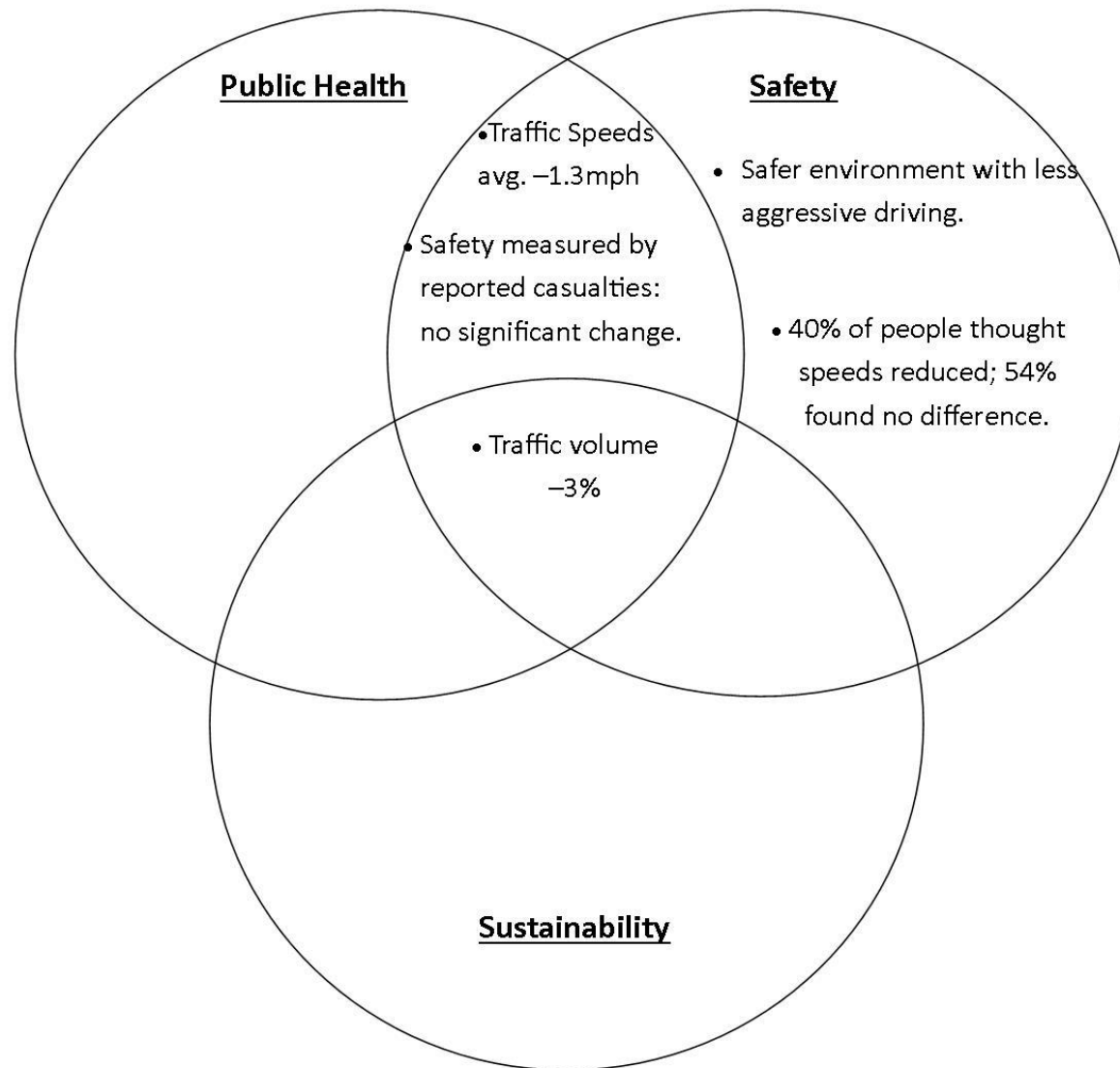
Scheme	Road safety	Sustainable transport	Public health
Portsmouth 20mph speed limit	Yes	-	-
Sustainable Travel Demonstration Towns		Yes	
Barclays Cycle Superhighways	Yes	Yes	
Change4Life			Yes

The Portsmouth 20mph speed limit scheme

57. The Portsmouth 20mph speed limit scheme was the first extensive, area-wide 20mph speed limit scheme in England. Unlike 20mph zones, the scheme did not involve new physical speed reducing measures to enforce the lower speed limits. It was intended to address actual and perceived safety issues associated with busy residential areas and inappropriate vehicle speeds. Portsmouth City Council had been planning a series of traffic calming zones over a longer period but launched the 20mph limit scheme on an experimental basis in the wake of a triple fatality on a main road in 2004. It was subsequently expanded to cover 410 km (94%) of the city's road length. The existing speed limit was 30mph and actual speeds were relatively low (below 30mph) before the limit was lowered to 20mph. The scheme was intended to be 'self-enforcing' without the need for cameras or extra police involvement. The Council sought support for the scheme through various channels, including neighbourhood forums, schools and the media.
58. Consultants Atkins undertook an interim evaluation of the scheme for the DfT in 2010, using data provided by the Council.⁵² Traffic speeds were measured at 223 sites in six sectors before and after implementation. Average speeds fell in all sectors, by an average of 1.3mph to 19.8mph. 19 sites, however, were found to still have average speeds between 24mph and 29mph. Annual counts suggested traffic had not re-routed systematically from the roads subject to 20mph limits to the main roads on the corridor.
59. A comparison was made of road casualties in the three years before and the two years after implementation. This found that casualties had fallen by around 41 (22%) from 183 per year to 142 casualties per year. This compared to a fall of 14% on similar roads nationally during the same period. The number of pedestrian casualties decreased by 7 (16%) per year after the 20mph limit came into effect and the number of pedal cyclists casualties by 6 (15%). Despite the overall fall, there was a slight rise of 2.5 (6%) in the average number of total casualties seriously injured – from 30 to 33 per annum – compared with a 15% decline nationally.
60. The Council's main objective implementing the scheme was to improve safety (actual and perceived). It hoped that the scheme might also contribute towards wider environmental, public health and social policy outcomes. Atkins found that there was no significant decrease in levels of congestion. The majority of car drivers surveyed claimed that the scheme did little to alter their travel mode or frequency. However, a small number did increase their levels of walking, pedal cycling and public transport usage.
61. A public opinion survey undertaken by the Council found that 40% felt that the scheme had decreased the speed of cars within Portsmouth, though 54% believed that the scheme had made no difference. 40% of respondents maintained that since the introduction of the scheme there had been a safer environment for walking and cycling; furthermore, nearly 40% surveyed believed that there has been less aggressive driving since the introduction of the scheme although half of those surveyed felt that there had not been the expected reduction in congestion. The survey found that the main sources of dissatisfaction with the scheme were that the drivers exceeded the speed limit and that there was no effective means of enforcing the scheme should drivers exceed the limit.
62. Overall, the scheme results are somewhat inconclusive and no further detailed evaluation has been undertaken. The casualty numbers were small and the evaluation period relatively short. The Council considers that the scheme has been accepted and understood by local residents. The DfT is commissioning a large scale study of 20mph limit schemes, although Portsmouth may not be included.

⁵² Atkins, [Interim Evaluation of the Implementation of the 20mph Speed Limits in Portsmouth \(Final Report\)](#), 2010

Figure 5. Portsmouth 20mph Speed Limit Scheme



Sustainable Travel Demonstration Towns

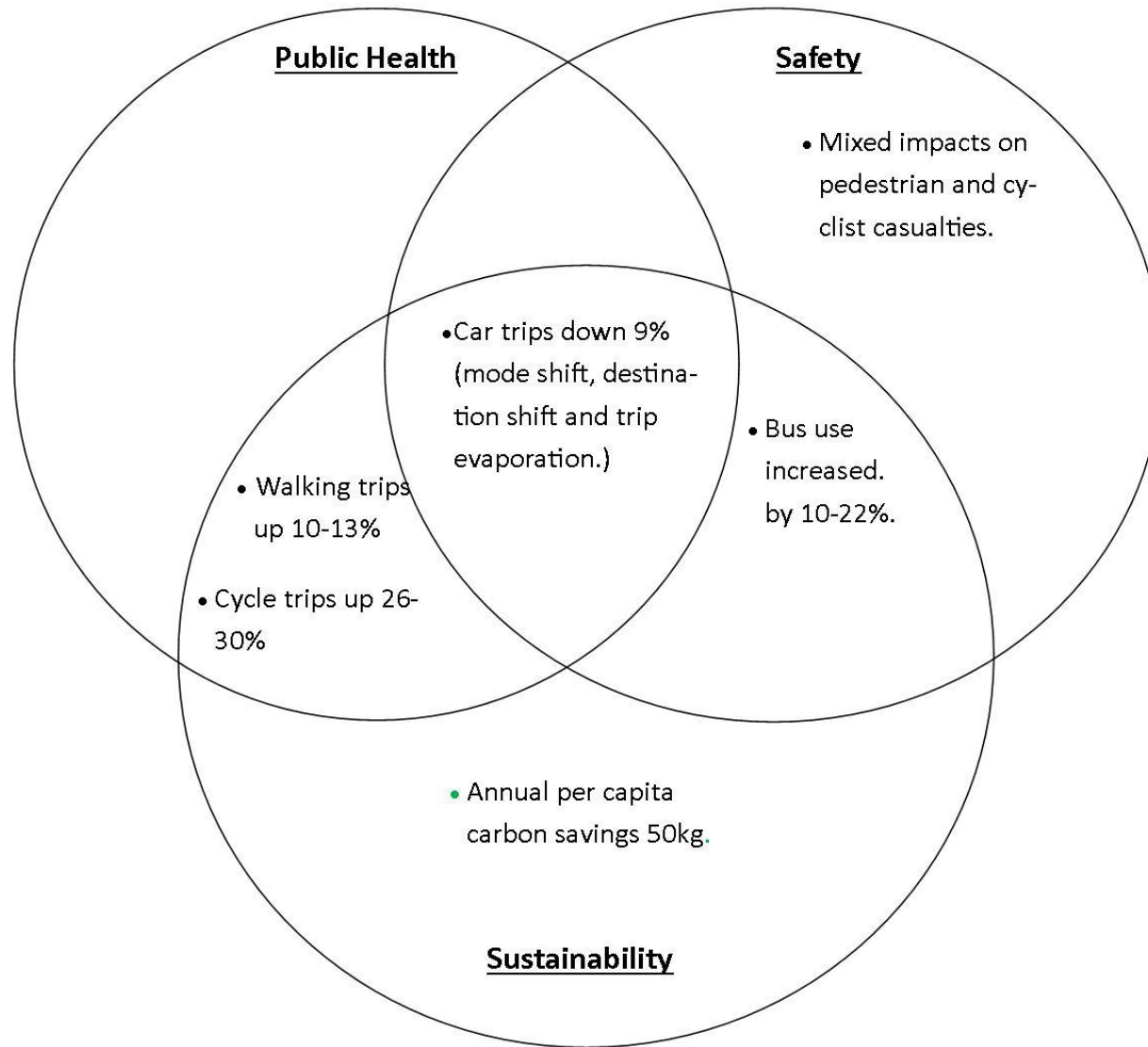
63. Sustainable Travel Demonstration Towns were a set of projects aimed at changing travel behaviour and encouraging active travel and public transport use. The schemes were intended to demonstrate the degree to which social, economic and environmental benefits could be obtained through promotion of sustainable travel. They were initiated, monitored and funded by the DfT and undertaken by Darlington Borough Council, Peterborough City Council and Worcester City Council between 2004 and 2008.⁵³ The schemes were primarily aimed at tackling congestion and ensuring good accessibility in these cities. The local authorities involved in the scheme made use of a strong brand identity; developing travel awareness campaigns, marketing schemes and encouraging school and workplace involvement in the formulation of travel planning on a city wide scale.
64. The monitoring report found that within the three cities there had been a shift away from car use (-9%) and an increase in walking (+10-13%), cycling (+26-30%) and bus trips (+10-22%). Worcester experienced significant increases in walking but levels of cycling appeared to decline. The report found that car driver mileage by residents of the towns fell 5%-7% (on trips <50km) during the course of the programme. This was calculated to produce an average annual carbon savings of 50kg per capita within the towns between 2004 and 2008.⁵⁴ It should be noted that reliably monitoring changes travel patterns at local over relatively short period is difficult.
65. Whilst the scheme primarily focused on sustainable travel, there are notable potential synergies with public health and road safety. Increases in active travel are typically associated with health benefits – although these were not measured in the study. Reductions in motor vehicle mileage may have contributed to reductions in carbon emissions and air pollutants.
66. Whilst a reduced volume of traffic might be expected to be beneficial for road safety, there was no consistent change in casualty numbers or severities. Darlington saw an increase in total cyclist casualties while Peterborough and Worcester saw falls. The changes for pedestrians were more mixed. In Darlington, there was a reduction in all pedestrian casualties (-17.7%) but an increase in fatal and serious pedestrian casualties (+9.5%). In Peterborough there was an increase in all pedestrian casualties (+7.0%) including an increase (+4.8%) in fatal and serious pedestrian casualties. In Worcester there was a small reduction in all pedestrian casualties (-4%) but a larger reduction in fatal and serious pedestrian casualties (-17.4%).⁵⁵
67. In conclusion, the Sustainable Travel Demonstration Towns took a holistic approach to promoting active travel and sought to demonstrate health, safety and environmental benefits and synergies. There were apparent successes but the impacts on vulnerable road user casualties was mixed.

⁵³ DfT, [The Sustainable Travel Demonstration Towns, Part III, Chapter 3](#), 2010

⁵⁴ DfT, [The Sustainable Travel Demonstration Towns, Part IV, Ch.18](#), 2010

⁵⁵ DfT, [The Sustainable Travel Demonstration Towns, Part IV, Ch.19](#), 2010

Figure 6. Sustainable Travel Demonstration Towns



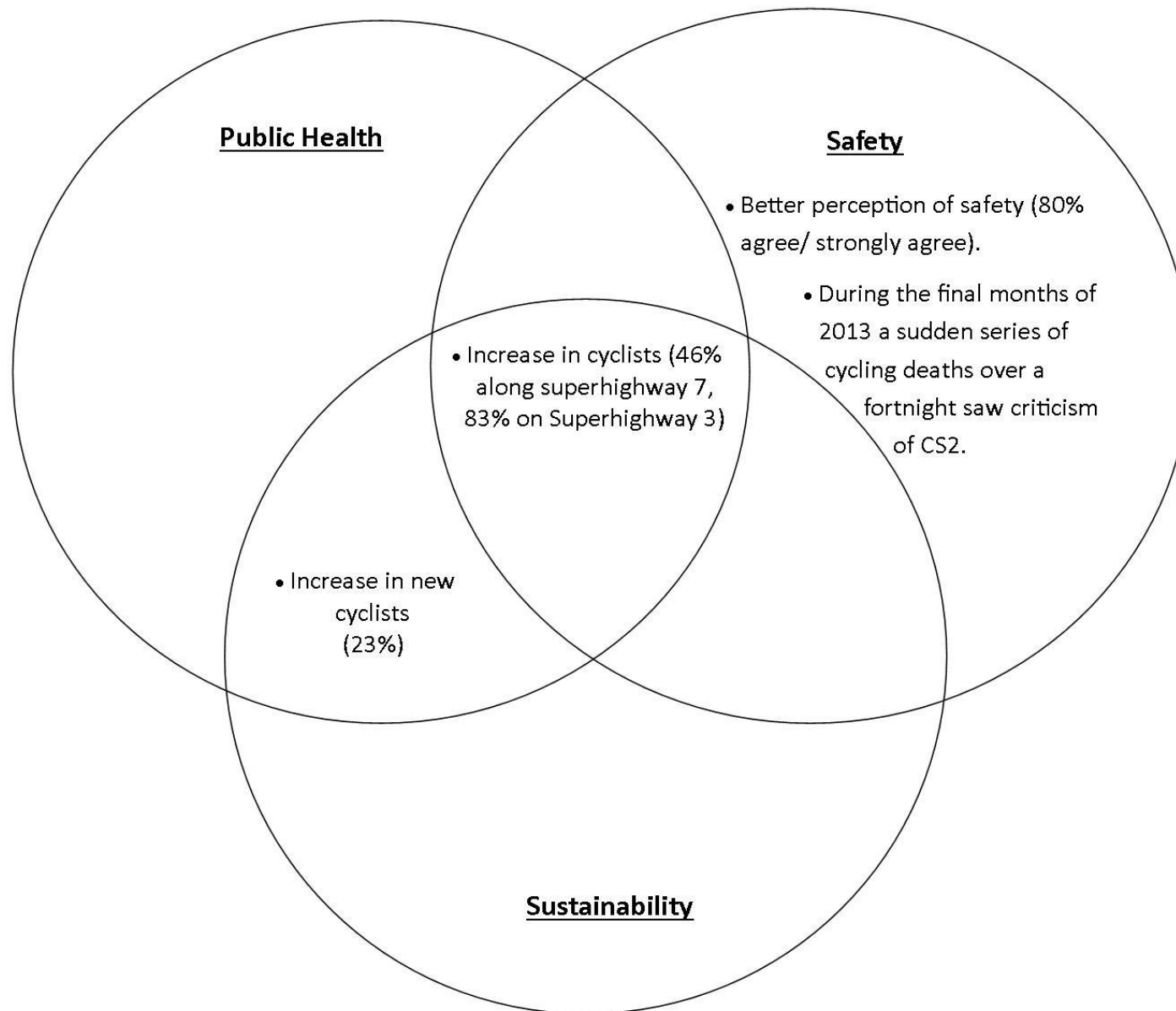
Barclays Cycle Superhighways

68. The Barclays Cycle Superhighways is an initiative of London Mayor Boris Johnson and delivered by TfL. The scheme was launched in 2010 and was aimed at providing safer, faster and more direct journeys into the city. The intention was to improve safety through improved infrastructure and “safety in numbers” resulting from an increased awareness of cyclists by motorists. The routes selected for the Cycle Superhighways (CS) were chosen as those best able to provide safer routes for cyclists than previously experienced on London’s busy roads.
69. The schemes have been monitored by TfL.⁵⁶ CS7 has seen an increase in cyclists of 83% while CS3 has led to an increase of 46%. Both of these routes received an 80% approval rating from individuals surveyed by TfL and there has been an increase in the number of cyclists within the city centre by 23% since 2010.⁵⁷
70. However, the Cycle Superhighways have not proved entirely successful in terms of safety. CS2 in particular has been criticised for insufficient physical segregation and poor safety standards for cyclists, particularly at the Bow Roundabout where three cyclist deaths have occurred since 2010. Cycle infrastructure in London and CS2 in particular received a great deal of media attention at the end of 2013 as a result of six cyclists deaths within a fortnight incidents (even though the total number for the year(14) was the same as for 2012.) The mayor and TfL have agreed that more comprehensive physical segregation will be needed in CS2 and in other schemes.
71. Cycling on the London Road Network has increased by 61% between 2005/6 and 2012/13, and the Cycle Superhighways have contributed to this growth. This is in line with the Mayor’s target to increase cycle use in the capital and is likely to have had health benefits. However, the perceived safety failures at specific locations combined with the spate of cyclist deaths in 2013 show the difficulties and tensions in delivering casualty reductions and improved sense of safety and increased cycle use.

⁵⁶ TfL, [Barclays Cycle Hire: Key Facts](#), 2010

⁵⁷ TfL, [Barclays Cycle Hire: Key Facts](#), 2010

Figure 7. Barclays Cycle Superhighways



Change4Life

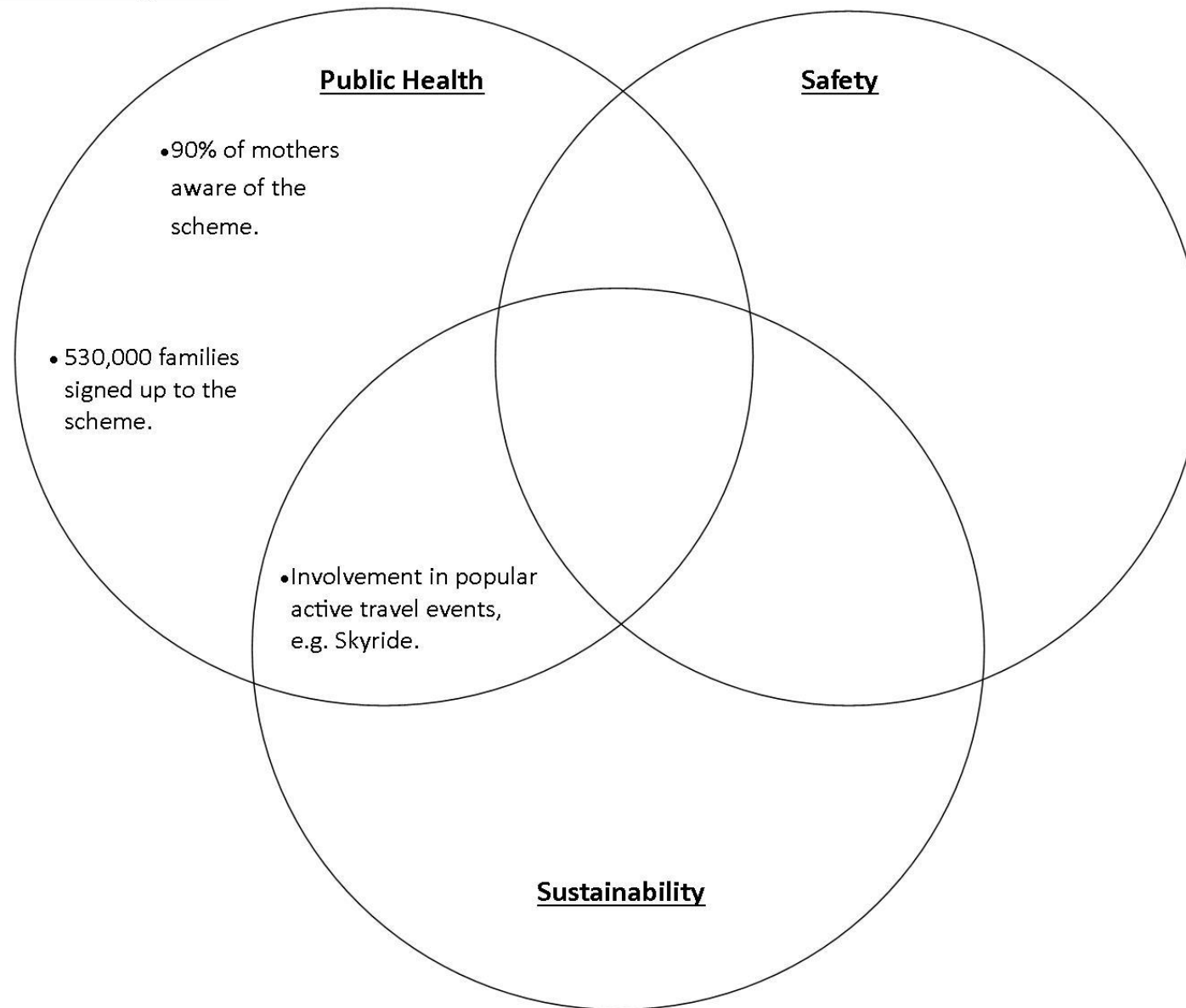
72. Under the authority of the NHS (Public Health Department), the Change4Life scheme was Britain's first national social marketing campaign designed to reduce obesity. It broke new ground with its involvement of the commercial sector in the process. The campaign was launched in 2009 and aims to encourage families to 'Eat well, move more, live longer', backed up by funding from both the government and commercial partners.⁵⁸ The Change4Life policy states a desire to "call upon support and action from all quarters of society".
73. It is based on what its strategy document refers to as a 'hypothetical model of behaviour change' in terms of diet and activity.⁵⁹ This approach towards health improvement states that its aim is to ensure that everyone plays their part in ensuring an improvement in the nation's general health and well-being. Its increased promotion of active travel provides a stakeholder involvement to the scheme which is particularly prominent in terms of increasing support for active travel schemes to school and parental involvement and encouragement relating to the scheme.
74. The outcomes of this scheme have been difficult to quantify due to the commercial and media-orientated direction of Change4Life. However, the policy has arguably increased awareness of the need to exercise as 530,000 families have signed up to the scheme and 90% of the mothers surveyed by the Department of Health indicated an awareness of Change4Life.⁶⁰ Furthermore, as a result of the Change4Life scheme there has been increased interest and involvement in popular active travel events (e.g. Skyride) by family groups. As such it demonstrated synergy between public health and sustainable travel. Overall, the scheme is judged to have raised awareness of health and physical activity but direct results in terms of improved health or long-term lifestyle change are lacking.

⁵⁸ NHS, [Change4Life Marketing Strategy](#), 2009, p.37

⁵⁹ NHS, [Change4Life Marketing Strategy](#), 2009, p.3

⁶⁰ NHS, [Healthy Weight, Healthy Lives: Consumer insight summary](#), 2008, p.2

Figure 8. Change4Life



Conclusion

75. Table 5 sets out the main aims and outcomes of the four case studies selected to illustrate potential policy intersections, providing background before considering just how these policies could allow for the formulation of joined-up working.
76. The case studies (particularly the Sustainability Travel Towns and the Barclays Cycle Superhighways) show some tangible outcomes; they also show the difficulties of achieving behaviour change. They show that co-benefits are not achieved automatically. There is potential for schemes to deliver more by partnership working with other sectors, widening the scope and the objectives of the schemes but not necessarily adding much to overall costs. In the new landscape for local authorities we would expect schemes to be more integrated and to seek to address multiple objectives. Achieving behaviour change would be more likely.

Table 5. Summary analysis of case studies

	Aims	Motivations	Strategy	Indicators and outcomes	Who
Portsmouth 20mph speed limits	Safety: address actual and perceived safety issues, with particular focus on children & other vulnerable groups To be self-enforcing	A triple fatality Public wish	Public engagement Commercial & services engagement	Traffic speeds avg -1.3mph Traffic volume -3% Safety measured by reported casualties: no significant change. Perceived safety – safer environment with less aggressive driving but not less congestion. 50% satisfied, 15% dissatisfied.	Portsmouth City Council (local highway authority) capital from LTP capital settlement.
Sustainable Development Towns	Change travel behaviour (promotion of cycling, walking and public transport, for travel to work and school)	A UK study outlining potential to reduce traffic, bring economic, social & environment benefits Tackle congestion Ensure good accessibility	Personal travel programme Travel awareness campaigns Strong brand identity Walking & cycling promotion Public transport information & marketing School travel planning Workplace travel planning	Car trips down 9% Bus trips up 10 – 22% Cycle trips up 26 – 30% Walking trips up 10 – 13% Annual per capita carbon savings 50kg Mixed impacts on pedestrian as cyclist casualties	Darlington Borough Council Peterborough City Council Worcester City Council DfT (initiation, monitoring and funding)

Barclays Super Cycle Highways	<p>Break down barriers and increase commuter cycling</p> <p>Improve safety and perception of cycling to encourage more cycling, generating a critical mass along the route & making the route more attractive to others</p>	<p>Mayor's vision for cycling: To make the physical & cultural changes required for London to become a cyclised city: one where people can ride their bicycles safely, enjoyably & easily</p> <p>Make London healthier, more environmentally friendly, less congested</p>	<p>Provide safe, fast, direct, continuous & comfortable way of getting to central London by bicycle along recognised commuter routes</p>	<p>Increase in cyclists (46% along superhighway 7, 83% on superhighway 3)</p> <p>Increase in new cyclists (23% on route previously used other transport)</p> <p>Better perceived of safety (80% agree/strongly agree superhighways improve safety)</p>	<p>TfL</p> <p>Consultation with London Borough Councils</p>
Change4Life	<p>Create a movement in which everyone in society plays their part.</p> <p>Engender changes in behaviour which lead to healthier lives.</p>	<p>Reduce the risk of chronic diseases becoming increasingly prevalent: heart disease, Type 2 diabetes and respiratory disease.</p> <p>Improve mental well-being.</p> <p>Reduction of obesity (adults and children)</p>	<p>Commercial promotion of Bikeability and 'Walk for life' schemes</p> <p>Route planning</p> <p>Physical activity guidelines and requirements provided for specified age groups.</p> <p>Bike Week events and mass participation cycling event.</p>	<p>Awareness and participation:</p> <ul style="list-style-type: none"> 530,000 families signed up to the scheme 90% of mothers are aware of the Change4Life scheme. <p>Involvement in popular active travel events, e.g. Skyride.</p>	<p>NHS (Public Health Department)</p>

Chapter 4: Pulling in the same direction?

“It can’t be said often enough: we have to take a broad policy approach and not just think of the transport aspects.” (Diane Abbott MP, Shadow Minister for Public Health, 2013⁶¹)

This chapter of the report draws on and quotes from the expert seminars and the PACTS’ *Triple Whammy* conference. It is intended to:

- Provide a summary of the issues raised regarding current joined-up working during two expert seminars;
- Set out the obstacles to and enablers of joined-up working at both a regional and national level which were identified during the expert seminars;
- Identify important conclusions on how to expand synergy, highlighted by transport professionals and academics; and
- Conclude that the primary question remains how far the alterations in policy enabled the development of “joined-up” solutions to any viable degree?

Testing the policies in practice

77. The previous chapters show that government policy documents for road safety, sustainable transport and public health acknowledge the co-benefits and promote joint working across the three sectors. They imply that objectives can be delivered more effectively and efficiently through this synergy. But to what extent is this being achieved in practice and what are the benefits, barriers and pitfalls? In order to answer these questions, PACTS organised two expert seminars and a national conference.

Expert seminars

78. PACTS held two seminars, in London and Birmingham, in July 2013, comprising central and local government officials, health professionals, academics and others from the three sectors. The London seminar focused on national and London aspects, particularly national policy and its interpretation by government departments. The Birmingham seminar addressed regional and local approaches to joined-up working, predominantly in the West Midlands. PACTS prepared an agenda for the chairs. The seminars were held under the Chatham House rule, whereby what is said is not attributed to any individual or organisation. The participants were happy for their names to be listed in the report (see Appendix I).

Triple Whammy conference

79. PACTS’ reasons for undertaking research are to bring about improved transport safety. The conference, *Triple Whammy: Achieving safety, sustainability and health goals in transport*, at the Royal College of Surgeons in October 2013, was intended to bring together people from the three sectors to promote more effective joint working. Over eighty people attended and the speakers’ presentations are available.⁶² The conference provided additional material for this report.

⁶¹ PACTS, [*Triple Whammy: Achieving safety, sustainability and health goals in transport*](#), PACTS conference; 26.10.13, Royal College of Surgeons, London.

⁶² PACTS, [*Triple Whammy: Achieving safety, sustainability and health goals in transport*](#), PACTS conference; 26.10.13, Royal College of Surgeons, London.

To what extent is policy already aligned?

80. During both expert seminars joined-up working was rapidly identified as a central issue, particularly in the current political and economic climate. The Government has made it clear that jobs and the economic growth are overriding priorities. The key drivers behind increased joint working were cuts in local authority funding, the need to align programmes to funding opportunities – “*turn and face the money*” - and to find schemes areas where several interests intersected. A further significant driver in the three sectors was the perceived shift in public and political support towards active travel and public transport.
81. One outcome of local authority budget cuts has, however, been the merging of a significant number of road safety teams with the sustainable transport teams. Sustainable transport teams have considerable interests in the public and personal health impacts of the active travel modes and this is driving change in road safety alongside the return of public health to top tier local government.
82. In terms of policy alignment there have been hindrances in terms of funding allocation, as departments at the national and regional levels are protective of their funding whilst simultaneously seeking out additional resources. This style of “protectionism” has proven a deterrent to the development of joined-up working between the different departments. Increasingly local authorities have been encouraged to avoid this “silo-mentality”, instead encouraging the identification of drivers for joined up working and areas of policy intersection in future policy and its implementation. Tensions have also emerged between policy-driven approaches led by councillors and more evidence-led measures advocated by council officers.
83. One hindrance to joint working was identified as the differing styles of learning and policy development between departments. Whilst public health has, primarily due to its connections to the NHS, experienced a more top-down influence from Whitehall in its policy direction, the local government functions of road safety and sustainable transport have developed in a more “organic” manner, learning and developing horizontally as well as vertically.

Does joined up working already exist and if so, to what extent?

84. Attendees at the seminars were positive about the level of joined up working already in existence in some local areas where localism and responsibility for public health has allowed greater opportunity for cross-departmental projects.
85. One of the key drivers of joined up working is concern about obesity, particularly childhood obesity. “In Birmingham one in four children are classed as obese. Can we live with that? It’s a public health emergency which must be dealt with.” This has given support to schemes such as Bikeability (a cycle training scheme) which address road safety, sustainability and health goals.
86. The significant dedicated funding for LSTF and cycling schemes (Cycle City Ambition etc) was highlighted as having strongly positive impacts on investment in active travel and schemes to provide safer conditions for these modes. Funding opportunities also helped to bolster political support for active travel, particularly cycling. However, there was concern about reliance on short-term funding sources, with the LSTF currently providing the main opportunity for joined up working and yet ending in 2015.

What are the enablers and obstacles to joined-up working?

Drivers

- **Obesity concerns:** these are proving to be a major driver for promoting physical active across departments, including those outside public health and transport. ‘In terms of our

priorities in sport and leisure...it's to get those in the city who are inactive to become active. That's where the biggest health gains are to be made."

- **Air quality agenda**: Recently the air quality agenda has received increased interest both from the European Union and from Whitehall; a shift which has been taken advantage of to push synergy to achieve beneficial sustainability results.
- **Political leadership**: This was key to pushing joined-up working as a concept. It was argued that schemes such as the Barclays Cycle Superhighways Scheme would only occur with the necessary "political leadership".
- **Dedicated funding**: dedicated funding was seen as much preferable to having to compete for funds against "conventional" transport schemes, despite the improved assessment tools. This not only enabled but drove sustainable transport and safety schemes.

Enablers

- **Localism**: This was identified as giving more flexibility to local authorities and assisting with joined-up working.
- **Public health in local government**: The transfer of public health responsibilities, staff and funding to local authorities, and the creation of Health and Wellbeing Boards, was seen as a significant enabler of joint working. A small example is where public health funds have been used to grit pavements to reduce slips and falls. *"With two years of funding this is big opportunity for joined up thinking."*
- **Improved economic assessment tools**: new assessment tools such as HEAT (Health Economic Assessment Tool) were helping in funding bids (although better tools were still needed).
- **Absence of opposition**: Some schemes were seen as positive and without opposition, e.g. Bikeability and Kerbcraft, despite the difficulties of evaluating their impacts. Schemes which impinged on road space or parking facilities for motor vehicles tended to generate opposition.
- **Local facilities and public transport**: it was easier to promote sustainable transport in urban environments with local shops and services and public transport than in rural areas where car dependency was higher.

Obstacles

- **Plans and objectives not aligned**: the Joint Strategic Needs Assessments (JSNAs), local transport plans and road safety strategies need to be better aligned.

"The JSNA's are very disappointing at the moment from a road safety perspectives...they just quote the national figures..."

- **"Silo-Mentality"**: A sense of separateness among departments within council authorities, the civil service and the government from parliament to the localities has proven to be restrictive in terms of interdepartmental co-operation. Improved interdepartmental awareness on shared objectives and outcomes was seen as important.

There's quite a difference between government departments. The DfT promotes walking and cycling but the Department of Health would say 'frankly we're worried about really fat people and you're never going to get them on a bike'. They weren't even terribly interested in getting them to walk to the shops as even that was seen as a bit of a step too far. They might try to get

them to tootle around the park but that wasn't particularly interesting from a transport perspective.

- **Professional fears:** "There is fear from individuals that they may lose their status, role and turning things on their head is sometimes quite difficult for some people."
- **Differences of language:** The difficulty in understanding agendas between the three different groups has stemmed partly from the three areas being "divided by language which has only exacerbated the challenge of partnership". The road safety and public health sectors use different definitions of risk and safety terminology.

Some of the ways partnerships break down is this lack of understanding of other people's agendas because they're couched in different language.

- **Different learning cultures:** "Local authorities learn in a very different way from the health sector ...there are different methods to deliver knowledge and sharing good practice. Health sectors tend to be very top-down... local authorities are much more organic."
- **Different timescales:** local sustainable transport schemes and small scale road safety interventions may be implanted within 2-3 years whereas "Public health timescales are 10 years or more. That is long for local government politics.". This creates challenges to joint working. "*Birmingham has a long –term strategy to tackle public health issues. We are saying "let's do Marmot" [tackle the causes of causes]*"
- **Population strategies versus sub-groups:** public health tends to focus on population strategies while road safety may target specific sub groups. Public health population strategies are based on the premise that small changes by lots of people achieve bigger changes overall than big changes by a small number of people.⁶³
- **Inconsistent / inadequate survey data:** e.g. the Active People Survey records only walk trips lasting over 30 minutes yet shorter trips, to public transport, are important for those concerned with sustainable transport or public health.
- **Uncertainty over ownership:** Localism allows flexibility but also means less direction from central government and legal duties on local authorities to consider handing responsibility for services and facilities to the community under "the right to challenge" provisions of the Localism Act. This creates uncertainty.

Challenges

- **Local authority funding.** Substantial additional cuts in local government funding are still to come. "*We are having to fund next year's road safety priorities in [redacted] region by scraping together bits of unspent allocations from last year. The money from local authorities has dried up! It's like shaking the piggybank!*"
- **New money?** There is an impression that additional funding is available when, in reality it may be a matter of doing more with less. Under the previous regime, some Primary Care Trusts already contributed towards road safety and active travel schemes. For example, Liverpool and Manchester PCTs contributed £400,000 and £500,000 respectively towards 20mph speed limit schemes in their areas, partly on basis of addressing health inequalities.
- **Optimism bias:** There remains a risk of assuming that synergy will be automatically achieved and of ignoring potential difficulties. "*We've got all the frameworks. The reality is that there*

⁶³ A Davis, *The prevention paradox and population strategies applied to transport*, [Essential Evidence 109](#), 2013

could be a lot more working together to actually deliver what they're saying on paper. There is almost an expectation that another section will deal with that."

- **Exacerbating health inequalities:** not all sustainable transport schemes address health inequalities. Cycling and leisure walks were highlighted as being most likely to be taken up by those who are already healthy or in upper-income groups.
- **Potential negatives:** Increases in active travel may increase road casualties and may not reduce car use or health inequalities. *"There is a danger the public health money will be used for other things."*
- **Conflicting messages:** Conflicts need to be recognised more fully. For example the Think! campaign which showed all cyclists wearing helmets was seen as promoting safety at the expense of public health. It was thought that it might increase fear of being killed or injured and reduce the number of people using a bicycle – and therefore the health benefits.
- **Walking overlooked:** Walking – on its own or in combination with public transport - has obvious potential for wide uptake with substantial health benefits but, unlike cycling, is not getting the policy attention it warrants.

In the round of things, pedestrian safety is important, we must be conscious to not just talk about cycling.

In my local authority the group that is relatively resistant the public health message is the public transport team who are missing a huge opportunity with potential walk trips.

Public transport is the safest mode – but the safety case is rarely made.

- **Freight:** freight issues are not generally addressed in sustainable policy. Yet van traffic has increased rapidly as a result of the growth in online shopping and "just in time" delivery and the dangers from HGVs to cyclists and pedestrians in London came to the fore in 2013.
- **Engaging planners and urban designers:** changing the physical environment was seen as crucial but long term and difficult.

PHE has a number of strands we're trying to weave together ...it's about saying how you design the spaces to make it easier for people to pursue active travel.

Chapter 5: Safety in the future

87. This chapter explores the following questions

- What can the safety community learn from this exploration of joined up policy objectives and working?
- Does the safety agenda need to be adapted in order to work with these other transport policy areas?

Addressing conflict

88. An area of potential conflict between safety, sustainable travel and public health is the way in which safety concerns are tackled in relation to pedestrian and cyclists. Negative perceptions of safety can be a barrier to active travel yet safety messages can heighten not allay, safety fears and discourage people from using active travel. Practical examples include pedestrian guard-rail, cycle helmets and the freedom given to child pedestrians.

89. Likewise, active travel can cause issues for the safety agenda, as encouraging active travel means a greater number of vulnerable road users. This presents the safety community with the challenge of bringing down the total number of casualties, whilst enabling the encouragement of more active travel. This challenge is acute for the safety agenda, as it can't always be assumed that any interventions by public health and sustainable travel will take safety fully into account. This was highlighted in chapter two when analysis of Change 4 Life suggested that even within such a well-developed scheme there remains the risk that other aspects such as safety might be side-lined.

A focus is required on keeping vulnerable road users safe in order to enable and aid the push for active travel whilst avoiding an increase in the number of casualties.

Getting the best out of links to other agendas

90. The safety community can also take advantage of links to other agendas, further to the benefits highlighted in previous chapters. Reducing inequalities is a priority for public health. It is possible that expertise in public health on closing the inequalities gap could translate over to safety, where there is a continued problem of inequality in injury risk.⁶⁴ Developing safety interventions should take this inequality into account.⁶⁵ Therefore there is a shared interest in tackling social causes of injury risk, as social factors influence both health inequalities and risk inequalities.

Further exploration of areas where safety, public health and sustainable travel agendas could help each other may prove fruitful, such as tackling social factors and inequality.

Ensuring that the safety agenda remains a priority

91. As the PACTS *Tackling the Deficit* report series found, local authorities have reported the perception that road safety is no longer a priority for central government, and that funding was consequentially being directed towards other services. Five in six respondents to a PACTS survey claimed that the Strategic Framework had no effect or a negative effect on road safety in general.⁶⁶ An IAM report published in April 2012 found that local councils in England cut their

⁶⁴ Clare Lowe, Grahame Whitfield, Liz Sutton and Jeremy Hardin (DfT), [Road Safety Research Report No.123: Road User Safety and Disadvantage](#), 2011

⁶⁵ ROSPA, [Social Factors in Road Safety Policy Paper](#), 2012,

⁶⁶ PACTS, [Tackling the Deficit: Checking the Health of Road Safety](#), 2011

road safety budgets by 15% (£23 million) the previous year compared to average spending cuts of just 6% for other council services.⁶⁷

92. PACTS recommended that government take action to reassure local authorities that road safety was still a priority, by developing a vision for road safety with stakeholders, and using platforms already in place to draw attention to road safety, its achievements and the work still to be done.⁶⁸
93. As discussed earlier the integrating of road safety in to other agendas could help maintain interest in it and push it higher up the priority list by piggybacking on other agendas which have political focus. However, it is important to ensure that safety does not get buried under other important issues. Though the relative freedom of recent funding streams has been appreciated by local authorities, there is a danger that road safety will continue to be squeezed out.

Ensuring that the safety agenda remains visible and a priority will be important as more joined up working develops.

The road safety approach

94. The traditional approach to road safety has focused on casualty reduction through “the three Es”: education, enforcement and engineering. In recent years the *Safe System* approach has been identified as international best practice, championed by Sweden and the Netherlands and promoted to all countries irrespective of their socio-economic status.⁶⁹ This was outlined in the following declaration which was developed for the PACTS conference *Aiming for Zero* in March 2012.

*This conference notes the progress towards the elimination of deaths that has been achieved through the adoption of a Safe System approach in the Swedish Vision Zero and the Dutch Sustainable Safety. It believes that Great Britain’s approach to road safety over the next decade needs to be informed by a similar ethical approach. Where road deaths are preventable and where the means to prevent them is identified and cost-effective where this is measurable, society has a moral and economic responsibility to act for the public benefit. Good safety management places an obligation on those in authority to manage risks and prevent needless incidents and casualties. It also places a responsibility on those using a network to comply with the law and not to import risk into the system.*⁷⁰

95. Both Vision Zero and Sustainable Safety maintain that “although a human being is often the cause of a crash, the crash can be prevented by a safe design of the traffic system. **The safety level of the system is measured by whether crashes can lead to severe injury or not; it is not measured by the number of crashes.** This assumes a joint responsibility of the road user and the traffic system designer. The user's responsibility is to obey the rules, and the system designer’s responsibility is to arrange the system in such a way that it can be used safely. Moreover, the system designer must take further steps in the system design if road users commit offences or if users get severely injured”.⁷¹

⁶⁷ Institute for Advanced Motorists, [The end of the road? Local investment in road safety in England](#), 2012

⁶⁸ PACTS, *Tackling the Deficit: Checking the Health of Road Safety*, 2011

⁶⁹ OECD, *Towards Zero: Achieving ambitious road safety targets through a Safe System approach*, 2008

⁷⁰ PACTS, *Tackling the Deficit: Checking the Health of Road Safety*, 2011, p.16

⁷¹ Institute for Road Safety Research, [SWOV Factsheet: Sustainable Safety, principles, misconceptions, and relations with other visions](#), p.3

96. The *Safe System* approach foresees that much more investment should go to creating segregated cycle networks, lower speed limits in urban areas and villages, higher pedestrian protection safety standards in vehicle design, including HGVs and other large vehicles, and roadside protection to reduce the impact of runoff crashes.

Serious injuries

97. As road safety integrates to a greater extent with public health and sustainable travel, and as the number of deaths continues to decrease, there is likely to be a more explicit focus on serious injuries. At an EU level, reductions in the number of injuries have not been as great as the reduction in the number of deaths, and therefore injury prevention is an important part of the EU's road safety priorities for 2011 – 2020.⁷²
98. In July 2013, the European Commission announced a common EU definition for road traffic serious injuries: those scoring MAIS3+ - usually involving long-term medical harm. The European Parliament welcomed this move and issued a number of recommendations to the Member States and the Commission, including urging the Commission to set an ambitious target for the reduction of road traffic serious injuries over the period 2011-2020. The European Transport Safety Council commented: *Tackling serious injuries must prompt a focus on improving road safety in urban areas, particularly for vulnerable road users. More than half of those seriously injured on EU roads are pedestrians and other vulnerable road users, such as cyclists, who are involved in a collision in urban areas.*⁷³
99. The UK (STATS 19) definition of serious injury is broader and includes less severe injuries. Whilst both definitions have merit, the more restricted EU definition may be closer to what the public would consider to be a serious injury and the type of injury that is of most concern to the health sector. This raises questions about how risk is defined and perceived by society, which is particularly pertinent for active travel where fear is a barrier.⁷⁴ PACTS has already argued⁷⁵ that the UK requires a road safety vision that goes beyond “remaining a world leader on road safety”,⁷⁶ and *Safe System* provides an internationally recommended approach which expressly seeks to address more effectively the needs of vulnerable road users.⁷⁷

⁷² European Commission: [Road Safety Report 2013](#), 2013

⁷³ European Transport Safety Transport Safety Council, '[European Parliament calls for EU to tackle serious road traffic injuries](#)', 2013

⁷⁴ Professor Johnathan Wolff, [Risk, Fear, Shame and the Regulation of Public Safety](#), *Economics and Philosophy*, Volume 22, Issue 03, November 2006, pp 409-427

⁷⁵ PACTS, [Tackling the Deficit: Checking the Health of Road Safety](#), 2011

⁷⁶ DfT, *Strategic Framework for Road Safety*, 2011, p.11

⁷⁷ J Breen, *Managing for ambitious road safety results*, 23rd Westminster Lecture, PACTS

Chapter 6: Conclusions and Recommendations

National integration of policy and delivery

100. The return of public health to top tier local government presents a very good opportunity to better align road safety, sustainable transport and public health policies. Greater integration of policy and delivery across the three sectors is necessary and desirable. The potential co-benefits are substantial and the pressure for further financial savings is strong. However, there are also risks and challenges ahead.
101. While government has broadly encouraged this direction current **policy and delivery is less joined up in central government than in local government**. This has been described as the Humpty-Dumpty syndrome whereby local government is expected to piece together the fragmented initiatives of central of government. Cross Whitehall collaboration, both at Ministerial and senior civil servant level, on road safety, public health, and the environment could challenge silo working at a national level to help achieve the synergies sought of reduced casualties, increased active travel use, lower carbon dioxide emissions and lower overall environmental impact from road transport. **Government must show stronger leadership to achieve results and demonstrate joined up working at central level.**

Integration of local delivery

102. There are clear trends towards integration of policy and delivery across the road safety, sustainability travel and public health sectors at local level. As a result of financial pressures and deliberate policy choices, a number of local authorities have combined their road safety ET&P staff and programmes with those delivering sustainable travel initiatives. In a few authorities, some public health staff have been located with road safety and sustainable travel teams. It seems likely that these trends will strengthen and spread to other authorities, not least because of further cuts and because concerns about obesity are becoming a primary driver of sustainable travel measures.
103. However, the picture is quite mixed. In some local authorities sustainable transport is not seen as part of the road safety remit and public health staff have yet to engage in transport issues and vice versa. Some of these divisions may be due to differences in professional cultures, language, definitions of risk and location. **We recommend additional training to bridge these divides, including a series of regional workshops, possibly modelled on the themes of the PACTS Triple Whammy conference.**
104. Greater public health influence may have other knock-on effects – some yet unknown. One may be to draw in greater collaboration with policy areas such as education, not least in helping to promote sustainable travel on the school journey **to reinforce the provisions of the Education and Inspections Act, 2006.**

Reduced resources

105. Difficult times lie ahead for local and central government. Local authority public health budgets are ring-fenced for two years, ending 2015/16. Synergies may deliver co-benefits and efficiencies but overall resources are being reduced. Each of the three sectors is hoping to win support for its priorities from the other two. **The best survival strategy for these services will be to emphasise the co-benefits of joint working, “one council” jointly delivering safer active travel with safety, health and environmental outcomes.** Interventions that do not have short-term or obvious benefits may suffer disproportionately. For example, planned highways maintenance – important to the safety of vulnerable road users and to avoiding higher long-term maintenance costs – is a perennial favourite for cuts. Equally, many important public health interventions require longer than an election cycle to implement. There is a need for **better and**

more easily used evaluation tools to assess the health and sustainability benefits of transport schemes. Local authorities feel that they are being asked to undertake tasks that are too complex and time-consuming and which should be made simpler by central government.

Delivery arrangements for road safety

106. Localism and freedom from central inspection seems to have allowed local authorities to develop their own priorities and delivery models which they consider to be beneficial. At the same time a range of new local decision-making institutions have been imposed by central government, including Local Enterprise Partnerships and Local Transport Bodies. As a result, there is greater variety in local policy and service delivery arrangements with Local Enterprise Partnerships, Local Transport Boards, road safety partnerships, local authorities, Fire and Rescue Services and other bodies involved in varying ways. There is no clear picture of local delivery models. Road safety engineering now seems to sit with traffic engineering and have less connection with road safety education, training and publicity (ET&P). If so, this seems unfortunate - it should have strong connections with both. **More information is needed about the service delivery arrangements and good practice at the local level and whether local authorities are fulfilling their statutory road safety obligations.**

Road safety as a means to deliver other agendas

107. Following the transfer of public health responsibilities to local authorities in 2013, public health is becoming a significant driver of sustainable transport policy. The policy has not necessarily changed but it has been given added emphasis. This trend seems likely to become stronger. This has consequences for road safety policy and priorities: road safety is seen as a means to contribute to sustainable travel and public health objectives. Creating safer conditions for walking and cycling, and making vulnerable road users, including children, older people and motorcyclists, feel safer are growing in importance alongside continued reduction in road casualties.
108. From a public health perspective, shifting the whole population distribution of a risk factor may prevent more injury and harm than simply targeting the far fewer high risk outliers. Such an approach may well be able to help unite road safety and public health in achieving population shifts in behaviour e.g. speed where sufficient offenders driving at around 35mph in a 30mph limit do more to increase traffic danger among vulnerable road users than fewer higher speed outliers.

Casualty reduction matters

109. The substantial falls since 2006 in the total number of people killed in road traffic collisions, and the long-lasting trend in reductions in total serious injuries, have led some to perceive that road safety is no longer a problem – particularly for vehicle occupants. Yet 1,754 people were killed and a further 23,039 seriously injured on the roads in Britain in 2012.
110. Much of the recent trend has, however, been attributed to the recession and there are concerns that an upturn in the economy may see a rise in casualties. The recent high profile for cycling safety and the demand for 20mph limits has also shown that the public is not satisfied with current levels of safety. And while cycling safety has received a high media and political profile, far more people have died as pedestrian or motorcyclists, and as young or older drivers.
111. Road traffic collisions are still the largest single cause of death for people in the UK aged between 5 and 25 years. Of all *accidental* deaths in 2012, road deaths accounted for 72% of those aged 15-19 years and 15% for all age groups.⁷⁸ In the absence of a long-term goal and casualty reduction targets to provide the framework for a comprehensive national road safety

⁷⁸ DfT, *Reported Road Casualties Great Britain: 2012*, Table RAS30035, 2013.

plan, insufficient attention is currently being given to road casualty reduction. PACTS is also concerned that key national public health policies do not seem to give the prominence to reducing road death and injury that the facts warrant.

112. The UK Coalition government has declined to set casualty reduction targets although the devolved administrations have done so. **We recommend that a future government and devolved administrations adopt casualty reduction targets for total deaths and serious injuries. These should be underpinned by targets to reduce the rate of death per mile travelled or hour of exposure for each major road user group.** This would demonstrate a commitment to improving the safety of all road users. Given the changes in modal share that are happening and sought, absolute targets for individual road user groups may not be appropriate. Targets would also help road safety compete for resources with other policy other areas, such as climate change and child safeguarding which are backed by targets and statutory obligations.

A better understanding of risks and benefits

113. The recent focus on cyclist deaths in London has again highlighted the need for better information about risk and not just casualty numbers. If vulnerable modes of transport are to be successfully promoted, **better information is needed about the relative risks and benefits of each mode. This should include casualties per unit of exposure (distance travelled, time and trip). This information needs to be combined with information on the health benefits of each mode.** The DfT, DH and PHE should collaborate more extensively in this task so that practitioners, the media and the public have a single reliable source. Road accident (STATS19) records and hospital (HES) data should also be more closely matched. The risks should be set within a wider frame of understanding the risks of sedentary behaviour and the premature deaths resulting so that physical activity is understood better in the context of assessing risks and benefits of different travel modes.
114. Information is also needed about the safety of the system – again, not the same as casualty numbers. The National Road Safety Framework included a number of indicators to measure progress in delivering safety, such as the percentage of vehicles complying with the speed limit. These indicators are also consistent with indicators of the *Safe System* approach to road safety. **Whereas the casualty data show almost universal progress, the National Road Safety Framework indicators show a more mixed picture.** Moreover, they do not seem to have been featured much in reporting by ministers or in scrutiny by the road safety community.⁷⁹
115. The DfT also needs to **improve its presentation of casualty data.** The 2012 GB casualty figures, which showed total deaths at the lowest levels since records began, received much negative press coverage along the line that “cycling is becoming more dangerous” because of a relatively small increase in cycling casualties. Subsequently, the DfT published the National Travel Survey which showed that cycling casualties have moved in line with the increase in cycling.

Cycling success needs to be applied to other modes

116. **Cycling has received substantial attention and support. Other sustainable transport modes need to emulate this success.** By comparison, the safety, environment and health benefits of public transport seem to receive inadequate attention. Walking – on its own or in combination with public transport – deserves much greater policy focus, not least because it offers health benefits to the greatest number of people and to those experiencing the worst health inequalities. And from a safety perspective, pedestrian casualties warrant even more attention as they outnumber cyclist casualties (in terms of fatalities) by a ratio of 4:1. The barriers to walking and the ways to encourage more walking are sometimes assumed to be identical to

⁷⁹ They do not appear until page 173 in Reported Road Casualties Great Britain 2012.

those for cycling where the reducing dangers is generally the priority.. Walking requires a subtly different set of measures, which may have more to do with land use, urban design and personal security than traffic safety. **A wider understanding of how to promote walking is needed, including more examples of international good practice.**

UK road safety in the future

117. Following this discussion, the road safety sector should consider the following points:

- The safety of vulnerable road users will be of vital importance in order to enable and aid the push for active travel whilst avoiding an increase in the number of casualties.
- There may be further areas where safety, public health and sustainable travel agendas could help each other, such as tackling social factors and inequality.
- While working with public health and sustainable travel could benefit safety, it will be important to ensure that the safety agenda remains visible and a priority.
- The *Safe System* approach should be promoted and is consistent with a more joined up approach with public health and sustainable travel. The road safety sector should also be contemplating long-term, fundamental matters such as how risk is defined and perceived, how it can be measured as an indicator of safety, beyond the current reporting of casualty figures and limited measures of exposure, and how it can be reduced in ways that are consistent with other aspects of the quality of life such as freedom of access and mobility, and affordable in the context of other calls upon public and private finances.

Appendix I: Participants in the Expert Seminars

Regional Expert Seminar, held in Birmingham, 11th July 2013

(Chair) Karen Creavin, Head of Community Sport and Healthy Lifestyles, Birmingham City Council
Lucy Amos, Research Assistant, PACTS
Naomi Baster, Policy and Research Officer, PACTS
Councillor Steve Bedser, Health and Wellbeing Cabinet Member, Birmingham City Council
John Charles, Team Leader, Road Safety and Sustainable Travel, Walsall Council
Mike Cooper, Smarter Choices Team leader, Birmingham City Council
Andrea Johnson, Road Safety Education lead officer, Birmingham City Council
Conrad Jones, Head of Sustainability, Centro (WMP TE)
Graham Lennard, Cycling and Walking, Transport Policy Team, Birmingham City Council
Ann Osola, Head of Growth and Transportation, Birmingham City Council
Andy Radford, Transport Programmes team, Birmingham City Council
Mark Roscoe, Commissioning Manager - Lifestyles, Birmingham Public Health
Andy Thorpe, Senior Transportation Planner, Sandwell Council.

National Expert Seminar, held in London UCL, 17th July 2013

(Chair) Adrian Davis, Public Health Bristol City Council
Lucy Amos, Research Assistant, PACTS
Naomi Baster, Policy and Research Officer, PACTS
Nicola Christie, Centre for Transport Studies, UCL
Ann Marie Connolly, Public Health England
David Davies, Executive Director, PACTS
Charlie Foster, Oxford University
Martin Gibbs, British Cycling
Katie Hunter, GLA/TfL
Jessica Matthew, DfT
Su Ormes, Road Safety GB
Jeremy Phillips, Devon County Council
Lucy Saunders, GLA/TfL
Graham Thomson, Transport Scotland
Duncan Vernon, RoSPA
Heather Ward, Centre for Transport Studies, UCL

Appendix II: Road safety powers and devolution

This note sets out the powers which are devolved as at March 2014. It was kindly provided by the Department for Transport, with assistance from the Department of Environment Northern Ireland, Transport Scotland, the Welsh Government, Transport for London and Road Safety GB.

International rules

The Westminster Government negotiates changes to international regulation (e.g. UN rules on vehicles) and European law on behalf of the United Kingdom.

EU directives require secondary legislation to be implemented. Where the responsibility for the issue has been devolved, the devolved administration is required to implement. So in practice the Westminster Government works in tandem with the relevant devolved administrations.

Northern Ireland

Northern Ireland is responsible for its own road traffic legislation, including driver and vehicle testing and driver licensing, road safety policy and legislation, and vehicle standards.

Vehicle licensing is an excepted matter with services delivered by Northern Ireland's Driver and Vehicle Agency under an agreement with the DVLA.

The Department for Regional Development's Transport NI is the sole unitary road authority for Northern Ireland, responsible for over 25,500 km of roads. All necessary infrastructure and speed limit powers are devolved to that Department, although to maintain consistency with the rest of the United Kingdom, most legislation and policy guidelines mirror those in effect in Great Britain and elsewhere.

The Police Service of Northern Ireland is responsible for operational policing, although policing policy is a reserved matter.

Great Britain

The Government in Westminster is responsible for the following areas, on behalf of all of Great Britain:

- The Highway Code.
- Some driving offences, including wearing of seatbelts and motorcycle helmets.
- Vehicle standards, including statutory requirements with regard to vehicle lighting and fitting of seatbelts.
- Driver training and testing.
- Driver and vehicle licensing, including medical conditions.
- Penalties for road traffic offences, including driver retraining schemes.
- Type approval of devices for detecting speeding and traffic signal offences (speed and red light cameras).
- Setting the national speed limit

- Regulation of street infrastructure, including making rules on design of pedestrian crossings and traffic signs

Scotland

Road safety education and training; and payments for the treatment of traffic casualties which are covered in the Road Traffic Act 1988 are devolved to Scotland.

Scottish Ministers also have the power to set limits for drink and drug driving. The Government in Westminster has responsibility for the Drink Drive Rehabilitation Scheme in England and Scotland.

Scottish Ministers also have the power to determine the level of the national speed limits on dual carriageways and motorways (currently 70mph) and single carriageway roads (currently 60mph), as well as associated vehicle speed limits in Scotland. The UK Government still has reserved responsibility for the national speed limit of 30mph.

The Scottish Government is also responsible for managing Scottish trunk roads and has strategic responsibility for safety on all Scotland's roads. It issues its own guidance on setting local speed limits and has its own safety camera programme.

Police Scotland is responsible for roads policing in Scotland.

England and Wales

For England and Wales, the Westminster Government is additionally responsible for setting drink and drug driving limits.

Policing in England and Wales is divided into territorial forces, with the Westminster Government setting policing policy.

Wales

The Welsh Government is responsible for the Welsh trunk road network. It sets policy on safety cameras and issues guidance on setting local speed limits. The Welsh Government has responsibility for the drink drive rehabilitation scheme in Wales.

London

The Mayor also sets the strategic direction for transport in London through the Mayor's Transport Strategy.

Transport for London is responsible for the management of the "red routes" within London, whereas the London Boroughs are responsible for their roads.

TfL is responsible for licensing private hire vehicles and minicabs.

Policing in London is the responsibility of the Metropolitan Police Service (and the City of London Police). The Mayor's Office of Policing and Crime is responsible for setting policing priorities, whilst the Metropolitan Police Commissioner is responsible for operational matters and is required to account to MOPAC for them.

Local authorities

Local authorities are responsible for the management of local roads, within the rules set by Government.

Local authorities outside of London are responsible for licensing private hire vehicles and minicabs.

Local Authorities are required by statute to promote road safety; to undertake collision/casualty data analysis and to devise programmes, including engineering and road user education, training and publicity that will improve road safety.

Anybody!

There are no rules on who may or may not set targets.

Providing funding for particular road safety initiatives and running public education campaigns may take place at any level of Government and from any part of Government (e.g. Transport, health...).

Glossary

Bikeability: A national training programme for cyclists in England, Wales and Scotland. It replaced the cycling proficiency test.

Clinical Commissioning Group (CCG): statutory groups as of 2013 and set up by the Health and Social Care Act 2012, they include all the General Practitioners in their geographical area and are aimed at giving GPs and other clinicians the power to influence commissioning decisions concerning their patients.

Disability-Adjusted Life Year (DALY): a measure of overall disease burden, expressed as the number of years lost to ill-health, disability or premature death.

Health Observatories: Produce information, data and intelligence on people's health and care for practitioners, commissioners and policy makers. There are currently 12 in the United Kingdom. The network of Public Health Observatories became part of Public Health England in April 2013.

Health Protection Agency: Was a non-departmental public health body set up in 2003 to protect health against infectious disease and provide advice. The HPA's role was to create an integrated approach to protecting public health within the UK and it was merged in 2013 with the Medicines and Healthcare Products Regulatory Agency.

Health Economic Assessment Tool (HEAT): an [international economic assessment tool](#) designed to capture the health benefits of walking and cycling schemes.

Public Health England: A new executive agency of the Department of Health formed from a number of expert organisations in public health. Designed to protect and improve the nation's health and well-being whilst achieving the reduction of health inequalities.

Joint Strategic Needs Assessment: Analysis of the health needs of UK populations to inform and guide policy direction. They are designed to provide advice on the commissioning of health, well-being and social care services within local authority areas.

Kerbcraft: National Strategy for Child Pedestrian Safety.

Localism: Describes a range of policies introduced by the Coalition Government to prioritise local decision making under the [Localism Act 2011](#).

Local Transport Plan (LTP): previously mandatory but now voluntary, LTPs are produced by local transport authorities to set out their transport objectives, policies and schemes. They may form a basis for bids for DfT funding. They would normally include a section on road safety strategy.

THINK! Programme: DfT road safety information to the public with the intention of encouraging safer behaviour to reduce the number of people killed or injured on the roads.

PACTS
Clutha House
10 Storey's Gate
Westminster
London
SW1P 3AY

Telephone: 020 7222 7732
Fax: 020 7222 7106
e-mail: admin@pacts.org.uk

www.pacts.org.uk

PACTS is an Associate Parliamentary Group
Registered Office: Clutha House, 10 Storey's Gate, London SW1P 3AY
Company Reg No. 2366277. Charity Reg No. 1068607. VAT No. 503 4869 48





Public Health
England

Protecting and improving the nation's health

Everybody Active, Every Day

An evidence-based approach to physical activity



About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

Public Health England

Wellington House

133-155 Waterloo Road

London SE1 8UG

Tel: 020 7654 8000

www.gov.uk/phe

Twitter: [@PHEuk](https://twitter.com/PHEuk)

Facebook: www.facebook.com/PublicHealthEngland

Prepared by: Dr Justin Varney, Dr Mike Brannan, Gaynor Aaltonen

Supported by: Dr Nick Cavill, Stuart King, Luis Guerra

Developed with: Over 1,000 health professionals, local authorities, research specialists, educationalists, charities and fitness experts at national and local levels through a process of discussion and engagement.

© Crown copyright 2014

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v2.0. To view this licence, visit OGL or email psi@nationalarchives.gsi.gov.uk. Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned. Any enquiries regarding this publication should be sent to physicalactivity@phe.gov.uk.

Published September 2014

PHE publications gateway number: 2014319



Contents

About Public Health England	2
1. Introduction	4
Infographic on physical activity	5
Chief Medical Officer's Guidelines	6
2. Inactivity is killing our nation	7
3. Inequalities: closing the gap	10
4. Responding to the challenge	11
5. The four domains for action	12
Active society: creating a social movement	13
Moving professionals: activating networks of expertise	14
Active lives: creating the right environments	15
Moving at scale: scaling up interventions that make us active	17
6. Measuring impact	18
7. Making it happen	19
8. PHE actions to support implementation	20
9. References	21

1. Introduction

Around one in two women and a third of all men in England are damaging their health through a lack of physical activity¹. It is an unsustainable situation, and one that is costing an estimated £7.4 billion a year^{2, 3}. If current trends continue, the burden of health and social care will destabilise public services, and take a real toll on quality of life for individuals and communities.

- over one in four women and one in five men do less than 30 minutes of physical activity a week, so are classified as 'inactive'¹
- physical inactivity is the fourth largest cause of disease and disability in the UK⁴

Public Health England wants to drive a step change in the public's health. Tackling physical inactivity is a key part of making this step change to reduce the burden of preventable death, disease and disability, and support people and their communities to achieve their potential.

We know from the experience of other high-income countries, like Finland,⁵ the Netherlands and Germany⁶, that this situation can be changed. The solution is clear: *Everybody needs to become more active, every day.*

If being active was a pill, we would be rushing to prescribe it. A wealth of evidence shows that an active life is essential for health. Activity reduces the risk of many preventable diseases, from cancer to diabetes, and conditions like obesity and depression. Being active increases your chances of staying independent in later life.

The benefits don't stop there. Being active is also good for children's educational attainment, it can boost workplace productivity and reduce sickness absence and it can even reduce crime and anti-social behavior⁷.

We know from the international experience that getting the whole nation active every day will only happen if we involve all sectors. To effect real and lasting change we need to take a long-term, evidence-based approach, building upon what we know works. We need to embed physical activity into the fabric of daily life and make it the easy, cost-effective and 'normal' choice in every community in England.

We want to engage with all professionals, providers and commissioners in health, social care, transportation, planning, education, sport and leisure, culture, the voluntary and community sector and both public and private employers to help us make the case for more – much more – physical activity for all of those who can.



33% of men and 45% of women do not reach CMO recommendations for physical activity (HSE)



18% of disabled adults regularly take part in sport compared to 39% of non-disabled adults (APS)



19% of men and 26% of women are 'physically inactive' (HSE)

21% of boys and 16% of girls aged 5-15 meet the CMO recommendations for activity for children
But...



47% of boys and 49% of girls in the lowest economic group are 'inactive' compared to 26% of boys and 35% of girls in the highest (HSE)



23% of girls aged 5-7 meet the recommended levels of daily physical activity, by ages 13-15 only 8% do (HSE)



Walking trips decreased by 30% between 1995 and 2013 (NTS)



64% of trips are made by car



22% are made by foot (NTS)



2% are made by bike (NTS)

Data Sources:
Health Survey for England 2012 (HSE)
Active People Survey 8, April 2013-April 2014 (APS)
National Travel Survey July 2014 (NTS)

The Chief Medical Officer's Guidelines on Physical Activity¹²

For early years (under 5s)

1. Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments.
2. Children of pre-school age who are capable of walking unaided should be physically active daily for at least 180 minutes (3 hours), spread throughout the day.
3. All under 5s should minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).

These guidelines are relevant to all children under 5 years of age, irrespective of gender, race or socio-economic status, but should be interpreted with consideration for individual physical and mental capabilities.

For children and young people (5-18 years):

1. All children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.
2. Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week.
3. All children and young people should minimise the amount of time spent being sedentary (sitting) for extended periods.

Based on the evidence, the guidelines can be applied to disabled children and young people, emphasising that they need to be adjusted for each individual based on that person's exercise capacity and any special health issues or risks.



The Chief Medical Officer's Guidelines on Physical Activity¹²

For Adults:

1. Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
2. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous intensity activity.
3. Adults should also undertake physical activity to improve muscle strength on at least two days a week.
4. All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Based on the evidence, the guidelines can be applied to disabled adults, emphasising that they need to be adjusted for each individual, based on that person's exercise capacity and any special health or risk issues.

For Older Adults (65+ years):

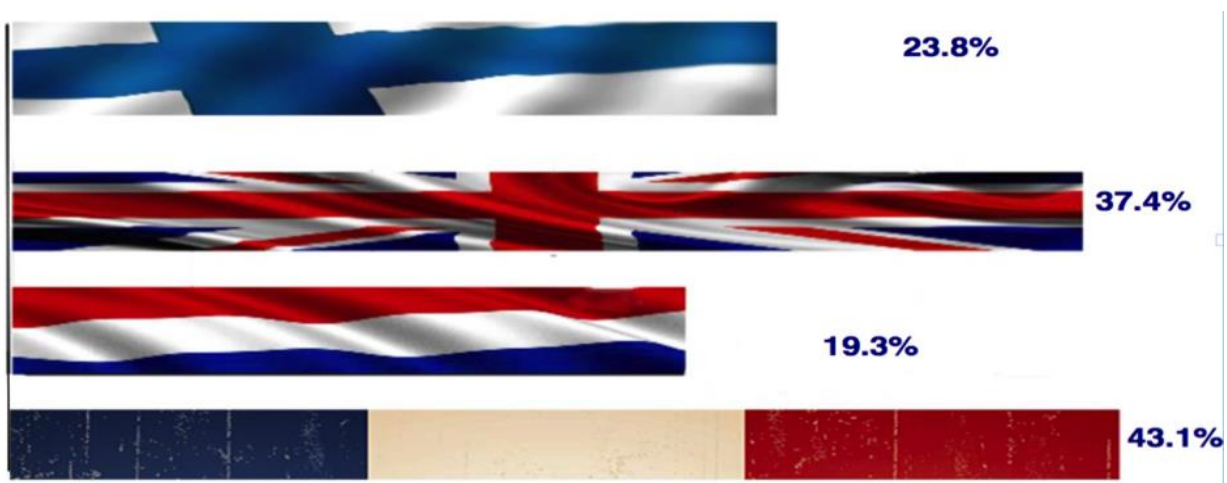
1. Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.
2. Older adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
3. For those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.
4. Older adults should also undertake physical activity to improve muscle strength on at least two days a week.
5. Older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.
6. All older adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Based on the evidence, the guidelines can be applied to disabled older adults emphasising that they need to be adjusted for each individual based on that person's exercise capacity and any special health or risk issues.

2. Inactivity is killing us

Physical inactivity is responsible for 1 in 6 (17%) of deaths in the UK⁸. This makes it as dangerous as smoking⁹. Yet over a quarter of us are still inactive, failing to achieve a minimum of 30 minutes of activity a week, and in some minority communities this falls to only one in ten adults. Whilst measurement differences limit direct comparisons, international studies using a single methodology consistently demonstrate that we lag behind most other similar countries in reducing physical inactivity (eg Figure 1).

Figure 1: Eurobarometer comparison of inactivity (Finland, UK, Netherlands and France)¹⁰



There are many reasons for the continued epidemic of physical inactivity. Social and economic trends over decades have ‘designed’ physical activity out of daily life. Fewer of us have manual jobs. Technology is more and more dominant in home and work, the two places where most of us spend much of our time. It encourages us to sit still for long periods – at the computer, mobile phones, tablets and the TV, or at electronic gaming systems. Over-reliance on cars and other motorised transport is another factor.

Our cities, towns, buildings and even parks too often work against physical activity. The design of schools, public buildings and urban spaces prioritise convenience and speed instead of encouraging people to walk or cycle. It is often easier to find the lift than the stairs. Concerns about vandalism and maintenance have left public spaces without the benches and toilets that allow older or disabled people to venture out. Traffic, not pedestrians, dominates most public spaces.

The Government’s target, reiterated in the *Moving More, Living More* as the Olympic and Paralympic legacy commitment, is to increase the number of adults taking at least 150 minutes of exercise per week and reduce the number taking less than 30 minutes per week, year on year. Although there has been progress, it remains too slow.

With time and commitment in short supply, being active every day is – and always has been – about integrating incidental activity into our daily lives. It's about taking the opportunity to make short everyday trips on foot, by bicycle or using public transport – as well as doing whatever you enjoy in terms of exercise, dance or sport.

A Quick Snapshot

- more than 1 in 17 adults in the UK¹¹ are living with diabetes; more than 90% with type 2 diabetes. Being active can reduce the risk of developing this illness by 30-40%¹². Those living with it can reduce their need for medication and the risk of complications by being more active¹³
- 1 in 8 women in the UK are at risk of developing breast cancer at some point in their lives¹⁴. By being active every day they could reduce their risk by up to 20%^{12,15}
- dementia affects 800,000 people in the UK. Repeated studies have shown that being active every day can reduce the risk of vascular dementia and also have an impact on non-vascular dementia¹⁶
- the link between physical activity and obesity is well established. With more than half of adults and almost a quarter of children overweight or obese¹⁷, most of us can benefit from being more active every day
- depression is increasing in all age groups. Inactive individuals have three times the rate of moderate to severe depression of active people¹⁸. Being active is central to our mental health and feelings of general wellbeing

Disease and disability creates costs, and not just for the NHS. Long term conditions like diabetes, cardiovascular and respiratory disease can lead to greater dependency on domiciliary care, residential and ultimately nursing care. This creates avoidable costs for local authorities as well as economic and social pressure on families

The problem of inactivity

Being inactive is an issue at every age. Spending long periods sitting in one place – so many of us are spending long periods on the sofa, the computer and the desk chair – can be bad for your health. This applies even to those who are already taking vigorous regular exercise.

This is important for our state of mind as well as the body; activity increases feelings of wellbeing, mental alertness and energy.

More than 40% of women and 35% of men are spending more than 6 hours a day sitting still. Those aged 16-24 and 64-75 have similar amounts of sedentary time¹. Although many of us become more sedentary as we get older, this is not inevitable. Lots of older adults remain active, which helps to keep them more engaged in the community, and contributing to society, as well as preventing falls and circulatory problems.

Generally, the more we do, the greater the benefit. Moving from being inactive to a significant level of activity has the greatest benefit to individuals (and consequently communities and local services) but any shift helps. There is a three-year difference in life expectancy between minimally active and inactive people¹⁹. This incentivises a focus on the most inactive; identifying these individuals and investing resources appropriately to support us all to be active every day.

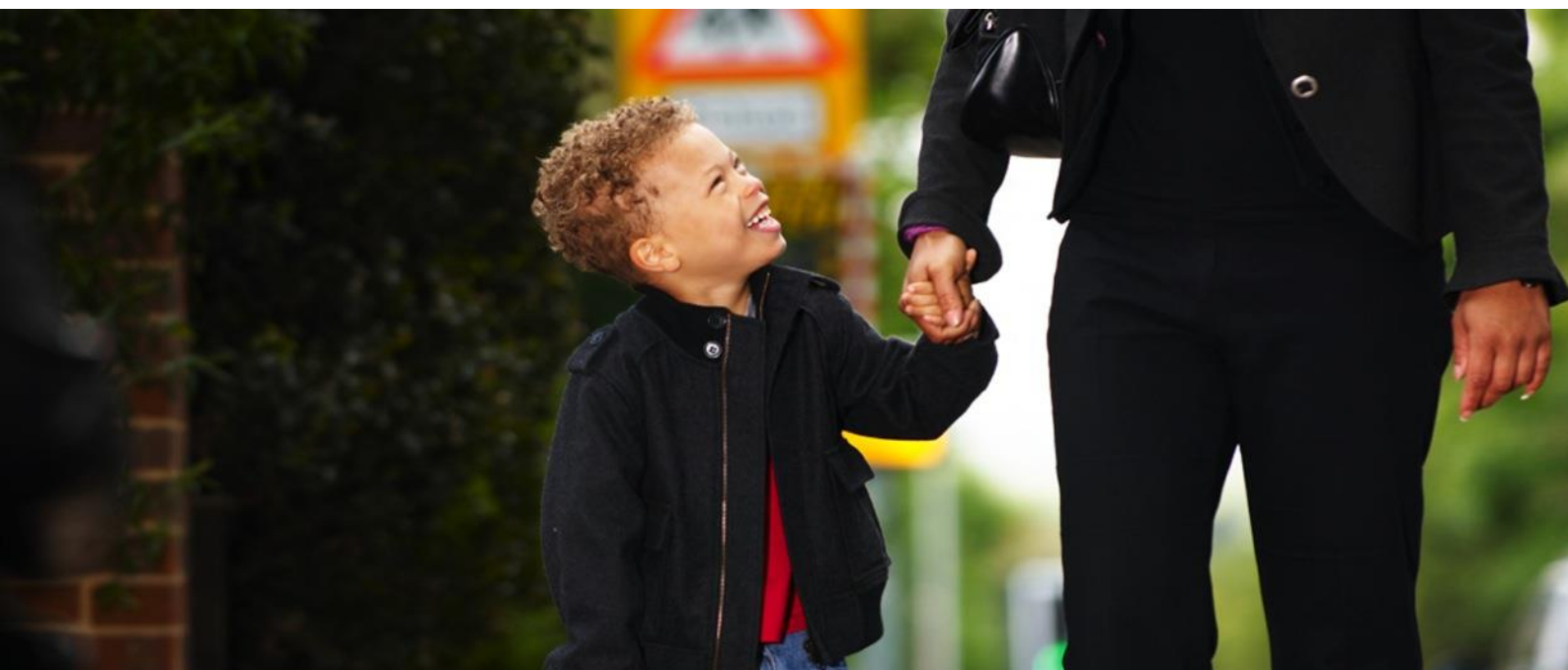
Payback

It's not just in terms of health and social care that physical activity pays back. Although there is much still to work on in terms of evidence, physical activity can create economic growth.

Businesses with more active workforces are more productive, have lower sickness rates and less staff turnover. Pedestrians help keep local high streets alive.

In every way, activity gets us outside the front door and connecting with others, avoiding social isolation and increasing social capital and community spirit.

So getting the nation moving every day is essential. At national level it will help keep the welfare state economically viable. At a personal level it's fun and sociable – and helps people stay well, both physically and mentally.



3. Inequalities: closing the gap

Being active every day needs to be embedded across every community in every aspect of life - not something where cost, access or cultural barriers are at issue. The association between physical activity and a healthy, happy life means an active life needs to be made easy and accessible for all.

Here are just some of the inequalities in physical activity in England:

- *Geography*
 - People living in the least prosperous areas are twice as likely to be physically inactive as those living in more prosperous areas²⁰
 - South East England has the highest proportion of both men and women meeting recommended levels of physical activity, while North West England has the lowest¹
- *Age*
 - Physical activity declines with age to the extent that by 75 years only 1 in 10 men and 1 in 20 women are sufficiently active for good health²¹
 - Between 2008 and 2012, inactivity in boys rose by 7% and in girls by 2%, and the proportion of those reaching the healthy recommended levels of activity fell by 7% for boys and 3% for girls²²
- *Disability*
 - Disabled people are half as likely as non-disabled people to be active
 - Only 1 in 4 people with learning difficulties take part in physical activity each month, compared to over half of people without a disability²³
- *Race*
 - Only 11% / 26% of Bangladeshi women and men are sufficiently active for good health, compared with 25% / 37% of the general population²⁴
- *Sex*
 - Men are more active than women in virtually every age group, with 6 in 10 women not participating in sport or physical activity²⁵
- *Sexual orientation and Gender Identity*
 - Over a third of lesbian, gay, bisexual and transgender youth do not feel they can be open about their gender identity in a sports club²⁶

Alongside this document we are publishing a series of specific topic overviews that give more detail about issues of inequality.

4. Responding to the challenge

We are 24% less active than in 1961. If current trends continue, we will be 35% less active by 2030.²⁷ We have to turn the tide.

Physical activity does not need to be strenuous to be effective. Thirty minutes a day of moderate aerobic activity can mean a brisk walk, a swim, or gardening. Each ten-minute bout that gets the heart rate up has a health benefit. Although sport is part of the picture, fitness does not have to be a 'regime'. Dancing can be as beneficial as going to the gym, and walking or cycling to the shops or work can be a great way to get heart pumping as part of doing the everyday chores.

Being active is not just about moving more. We also need to build our muscle strength and skills, and our 'physical literacy'. In the early years of life, active play is a fundamental part of physical, social and emotional development. As children grow, being active builds the foundation for an active life. Once learnt, a skill like swimming or being able to ride a bike is there for life.

From the age of 30, an adult's muscle and bone mass peaks and begins to decline slowly²⁸. Performing simple resistance-type activity - such as press-ups or light lifting - twice a week improves muscle strength and stability. It also helps prevent the development of musculoskeletal disease. We need to revise our physical literacy as we get older, changing our expectations of what we can do so that we have the confidence to do it. That will help maintain independence as long as possible.

With over a fifth of the nation not managing even 30 minutes of physical activity a week, this may seem like too major a challenge. However, change on a national scale is possible.

Once the world record holder for heart disease, 40 years ago Finland started a nationwide campaign for change⁵. The government shifted money to local authorities, a move similar to the shift in England of the Public Health Grant. Authorities responded by creating heritage and conservation trails; building active outdoor play and exercise spaces; and encouraging sport at all levels, both formal and informal. They developed innovative approaches for distinct groups, such as the elderly or the persistently hard-to-reach. Increases in leisure time physical activity have been seen across all age groups: young people, working aged and older people⁵.

A number of common characteristics are apparent in effective action to increase population levels of physical activity²⁹. These include two common factors: persistence and collaboration. Change requires all of us to take action: no single agency or organisation can respond to the challenge alone.

5. Four domains for action

What we need to do is simple: be more active.

This is a question of creating cultural change. Numerous reports have already stated the urgent case for a more active nation, including national government³⁰, across all parties³¹, the private sector³² and the voluntary sector³³, which makes vital contributions. We now need it to happen.

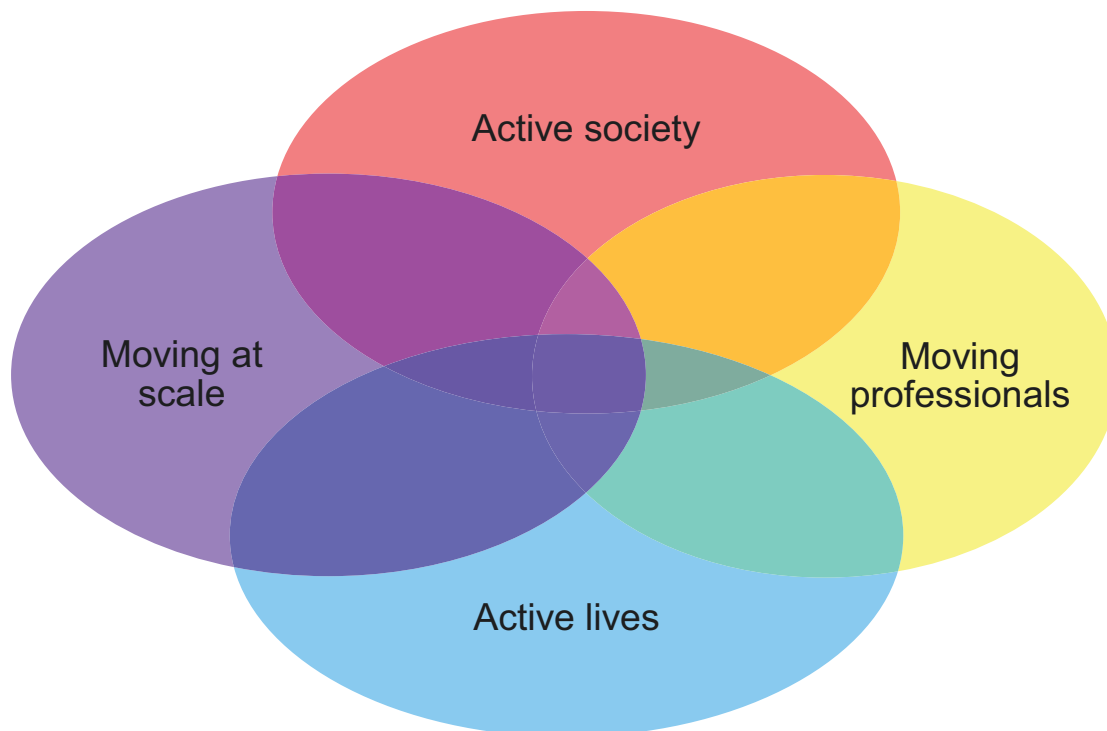
Physical activity needs to be made easy, made fun and made affordable. If we want everyone to be active every day, exercise and active recreation must be available to all, at every stage of life in every community across England.

To deliver this vision requires action across four areas (Figure 2), at national and local level.

- active society: creating a social movement
- moving professionals: activating networks of expertise
- active lives: creating the right environments
- moving at scale: scaling up interventions that make us active

A pro-activity movement needs to cascade right through society. To enable the country to get on its feet, we need to think smarter, using existing resources better. Government (national and local), the private sector, voluntary sector, communities and individuals must use their joint muscle to make this happen.

Figure 2: Four domains for action at national and local levels



Active Society: creating a social movement

PHE has already developed a communications strategy that aims to strike deep into the national psyche. This includes the Change4Life '10 minute shake-up' campaign, with the entertainment giant Disney. This initiative saw a quarter of million families sign up in the first month. PHE will build on this success, with new campaigns for adults and young people; yet this is only part of the action needed to change the social 'norm'.

Social norms can only truly shift if we can change general attitudes to physical activity. The message that being active is not just fulfilling and fun, but can be an easy choice needs to be a linking thread that unites the public sector with the voice of charities and community leaders. It's a message that can be woven into the policies, commissioning and planning decisions made every day across the country, by all of us.

This is especially true in communities where there are significant inequalities in health. The communities with the lowest levels of physical activity often have the highest burden of disability and disease.

PHE can help lead the movement for change, but this can only come about if all sectors in the places we live and work act together. These include: national and local government; schools; transport, leisure and sports providers; community and voluntary leaders and organisations; employers and health and social care professionals.

The common vision is to get everybody active every day, driving a radical shift in the take-up of physical activity on a national scale - and make it a routine part of daily life in England.

We need a cultural turnaround in attitudes to physical activity. There is no quick fix. We need long-term promotion of physical activity over months, years and decades. This is a journey which starts today.



Moving professionals: activating networks of expertise

We already have the ideal information network available; the hundreds of thousands of professionals and volunteers who work directly with the public every day.

The existing push for ‘making every contact count’³⁴ needs to come from all sectors and disciplines, not just health specialists. We need to activate professionals in spatial planning, social care, psychology, sport and leisure, the media, trades unions, education and business to bring about radical change.

Education

Teachers at every level of education, from early years and primary school to further education, have a huge impact on people’s emotional, physical and social development and wellbeing. There are many ways to inspire the next generation to be active every day. It can come through discussing forces and energy transfer in physics, designing active cities with urban planning students, or understanding team dynamics within psychology or business studies.

Sports

It is easy to assume that sport and fitness professionals do not need support, but many welcome the opportunity to know more about the impact of physical activity. They will find new ways to use that knowledge to motivate and inspire the people they work with. We also need to do more to develop and engage those professionals working in very targeted programmes with individuals who need extra support to be more active; those with complex health needs or impairments.

Health

Social care professionals and volunteers need more information about the ways physical activity can increase independence and autonomy for the people they care for. When it comes to health professionals, in both primary and secondary care, the evidence is clear: there is not enough action taken to integrate and recommend physical activity as a part of treatment. Both the NHS and patients are losing out because of it.

Active lives: creating the right environments

The World Health Organisation defines a healthy city as one that: ‘supports health, recreation and well-being, safety, social interaction, easy mobility, a sense of pride and cultural identity and ... is accessible to the needs of all its citizens’. The same principles apply to rural villages, towns and communities of all shapes and sizes.

The way land is used in communities has an immense impact on the public’s health. Although many surveys show it’s the quality, not just the quantity of public parks and spaces that make people want to walk more, there is evidence that just having access to open space makes a crucial difference. One study in Bristol showed that respondents living closest to formal parks were more likely to achieve good physical activity levels. They were also less likely to be overweight or obese³⁵.



Those with close access to green space live longer than those without it, even adjusting for social class, employment and smoking. The impact is most significant amongst the least well off. The health of older people increases where there is more space for walking near home, with parks and tree-lined streets nearby³⁶. Children become more active when they live closer to parks, playgrounds, and recreation areas³⁷.

Being active can be for fun, but it can also be part of the daily commute or the journey to school. We are surrounded by existing spaces which can be used to help everyone become more active, from forests to multi-storey car parks. With imagination and communities at the heart of the planning, these can become vibrant spaces that reduce isolation, sustain communities and improve health.

Creating environments that support active living is about re-shaping the world we live in. We need to make active living the easy and enjoyable choice. We can help older people and those with impairments to be more active with simple measures such as dropping the kerbs on pavements and introducing park benches. Introducing cycle parking and showers at workplaces; improving stairwells so they are as attractive a choice as the lifts, are just some of the ways we can make being active a more attainable goal.

Local authorities are seizing the opportunity to link local health policy with other policy strands such as planning, transport infrastructure and housing. This opens up the opportunity to create new networks of expertise, and design in physical activity from the ground up. New partnerships - for example between architects and urban planners working directly with professionals in health and leisure - are already finding new ways of reversing the downward trends in activity levels.



Moving at scale: scaling up interventions that make us active

We need to create the appetite for a revolution in physical activity and health. In partnership with local and national government, professionals in schools, the health sector, transportation, the sports, leisure and voluntary sectors can all be energized to achieve the common goal. We just need to light the touch paper.

The evidence shows that positive change needs to happen at every level, to everyone, in every locality. It needs to be measurable; permanent and consistent. It needs hardwiring into our national culture and consciousness.

NICE has published multiple pieces of guidance which will help to get the nation active every day. Local Health and Wellbeing Boards have the right knowledge and understanding of their local community and the assets they can build on to implement this guidance and make it a reality.

Existing NICE guidelines

Guideline	Date published	Title
PH2 ¹	2006	Four commonly used methods to increase physical activity
PH8	2008	Physical activity and the environment
PH13	2008	Promoting physical activity in the Workplace
PH17	2009	Promoting physical activity for children and young people
PH41	2012	Walking and Cycling: local measures to promote walking and cycling as forms of travel or recreation
PH44	2013	Physical activity: Brief advice for adults in primary care

Much of this is not about new investment; it's about maximizing the potential of the many assets we already have in parks, leisure facilities, community halls, and workspaces, and thinking differently about the way we commission and plan public sector services so that being active is at the core of everything we do every day.

There are challenges in evaluating what works. PHE has published alongside this document an overview of the evidence base, a set of promising practice case studies and an overview of existing 'return on investment' tools. We will add to this with additional guidance on using the standardised evaluation framework. Building the evidence base will boost our understanding of what works.

¹ We anticipate PH2 Recommendation 5 will be superseded in September 2014 and the document will be updated once the new guidance from NICE is published.

6. Measuring impact

As we call for everybody to be active every day we recognise the need to monitor progress and measure impact at a population, organisational, programme and individual level.

A range of population level surveys of physical activity provide information at national, regional and local levels. These include:

- Health Survey for England
- Active People Survey
- National Travel Survey
- Labour Force Survey

Most surveys use self-reported physical activity data. Although surveys which contrasted this with accelerometers showed that most of us overestimate the level of activity undertaken, the Chief Medical Officer's Guidelines took this into account.

To support the evaluation at a local level of interventions, Public Health England has developed the **Physical Activity Standard Evaluation Framework (SEF)**³⁸. This explains what information should be collected in any evaluation of an intervention. It is aimed primarily at interventions which work at an individual or group level. PHE also provides training and guidance on how to use the SEF, and we will be further developing this in 2015-16.

We recognise the significant challenge in measuring impact and return on investment. PHE will continue to work with partners to support better evaluation of interventions, as well as monitoring the impact of our own work in getting everybody active every day.

7. Making it happen

Capacity-building over time

Delivering a vision of everybody active every day will not be achieved in one, five or even ten years. This document provides a framework for action and is supported by resources that will be updated and adapted to keep pace with change.

A companion *Implementation and evidence guide* is being consulted upon alongside with evidence-based opportunities for action that could be taken at National, local and organisational levels across the public health system. These include five steps for local areas to support change:

- teach every child to enjoy, value and have the skills to be active every day
- build environments that are age friendly, safe for cyclists and make walking easier
- make every contact count for professionals and volunteers to encourage active lives
- lead by example in every public sector workspace
- evaluate and share the findings so that the learning of what works can grow

Public Health England is working with partners including the Local Government Association, ukactive and the County Sports Partnership Network to continue the programme of regional fora to support and energise action at a local level and continue to build capacity across the public health system to make this change happen.

Governance and Leadership

At National level, the Parliamentary Under-Secretary of State for Public Health through the chair of the Olympic and Paralympic Cabinet Committee - Ministerial Sub-Group on Physical Activity will continue to oversee action to deliver the national commitment to increasing activity across the nation, supported by the civil service officers group.

At local level, Health and Wellbeing Boards are pivotal to developing and delivering the partnership actions required to truly shift society forward. Local Community Sports Partnerships are developing in many areas to become Active Networks that bring together organisations providing sport, active travel, dance and cultural activity and outdoor activity opportunities to support Local Government and their partners in delivering at pace.

Public Health England will continue to work with partners at National level and through our Centres to support their implementation and build the evidence base around their return on investment.

8. PHE actions to support implementation

Alongside Everybody Active, Every Day PHE is publishing supporting documents that provide in-depth information and resources to support local and national action.

These include:

- a set of topic overview reports providing more in-depth discussion and analysis of issues specific to certain groups. We will continue to add to and expand these over the next 18 months. The first set launched alongside *Everybody Active, Every Day* include: *Older People; Children and Young People; Disability; Ethnicity; Gender; Lesbian, Gay, Bisexual and Transgender People; Data and Evaluation; and Active Places*
- a toolkit for members of parliament and local elected members, to support their role in local leadership on physical activity
- a report commissioned from Sheffield Hallam University and ukactive on promising practice interventions from across England. Using the NESTA criteria to evaluate the 960 submissions received by PHE, the academic team has identified those with the strongest published evidence of impact, and those developing strong design and evaluation
- free E-learning resources commissioned from BMJ learning. Subjects include motivational interviewing techniques to support behaviour change and nine modules on physical activity and clinical conditions, including diabetes, depression and cancer
- a definitive review of return on investment evidence for health and wider outcomes. This is commissioned from the British Heart Foundation National Centre – Physical Activity + Health and Brunel Health Economic Research Group. This will summarise the economic benefits of physical activity not only on health but the wider social benefits. The review will consider social care, regeneration, travel and transport, business and economic productivity, crime and education. The results should help those building the case for intervention locally. It will also give practical guidance on return on investment tools available for local practitioners
- work commissioned from the British Heart Foundation National Centre and University of Brunel to map the academic landscape for physical activity.
- work with the National Centre for Sports and Exercise Medicine on how physical activity can be implemented practically into clinical care pathways in acute settings
- PHE will also be working with professional bodies and leaders (eg Royal Colleges, Health Education England, Allied Health Professionals Networks) to develop expertise and leadership amongst health professionals

References

- ¹ Health Survey for England, 2012
- ² Scarborough P, Bhatnagar P, Wickramasinghe KK, Allender S, Foster C, Rayner M (2011) The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs. *Journal of Public Health* 33 (4): 527-535.
- ³ Ossa D and Hutton J (2002) *The economic burden of physical inactivity in England*. London: MEDTAP International.
- ⁴ Murray *et al.* (2013) UK health performance: findings of the Global Burden of Disease Study 2010. *The Lancet* 381: 997-1020.
- ⁵ Vuori I, Lankenau B, Pratt M (2004) Physical activity policy and program development: The experience in Finland. *Public Health reports* 119: 331-345.
- ⁶ Pucher J (2003) Promoting safe walking and cycling to improve public health: Lessons from the Netherlands and Germany. *American Journal of Public Health* 93: 1509-16.
- ⁷ Laureus Sport for Good Foundation. **Teenage Kicks: the value of sport in youth crime**. 2011
- ⁸ Lee I-M, *et al.* (2012) Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. *The Lancet* 380: 219–29
- ⁹ Wen CP, Wu X (2012) Stressing harms of physical inactivity to promote exercise. *The Lancet Online* S0140-6736 (12) 60954-4
- ¹⁰ M. Sjöström . P. Oja . M. Hagströmer . B. J. Smith . A. Bauman. Health-enhancing physical activity across European Union countries: the Eurobarometer study. *J Public Health* (2006) 14: 291-300
- ¹¹ Diabetes UK (2014). **Diabetes: Facts and Stats**
- ¹² DH (2011) *Start Active, Stay Active: A report on physical activity from the four home countries' Chief Medical Officer*.
- ¹³ Boule NG, Haddad E, Kenny GP , *et al.* (2001) Effects of exercise on glycemic control and body mass in Type2 Diabetes mellitus. A meta-analysis of controlled clinical trials. *Journal of the American Medical Association* 286:1218–1227.
- ¹⁴ Cancer Research UK (2012). **'Breast cancer – risk factors'**
- ¹⁵ Breakthrough Breast Cancer (2014) **Physical Activity and Cancer Risk**
- ¹⁶ **The Blackfriars Consensus Statement**
- ¹⁷ Public Health England. **Child weight data factsheet**. 2014
- ¹⁸ Weyerer S (1992). Physical inactivity and depression in the community. Evidence from the Upper Bavarian Field Study. *International Journal of Sports Medicine* 13:492-6.
- ¹⁹ Wen CP, *et al.* (2011) Minimum amount of physical activity for reduced mortality and extended life expectancy: a prospective cohort study. *The Lancet* 378: 1244–1253
- ²⁰ Active People Survey 8, April 2013-April 2014.
- ²¹ Health Survey for England - 2009 Trend tables. (2010) The Health and Social Care Information Centre; available at www.ic.nhs.uk/pubs/hse09trends Accessed 20th April 2014
- ²² Public Health England. Child Physical Activity Data Factsheet. P7. August 2014. London. Data sourced from Health Survey for England 2012.
- ²³ Sport England Active People Survey December 2013 (sport once a month, any sport, any duration)
- ²⁴ Joint Health Surveys Unit (2006). Health Survey for England 2004: Health of Ethnic Minorities. The Information Centre: Leeds.
- ²⁵ Active People Survey 2007.
- ²⁶ METRO Youth Chances (2013) 'Survey of 16-25 year olds: First Reference Report'. London: METRO
- ²⁷ Ng SW, Popkin B (2012) Time Use and Physical Activity: a shift away from movement across the globe. *Obesity Review* 13(8):659-80.
- ²⁸ Rogers MA, Evans WJ (1993) *Changes in skeletal muscle with aging: Effects of exercise training*. In Holloszy, JO (Ed), *Exercise and Sport Science Reviews*. (pp.65-102). Baltimore: Williams & Wilkins.
- ²⁹ Bull F, Milton K, Kahlmeier S, Arlotti A, Backović Juričan A, Belander O, Martin BW, Martin-Diener E, Marques A, Mota J, Vasankari T, Vlasveld A (2014) Turning the Tide: national policy approaches to increasing physical activity in seven European countries. *British Journal of Sports Medicine*. Published online 28 March 2014.
- ³⁰ Her Majesty Government (2014) *Moving More, Living More: The physical activity Olympic and Paralympic Legacy for the Nation*. London: HMG.
- ³¹ All Party Commission on Physical Activity (2014) *Tackling physical inactivity – a coordinated approach*.
- ³² Designed to move (2013) **Designed to Move: a physical activity agenda**.

³³ Macmillan Cancer Support (2013) *Move More: physical activity the underrated wonder drug.*, and UKActive (2014) *Turning the Tide of Inactivity*

³⁴ NHS England (2014) *An Implementation Guide and Toolkit for Making Every Contact Count: Using every opportunity to achieve health and wellbeing*. London: NHS England.

³⁵ The relationship of physical activity and overweight to objectively measured green space accessibility and use, Emma Coombesa, Andrew P. Jonesa, Melvyn Hillsdonb
<http://www.sciencedirect.com/science/article/pii/S0277953609008156>

³⁶ Maas J, Verheij RA, de Vries S, Spreeuwenberg P, Schellevis FG and Groenewegen PP (2009) Morbidity is related to a green living environment. *Journal of Epidemiology and Community Health* 63: 967–97

³⁷ Davidson K and Lawson C (2006) Do attributes of the physical environment influence children's level of physical activity? *International Journal of Behavioural Nutrition and Physical Activity* 3 (19): 1-17.

³⁸ National Obesity Observatory (2012) *Standard Evaluation Framework for physical activity interventions*.