ukactive and Active Partnerships Network

Designing and delivering services to support the implementation of the 10 year vision for the NHS (2025)

Building the Optimal Relationship Between the Health and Care System and the Physical Activity Sector

From Treatment to Prevention / From Hospital to Community
From Analogue to Digital / Increasing the Value of Every Pound Spent

A BLUEPRINT OPERATING MODEL

Executive Summary

This blueprint sets out, in simple terms, a set of principles and actions that will support the NHS and its partners to achieve the 10-year vision for health and care in this country. It focuses on how, through greater provision and uptake of physical activity (in its myriad forms), there could be a rapid boost to the health of the population, including from supporting improved outcomes from hospital treatment.

Following a long process of engagement with leading players in both the healthcare and the physical activity sectors, this document sets out eight components for action, which, if facilitated by Integrated Care Boards (ICBs) working with physical activity providers, would deliver reduced demand for healthcare services, faster access to care, better outcomes from treatment and enhanced value for every pound spend.

This document is not designed to be prescriptive but rather serves as a framework for how the NHS, Local Authorities and the physical activity sector can collaborate to empower individuals, create supportive environments, and expand opportunities for people to improve and sustain their health through physical activity and moving more.

Components of the Optimal Relationship

The eight elements below have been identified as areas that should be focused and delivered on to facilitate the integration of physical activity into the health and care system:

1	Coordinated governance and oversight at the most senior level, with joined up planning, accountability and financial/clinical incentives
2	Establishment of effective partnerships and networks at place and local neighbourhood level
3	Establishment of routine data sharing between the sectors
4	Delivery of evidence-based physical activity programmes in prevention and in treatment and care pathways
5	Specific support for the elective recovery programme
6	Creation of opportunities for improving productivity, stimulating economic growth, and enhancing workforce growth and employment opportunities
7	Commitment to a shared approach to physical activity promoting individual and collective engagement, communication and campaigning
8	Development of existing small and partial interventions into comprehensive, financially sustainable programmes available and accessible to all the ICS population

Context

The health and care system in the UK, in common with other countries across the world, is facing unprecedented levels of demand for its services. These have been compounded by the effects of the COVID-19 pandemic which has created long waiting times for physical, mental and social services and poorer health outcomes. This has widened health inequalities in a constrained economy to fund such a commensurate response.

In September 2024, the new Government published an assessment by Lord Ara Darzi that described the NHS and care system to be 'broken' as it stands and pointed to the need for reform in its direction of travel to find a solution.

This assessment highlighted the need to embrace three key shifts in the way the NHS design, deliver and maintain health and care:

- from sickness to prevention
- from hospital to community
- from analogue to digital

It is the physical activity sector's overwhelming belief, supported by research from WHO that, **by enhancing the nation's levels of physical activity (getting people to move more), and by building evidence-based physical activity into our care pathways, programmes and frontline treatments, we can provide a significant contribution to delivering these shifts.**

But also, **by doing so, we can underpin the Government's ambition for economic growth** by reducing the economically inactive and by stimulating an increase in jobs and inward investment.

We contend that no health promoting intervention other than physical activity has the same scale and ability to simultaneously meet both key Government missions whilst also delivering the ambitions of ICBs, Local Authorities, local neighbourhoods and local people. Physical activity promotion can initiate positive change cascading from individual micro-level behaviours to macro level to influence the wider societal structure[2].

[1] WHO Global Action Plans on Physical Activity 2018

[2] Global action plan on physical activity 2018–2030: more active people for a healthier world ISBN 978-92-4-151418-7 World Health Organization 2018

Moving From Rhetoric to Action

The physical and emotional health benefits of physical activity and moving more have long been known and accepted, whether to maintain good health, reduce the impact of poor health, or improve recovery from episodes of severe health problems. Yet as a nation we continue to find maintaining an active lifestyle, accessing and delivering physical activity programmes at scale elusive, despite the strong and growing evidence base.

Consequently, in 2023 and 2024, ukactive convened a series of summits with key leaders from the NHS, wider health and care sectors, and physical activity leadership at national and local level. The summits identified an opportunity to work with a small number of developer **ICBs, the statutory body, leading their Integrated Care Systems (ICSs)**[3] on developing a blueprint that, if followed, would exemplify what could be achieved through establishing an effective relationship between the health and care system and the physical activity sector.

The six developer ICBs, drawing on the experience of many ICBs, ukactive and the Active Partnerships, have been working hand in glove with physical activity providers to define and deliver the optimal relationship between the two sectors. This covers all the aspects of the relationship - including enhancing physical activity levels to maintaining good physical, mental and social health, offering support for workplace health and return to work, and delivery of comprehensive access to evidence-based care programmes that will deliver the full potential value of the partnership.

The six developer ICSs identified were:

Greater Manchester	Lincolnshire	West Yorkshire
South East London	Cambridgeshire and Peterborough	South Yorkshire

Key partners from interested adjacent sectors have also been included in the design of the blueprint, including:

- Commercial suppliers to the physical activity sector
- Representatives of wider interested Government Departments and Agencies (DHSC, DCMS, NHSE, Sport England, DWP etc.)
- Key national health charities
- Digital and data management companies
- Potential financial investors in the sector

The blueprint concept recognises the need for agility and flexibility in both creating and implementing a comprehensive approach in every ICS. It has enabled the development of a standardised set of actions. The blueprint has been designed to act as a catalyst for change and to provide a supporting framework to foster sustainable partnerships, that can be adapted locally to each place, neighbourhood and community.

[3] This document refers generically to ICSs but in doing so, we recognise that an ICS consists of its multiple constituent parts (Places, Trusts, LAs, neighbourhoods, PCNs VCSE providers etc) and that each has its own operating model in which decision making and planning may be devolved to different levels. As such we advocate flexibility in implementation of the blueprint but retain the desire to set some clear standardised actions for local systems.

The Eight Components of the Optimal Relationship

1

Coordinated governance and oversight at the most senior level with joined up planning, accountability and financial/clinical incentives

This will ensure that physical activity is within the purview and influence of the most senior decision makers who set the systems priorities at ICS, ICP (Integrated Care Partnership) and place level, and that interventions and programmes can be commissioned and funded based on local need and strategy.

In practice, some systems already have a programme board linked to physical activity. However, these are too often subsidiary.

Consequently, ***it is essential to identify formal governance arrangements within ICBs and ICPs, to ensure senior leadership oversight and establish effective mechanisms that influence finance and resource allocation. This includes embedding physical activity within existing structures to drive strategic priority setting and investment. This would also provide a clear framework for decision making, ensuring physical activity is integrated into system wide planning and resource distribution.***

Such an approach would facilitate effective collaboration between the NHS, LAs and the physical activity sector on an equal footing - supporting:

- Advocacy for and championing of the physical activity agenda in setting population health strategies, priorities and budgets from the ICB, its local constituent organisations and Mayoral Combined Authority or individual local authorities
- Encouraging and promoting the links between clinical practice and general management/financial processes (sharing best practice when available)
- Strengthening connections between the ICS leadership and Local Government Health and Wellbeing Boards, offering scale that can amplify impact
- Oversight and coordination of physical activity within the ICS to along with health and care priorities
- Coordinating planning
- Systemic monitoring and evaluation of progress and achievement of objectives and goals
- Alignment of financial and clinical delivery incentives between partners and service providers

In addition, ***there is a clear need to link accountability with incentives, ensuring that funding, resource use and rewards are aligned to achieve better outcomes (including for preventive interventions where the return on investment (ROI) is high).***

Research demonstrates that most health interventions provide a positive ROI, through both financial benefits to the NHS, local government and the wider economy and, importantly, to society through improved health outcomes. What is particularly interesting as many interventions do not sit solely within the budgetary or decision-making scope of any one sector and certainly not the NHS, highlighting the need to focus on prevention in its broadest sense and starting with places and populations. Delving below the broad categories to look at the top 20 specific interventions themselves (see figure one), all were based in care settings in the community. This further supports that investing in community-based interventions brings tangible economic and health benefits[4].

[4] https://www.carnallfarrar.com/wp-content/uploads/2024/10/Pathway-to-prevention-CF.pdf

Figure 1: Top 20 Interventions by Category and Care Setting with Physical Activity and Exercise Ranking 2, 3 & 10

Local Authority
NHS

Rank	Category	Care Setting	Intervention	ROI
1	Housing	Homes	Adapting 100,000 homes where a serious fall is otherwise likely to occur	34.8
2	Exercise	Community	By training healthcare professionals, via clinical champions, to provide **physical activity** brief advice	23.7
3	Exercise	Community	Birmingham City Council's scheme to provide free leisure services to its residents	20.7
4	SMI	Mental Health	Suicide/self-harm prevention (restrict access to means, making transport safer and reduce harmful drinking)	19.6
5	Housing	Homes	Adapting 100,000 homes where residents are likely to require treatment due to the excess cold	17.1
6	Employment	Community	Tower Hamlets 'work it out' scheme (employment support, work experience, CV help, interview prep)*	17.1
7	Smoking	Primary Care	NHS Stop smoking service + Text-message (TMB) based interventions**	15.3
8	Education	Schools	Anti-bullying programmes*	15.0
9	Education	Schools	Smoking prevention in schools**	15.0
10	Diabetes	Primary Care	Digital behavioural counselling to promote a healthful diet and **physical activity** for CVD prevention in adults with prediabetes and CVD risk factors	15.0

The evidence is clear: the top 20 interventions by Return on Investment (ROI) were all community-based with a range of ROI from up to £34.80 for every £1 spent.

For example, this could enable supporting agreed local population health outcomes, alongside connecting with concurrently running national incentives. This could be delivered in the following ways:

- Reference to physical activity in the future Planning Guidance and the implementation strategy for the 10-year Health Plan for the NHS (including the possibility of setting local prevention goals and targets)
- Explicit inclusion of measures and rewards in the General Medical Services Contract Quality and Outcome Framework (QOF), alongside Primary Care Network (PCN) core requirements in the Direct Enhanced Services (DES) for PCNs and their enhanced roles
- Financial reward linked to elective recovery incentives alongside capital funding rewards (see component five)
- Overall recognition and reward for ICSs and Trusts that implement the blueprint model in the National Oversight Framework (NOF) process
- Link to other local priorities (e.g. Children Young People, mental health, health and wellbeing of staff)
- Encouragement of risk and gain share arrangements with NHS/Local Authorities and the sector, including pooling or aligning revenue and capital budgets and establishing shared objectives

*The timeline used to calculate the ROIs for these interviews were not provided.
**The ROI for these interventions are calculated over a lifetime horizon

2

Establishment of Effective Partnerships and Networks at Place and Neighbourhood Level (to Supercharge Social Prescribing Opportunities etc.)

Understanding how to access services and facilities and then build mutually 'value adding' partnerships is the second fundamental component of the blueprint.

Often, the existence of locally provided and online services that are available to maintain health and wellbeing, support the recovery of people who are experiencing health challenges, and provide programmes to enable people to return to work, is not well known.

We believe this could be addressed effectively with more coordination and better communication and engagement approaches, which would bring immediate added value to both sectors.

This would be based on the **two major opportunities.**

The first - to build the physical activity sector and its workforce into the new model of delivering neighbourhood health and care (along with primary care, social care, other Voluntary, Community and Social Enterprises (VCSE) and commercial services such as pharmacists).
Such an approach would enable:

- Optimising the human resource across the sectors
- Optimising local facilities (research demonstrates that individuals prefer to receive health care and advice in non-NHS settings like leisure centres etc.)
- Optimising existing collective health enhancing opportunities such as parkrun

The second - to use technology to enable access through existing channels such as current search engines, or to create new or develop existing portals/databases (often provided by local Active Partnerships) that list physical activity providers and programmes that offer physical activity programmes for health maintenance and health condition management. This is to provide online mechanisms to:

- Enable access to online physical activity programmes as well as signposting local provision (NB: Health Innovation Networks often have information on leading edge developments on this sphere)
- Underpin ICS-wide campaigns and collective calls to action (e.g. Greater Manchester Moving)
- Support social prescribing as a major route for accessing physical activity programmes
- Publicise local programmes and services
- Use and inform the wider spread of social prescribing by GPs
- Link to wider health checks and screening programmes
- Link NHS staff into physical activity programmes as a vehicle for reducing sickness absence and enhance staff wellbeing
- Link wider employers to programmes in a similar fashion
- Link local employment and benefits agencies with programmes to support reductions in the levels of the local economically inactive population

These opportunities will require existing service providers to provide detailed, up to date information on their programmes, such as qualifications of staff, access criteria and cost, which will ensure effective patient and public awareness and uptake.

3

Establishment of Routine Data Sharing Between the Sectors

Establishing routine data sharing between sectors is a key third component of the blueprint, enabling better collaboration and informed decision making. This must be carried out in line with data protection, compliance and information governance requirements, to ensure that data is shared securely, ethically and with appropriate safeguards.

In support of the overall drive to undertake effective population health management, and building on patient, client and wider population consent, the sharing of data will assist with:

- Identifying and directing resources to the inactive population to ensure support reaches those who would benefit most.
- Enabling access and use of data to support the work of staff in both sectors as 'navigators', to help people find the right support for their conditions.
- Improving treatment regimes and programmes for those with conditions amendable to management or improvement through physical activity.
- Providing insights into tackling health inequalities.
- Providing a holistic health profile of service users and potential service users.
- Evaluating treatment programmes and interventions where in line with local protocols and approaches (e.g. GLP-1 programmes).
- Creating condition specific online programmes that offer insights and information tailored to each individual's circumstances, personal ability to cope and need for support.

The facilitation of data sharing (including by and with the physical activity sector) should be central to the investment that the Government is making into digital transformation in the NHS and the creation of both statutory data systems (such as Electronic Patient Records) **but more importantly through the evolution of the NHS App.**

4

Delivery of Standardised, Reliable, and Evidence-Based Physical Activity Programmes on Prevention and in Treatment and Care Pathways (in Mental, Physical and Social Care)

The evidence base for physical activity as a core element of preventive, treatment and care programmes is vast. Physical activity, exercise and moving or activity related community rehabilitation is recommended in 98 NICE clinical and condition and setting specific guidelines and quality standards, including those for cardiovascular conditions, musculoskeletal conditions, mental health conditions, cancers, fertility, irritable bowel syndrome, liver disease and ante and post-natal care[5].

The fourth component of the blueprint is to ensure that physical activity and moving more is built into all the relevant programmes and pathways as routine. This involves ensuring that these are universally used, and that interventions are supported by accessible high quality supportive service offers from the sector.

To enhance the connection between the health and physical activity sectors, guidance and recommendations from the Physical Activity for Health Pathways project by Move Consulting and the Active Partnership Network should be considered as part of the delivery of this blueprint. This community-based practice research has identified local challenges and co-designed potential solutions in developing a pathways framework to enable the health sector to refer patients to various physical activity options while ensuring that these patients receive personalised support to address their specific needs.

We recommend developing relevant pathways across primary, secondary and tertiary prevention outlined below. These pathways would help to integrate physical activity into health and care systems, ensuring a proactive approach to prevention and rehabilitation.

- **Primary prevention** (e.g. role of physical activity in being healthy and staying healthy, maintaining cardiorespiratory fitness, strength in bones and muscles through the life course.)
- **Secondary prevention** (e.g. role of physical activity and moving more in care programmes and pathways, recognising multiple morbidity that might include conditions such as cardiovascular, cancer, diabetes/metabolic disorders, depression, eating disorders, but which should be individually tailored as much as is feasible to patient identified needs etc.)
- **Tertiary prevention** (e.g. role of physical activity and moving more for better surgical outcomes, waiting well and cardiac and cancer rehabilitation, supporting and offering respite for carers, such as those offered through dementia-friendly swimming, golf etc.)

Implementing these pathways may require investment and capability in both the NHS and in the physical activity sector (e.g. in behaviour change skills). This requires specific understanding of the training needs, and strong input from training bodies such as CIMSPA, to recognise and respond to this growing need.

Many pathways are already available, and it will be the role of the ICS, Place and Trust to ensure that evidence-based care is consistently available to their populations with minimal unwarranted variation (as seen in previous NHS initiatives such as Getting It Right First Time (GIRFT)). Given the scale of the opportunity and the challenge here, it would be sensible to use this benchmarking data to identify priorities for development based on health benefits and return on investment.

Such programmes should also be made available to staff and carers as a matter of routine to reduce sickness absence levels.

Access to these programmes should be based on the whole life course and be accessible to all - irrespective of gender, background, orientation or socio-economic status. This is all whilst also being aimed at taking a holistic approach to care and wellbeing, addressing mental, physical and social health.

[5] NICE guidance mapping: Where Physical Activity, exercise and community rehabilitation appear in condition specific NICE Clinical guidance, NICE guidance and quality standards. Sport England November 2024

5

Specific Support to the Elective Recovery Programme (Working With Both Public and Private Sector Providers)

There is ***increasing evidence of the value of offering physical activity programmes for those people on waiting lists. This is done to offer alternative routes to treatment and improve treatment outcomes*** when individuals do get treated. ***This forms the fifth component of the blueprint for the ICS.***

The value of physical activity interventions:

- MSK Physical Activity Hubs based on a physical activity programme can lead to patient scores (e.g. Oxford hip and knee scores) reducing below the recognised pain and mobility levels for surgery and thereby allowing people to withdraw from a waiting list without an operation

- Physical activity programmes improving the fitness level of patients with a range of conditions (drawing for example on the guidelines from the Centre for Perioperative Care) prepare patients to face operations under general or local anaesthetic and emerge with better outcomes and shorter lengths of stay

- Post-surgical care plans offering physical activity as a means of avoiding readmissions and patient initiated follow ups

These activities should be made available and built into local action plans to respond to the Government's target commitment to reduce waiting times and numbers within the lifetime of this Parliament. **They are a very cost-effective way to reduce both waiting times and numbers allowing new investment in extra activity to go further, faster towards the Government ambitions.**

6

Creating Opportunities for Improving Productivity, Stimulating Economic Growth, and Enhancing Workforce Growth and Employment Opportunities (Including Return to Work and Reduction in Short – and Long-Term Sickness Absence)

Ensuring that the physical activity sector is delivering its full potential in support of economic growth is the sixth fundamental component of the blueprint.

This will largely be achieved through a systematic approach to targeting economic inactivity, essentially deploying three routes:

- **Reducing sickness absence levels** starting with the NHS and care workforce (as a direct means to avoid unnecessary extra costs of temporary labour) and moving into the wider workforce
- **Addressing the high levels of economic inactivity** in the general UK population
- **Creating high quality jobs** in the physical activity sector that include starter jobs as well as longer term more senior executive positions

The NHS needs to set a leading example in supporting its own workforce, as many Trusts do through offering staff health and wellbeing programmes that provide physical activity opportunities to team build, generate staff engagement, support staff to avoid short term sick leave, and enable the return to work of longer-term absentees. These could be **mirrored by or offered in partnership with other local employers including care providers.**

Through partnership working, ICBs can influence local welfare and benefit agencies to integrate physical activity programmes for musculoskeletal and mental health conditions addressing two of the leading causes of long-term sickness and economic inactivity.

The ability of the sector, in **supporting the NHS care system and wider employers to generate job opportunities, should be recognised and incentivised** through apprenticeships and access or return to work schemes.

The **physical activity sector should feature as a core component of any overarching local district's economic plans** - with a recognition of its contribution to employment, community engagement and cohesion, and the health and wellbeing of the population. This could be enhanced through the establishment of health and wellbeing budgets as used in New Zealand and Iceland.

7

Commitment to a Shared Approach to Physical Activity, Promoting Individual and Collective Engagement, Communication and Campaigning

The seventh component of the blueprint recognises that there is a significant opportunity for the physical activity and health sectors to join forces with their populations and customers to develop a shared communications approach that mobilises both populations and markets. Joining forces and expertise on this would provide real insights into overarching population wants and consumer needs.

A shared approach would serve to support health promotion messages from health professionals and give credibility and substance to the marketing campaigns of physical activity providers.

The opportunity for coherent messaging from health professionals to people in their care, at all stages of their patient interactions, represents a significant chance to embed physical activity and support to move more into their treatment or preventive programme. Positive outcomes of this could include avoiding de-conditioning whilst in hospital and promoting behaviour change in primary care. This approach could be developed further by offering better basic training and continuing professional development in the benefits of physical activity.

Coordinated campaigns and messaging at the ICS level (or multi-ICSs in the case of London) would attract regional media attention and would underpin national messaging. The use of social media can also make this activity more direct and targeted whilst reducing its cost.

There are numerous examples of campaigns of this nature (Greater Manchester Moving is one of the most prominent) and aligning these with other local and national campaigns - such as 'This Girl Can' - would also add value.

Past adversity and trauma can significantly shape a person's relationship with movement and physical activity, so use of inclusive and adaptable language within programmes and pathways is essential to make them more approachable for everyone. This includes social prescribing when connecting individuals to movement opportunities, considering lived experiences, and including supportive options like peer mentors. Physical activity can also be a vital tool for trauma recovery and should be integrated into mental health services.

8

Development of Existing Small and Partial Interventions Into Comprehensive, Financially Sustainable Programmes Available and Accessible to All the ICS Population (Either Directed Where Appropriate, or at Their Discretion), With a Renewed Commitment to Measurement and Evaluation of the Benefits

The eighth and final component of the blueprint relates to the provision of these interventions and programmes at scale for their whole population rather than in small scale pilots. These should be ***funded from mainstream budgets and be built into spending plans on a long-term basis.***

Finally, there is a need to establish the ability to set and measure progress towards ambitious targets that seek to secure the UK position internationally (and at every level from neighbourhood upwards) as the most active in Europe.

Conclusion

This blueprint outlines principles and actions to help the NHS achieve its 10-year vision by increasing the provision and uptake of physical activity and enhancing overall population health.

With the NHS facing unprecedented demand and growing health inequalities, key shifts are needed towards prevention, community care, and digital solutions. The eight components for action within this blueprint have been identified to facilitate the integration of the physical activity and healthcare sectors, to maximise the ability of the physical activity sector to support in reducing healthcare demand, improving treatment outcomes and driving economic growth.

This document has been designed to implement health policy development and planning at a national level, but also for specific use and implementation by individual ICBs and ICSs by enabling them to deliver national policy. Continued collaboration at all levels across Government, NHS, ICS, Local Authorities, Active Partnerships, local facilities and the wider healthcare and physical activity sectors, will be imperative to drive the outcomes that can be achieved through its implementation.

As part of ongoing development and recognising that there are already a lot of excellent examples of the eight elements of the blueprint being delivered in pockets across the country, work between partners will continue and include the production of a ‘best practice’ guide, with case studies illustrating positive implementation of the blueprint.

ukactive and Active Partnerships Network

Designing and delivering services to support the
implementation of the 10 year vision for the NHS (2025)

kennybutler@ukactive.org.uk