Cheshire and Merseyside Local Engagement on a Physical Activity Strategy for Health & Social Care

Final Report for Cheshire & Merseyside Health & Care Partnership

Proper Active

In partnership with Active Cheshire & MSP

June 2022

Cheshire and Merseyside Health and Care Partnership

Champs Public Health Collaborative

Active Cheshire

MSP

SPORT ENGLAND

Contents

1. Executive Summary

The Marmot Reports have demonstrated that health inequalities across England are stark and have grown over the last 20 years, fuelled by austerity and the Covid-19 pandemic. The All Together Fairer Report (2022) has shown that, in Cheshire and Merseyside, these effects have been keenly felt, with significant disparities in both life expectancy and healthy life expectancy between the richest and poorest neighbourhoods.

Whilst not a silver bullet, the wide-ranging physical and mental health benefits of physical activity are well recognised, with the UK Chief Medical Officer stating in 2019 that 'If physical activity were a drug, we would refer to it as a miracle cure'. The Cheshire and Merseyside Health and Care Partnership (C&MHCP) are keen to capitalise on this opportunity. Since 2019, they have been working in partnership with Active Cheshire and MSP, with support from Champs, Sport England and the C&MHCP Physical Activity Subgroup, towards a physical activity strategy for health and social care for the Cheshire and Merseyside region.

Following initial work to establish local needs and priorities, in January 2022, Proper Active were commissioned to support engagement with local stakeholders and members of the public. This work took place in Spring 2022 and engaged over 100 diverse stakeholders from across the region. It also engaged almost 200 residents, who represented many of the communities experiencing the greatest health inequalities across the region.

The stakeholder engagement process found strong support for a unifying strategy for physical activity across the region, with particular enthusiasm for targeting those experiencing the greatest health inequalities. There was a significant appetite for adopting a whole system approach, moving beyond a focus on individual behaviour change towards addressing the environmental and systemic issues which impact on people's health. It was felt that a strategy could act as a powerful tool to bring together and build on the many examples of effective, but often fragmented, good practice in using physical activity to support better health. It was also an opportunity to integrate physical activity directly into patient care pathways.

Whilst an overarching set of priorities and a clear direction for physical activity in the region was welcomed, it was also clear that alignment with local priorities and the flexibility to meet local community needs were seen as crucial for successful implementation. Strong local ownership and clear, bespoke planning for each of the nine local authority areas within Cheshire and Merseyside were thought to be essential.

Aligned to this, the need for ongoing engagement with both Health and Social Care Professionals (HCPs), as well as local communities, was frequently raised as a necessary part of planning and implementation to ensure local needs and circumstances are considered throughout.

Draft Strategic Themes

As part of the engagement process, a number of draft strategic themes were also tested with stakeholders under the headings People, Places and Purpose. The themes were broadly well received; however, a number of gaps were identified.

Specifically, in terms of People themes, there was good support for a life-course approach. However, it was felt that not explicitly identifying groups who experience the greatest health inequalities within the People themes presented a risk that vulnerable audiences could "fall between the cracks."

The key role played by the VCSE sector in health and social care was also highlighted and this was not felt to be encapsulated through the draft representation of Place themes. Aligned to this,

wider community settings, such as green spaces and community centres, were also emphasised as a gap, and they were deemed to be particularly important for vulnerable audiences, such as those with long-term health conditions (LTHCs).

Public engagement focused on what mattered most to residents, their perceptions and past experiences of physical activity, and how it made them feel. It demonstrated that our audience has a wide definition of being active, with mentions of walking, and day to day tasks as much as sports, running, or the gym.

Nonetheless, physical activity in and of itself is not necessarily a priority for many in our audience, but that it can be a valuable tool in supporting the things that are. For example, as an opportunity to spend time with friends and loved ones, take a break from life, connect with the outdoors, gain a sense of achievement, or as a means to simply *feel better.*

But for many, their lived experiences of being active were much more negative, with many citing associations with pain, embarrassment, anxiety, and feelings of inadequacy. For many physical activity was seen as a *means to an end*, and something they *should* do, rather than something which is enjoyable in its own right.

Importantly, health was only cited as front of mind for a minority of people in the context of their daily lives. This suggests that, whilst the language of clinical outcomes remains essential for health and social care professionals to consider the clinical benefits of physical activity for patients, a wider framing of physical activity as something which is more than just good for your health is needed with individuals to initiate and maintain activity.

Looking to the future, the vast majority of stakeholders were keen to remain involved in further work to develop and implement the strategy. Particularly pleasing was that almost half of stakeholders said that they would want to be part of delivering pilot projects or future services. A similar number said they would be willing to connect Active Cheshire and MSP with their service users, to maintain the voice of the public in ongoing work. A significant number of those who took part in the public engagement also said they would like to be involved in further opportunities to help shape future work.

The challenges of implementation did not, however, go unrecognised and stakeholders identified a number of key challenges that they would be keen to come together and collaborate on. These included prioritisation of physical activity in a complex health and social care landscape facing many urgent priorities; translating strategic themes into local action within individual communities; and ensuring measurement and learning is embedded in a way which is both practical and actionable.

Nonetheless, support for the strategy was overwhelming, suggesting that now is an ideal time to capitalise on the potential of physical activity for health outcomes across the region. In order to do this with greatest effect, the report concludes with a number of recommendations for consideration by the Cheshire and Merseyside Health and Care Partnership leadership team. These are summarised below.

Key Recommendations:

1. Reflect on the strategic considerations (Section 6) to refine the overarching strategic purpose and vision for the strategy, reflecting the appropriate role for C&MHCP, its partners, and the newly formed ICS. Evolve the People, Place, Purpose model to provide *a plan on a* page which summarises the core strategic purpose.
2. Give frank and honest consideration to the likely funding and resources available to ensure strategic aims are ambitious, but achievable.
3. Ensure priority audiences who experience the greatest health inequalities are explicit within the strategy and consider where physical activity is and isn't well placed to support progress against the Marmot Indicators (Appendix 7).
4. Design-in actions to tackle systemic and environmental issues which limit movement in day to day life, including public perceptions of physical activity and sport.
5. Commit resource to mapping and guiding the system, progressing the strategy, securing funding, and building the network of system leaders.
6. Capitalise on stakeholder energy, by convening opportunities to work collaboratively, especially at a place-based level, to translate the strategy into local plans and address key challenges (including those identified in section 4.5). Ensure flexibility and place-based leadership is embedded in everything.
7. Engage with health and social care professionals (including care homes) to understand what is realistic and what will be supported in healthcare settings, in particular in the wake of the pandemic.
8. Incorporate the significant role to be played by community settings as a formal or informal referral pathway to support HCPs; and seek to support capacity building.
9. Build in explicit and frequent points for community engagement to all future iterations of both the strategy and implementation; including actively seeking opportunities for co-creation with both communities and HCPs.
10. Consider the different language and approach required to engage a professional versus community audience in physical activity.

2. Introduction

2.1 Background

In 2010, the Marmot Review[1] highlighted that, in England, gains in life expectancy, alongside long-term improvements in population health, had stalled. It also exposed the growing inequalities which existed in health, depending on your background and where you live and work (known as the social determinants of health).

In 2020, a team led by Professor Sir Michael Marmot reviewed progress against the recommendations made[2] in the original report. They emphasised the gruelling toll that austerity has taken on health, with the worst effects felt in the north of England. This includes the widening of health inequalities, which are experienced even more acutely by people from ethnically diverse communities and those with disabilities or long-term health conditions (LTHCs).

In the Cheshire and Merseyside region, these effects are being keenly felt, and data shows there are growing disparities in life expectancy between the richest and poorest areas[3]. In 2019, leaders across the region committed Cheshire and Merseyside to becoming a Marmot Community[1] and, although work was delayed by the pandemic, this has been progressing since 2021. The All Together Fairer Report for Cheshire and Merseyside[4], published in May 2022, describes the current state of play in the region, and the key actions required for change. The report places significant emphasis on community engagement, as well as partnerships with other sectors, recognising that different organisations can play their own unique role in achieving overall aims.

Aligned to this, over half a million adults in the Cheshire and Merseyside region are classed as inactive (undertaking less than 30 minutes of moderate intensity physical activity per week)[5], with many of these being the same people who experience the greatest health inequalities. Whilst not a panacea for all health inequalities, physical activity has been identified as a key tool in health improvement. In 2019, the UK Chief Medical Officer wrote a clear message: 'If physical activity were a drug, we would refer to it as a miracle cure, due to the great many illnesses it can prevent and help treat'.

In the same year, Active Cheshire and MSP were commissioned by the Cheshire & Merseyside Health & Care Partnership (C&MHCP) to work towards developing a joint Physical Activity Strategy for the Cheshire and Merseyside region, in order to exploit the potential benefits of an active lifestyle for those who could benefit most. This work has been supported by the Champs Public Health Collaborative and Sport England, and the strategy will run to 2026.

Whilst it is recognised that much good work is already underway in this space, the approach is currently fragmented and inconsistent in different places. A strategy will aim to take a whole-systems approach to unify stakeholders across the region behind a shared set of aims and priorities, sharing learning and best practice. It will seek to target resources to the benefit of those currently experiencing the greatest health inequalities.

Over the course of the last two years, a number of activities to develop a strategy have already taken place, including initial research to establish local needs and opportunities, and the

[1] A Marmot Community is one which demonstrates a determined and joint effort to true integration across of number of sectors in order to achieve the six common goals, set out in Sir Michael's original 2010 report, plus the two additional goals added in 2020 following the onset of the pandemic (Appendix 1).

establishment of the C&MHCP Physical Activity Subgroup to steer the work. (For further details see Appendix 2).

The next stage in the roadmap was to carry out further engagement with key stakeholders and communities and, in January 2022, Proper Active were appointed as an independent third party to support Active Cheshire and MSP with this work.

This engagement programme took place in two phases and this report summarises findings from both phases of the engagement, building on the interim report produced in April 2022.

2.2 Phase 1: Stakeholder Engagement

The first phase took place March-April 2022. It engaged with a representative group of organisations across the whole-system in Cheshire and Merseyside to test and evolve thinking to date and begin to establish shared ownership. The opportunity was also taken during this phase to bring partners up to date with work done so far.

Phase 1 Objectives

The main aims of this phase were to:

- Establish buy-in to the overall approach for strategy development.
- Check and challenge draft strategic themes which had emerged from early work.
- Understand how organisations see themselves as part of the strategic ambitions.
- Act as a platform to long-term relationships with partners to support development and delivery of the strategy going forward.
- Identify where the energy is in order to progress pilots/further engagement.
- Identify priorities for Phase 2 engagement with the general public.

2.3 Phase 2: Public Engagement

The second phase took place April-May 2022. It engaged members of the public from a variety of communities who currently experience the greatest health inequalities. Whilst these audiences could benefit most from physical activity, they are often the least likely to take part. Engagement was carried out though local trusted organisations (LTOs) who work with and support many of these audiences.

Phase 2 Objectives

The LTOs were commissioned to:

- Establish public buy-in to the engagement process.
- Understand what is important to communities experiencing health inequalities in order to cross-check how this aligns to the proposed strategic themes.
- Develop a deeper understanding of the drivers of physical inactivity within communities experiencing health inequalities and explore what might support them to become more active.
- Identify opportunities to stay in touch with participating communities to enable continued engagement and co-design.
- Where appropriate, identify passionate local Ambassadors/Champions for physical activity that Active Cheshire and MSP can work with in the future.

3. Method

3.1 Overview

This section outlines the methods used in each phase of this work to ensure a wide range of stakeholders could be reached. Phase 1 adopted a mixed methods approach, with both quantitative and qualitative tools to enable breadth and depth in the findings. In total over 100 local stakeholders were engaged.

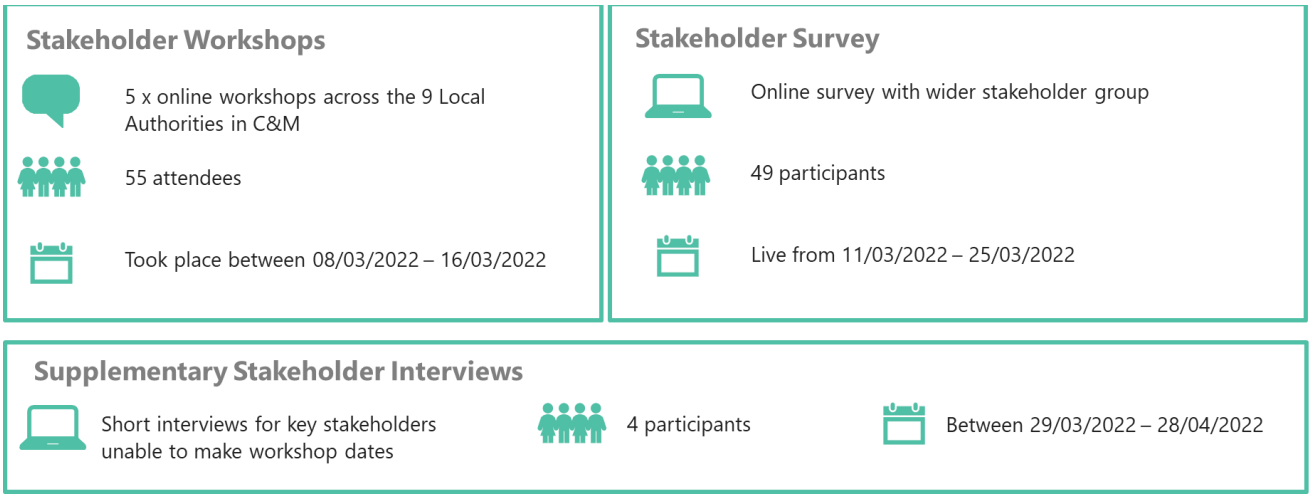
For Phase 2, a fully qualitative approach was chosen in order to gain a depth of understanding about the lived experiences of the target audience. It also ensured that conversations could be handled sensitively and appropriately with more vulnerable members of the public.

It was decided to partner with local trusted organisations (LTOs) for Phase 2, which further enhanced both of these intentions. Feedback from stakeholders in Phase 1 advocated that this would be an effective approach given LTOs hold existing trusted relationships with the target audience and understand their needs and circumstances. Participants could therefore feel comfortable to speak honestly and openly in the knowledge that their wellbeing was being prioritised. In this way almost 200 members of the public took part.

3.2 Phase 1 Methodology

The range of methods used is outlined in Figure 1 and included online workshops, held over Microsoft Teams, an online stakeholder survey and a small number of supplementary interviews, for key stakeholders who had been unavailable for workshop dates.

Figure 1: Summary of Methods



Stakeholder workshops were designed to be upbeat and interactive in nature. As well as conventional group discussions, the workshop also took advantage of music and digital tools, such as online polling and Easy Retro boards. This enabled significant feedback to be collated against each of the objectives outlined above, and ensured all stakeholders who took part had an opportunity to feed in.

The survey and interviews followed a similar flow of questioning to the workshops, but in a simpler, shortened format. Survey questions can be found in Appendix 3.

This blend of approaches ensured a mix of stakeholders was reached across the nine local authority (LA) areas which make up the Cheshire and Merseyside region (Cheshire East, Cheshire

West & Chester, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington and Wirral). There were also a number of stakeholders who work across the whole of Cheshire and Merseyside. The geographical spread of all partners engaged is shown in Figure 2.

Figure 2: Geographical coverage by stakeholders in Phase 1 Engagement

As the strategy intends to employ a whole-systems approach, it was also important to engage with stakeholders from different parts of the system. Stakeholders included representatives from public health, primary and secondary healthcare, social care, VCSEs and physical activity delivery partners. There were many representatives from local authorities, including from transport, parks and green spaces, leisure and environmental departments. There were also stakeholders who worked with and supported people from a range of backgrounds, including people with disabilities and LTHCs, people experiencing poor mental health, young people, older people and people who are out of work.

3.3 Phase 1 Considerations

Whilst this process has reached a large number of stakeholders with differing experience across Cheshire and Merseyside, it should be born in mind that the sample was selected purposively by the project team, based on a previous system mapping exercise (see Appendix 4), and that many of the findings are qualitative. There was also a degree of self-selection arising from stakeholders choosing to take part or not.

This means that findings cannot be generalised as representative of all stakeholders in the region and, as such, should be treated as descriptive. Nonetheless, the wide range of inputs will inform a robust approach going forward and provide a firm foundation for ongoing engagement with this audience as the strategy develops.

3.4 Phase 2 Methodology

As noted, Phase 2 took a qualitative approach to engagement with a cross-section of the general public. It focused on individuals who are part of communities currently experiencing the greatest health inequalities across the Cheshire and Merseyside region.

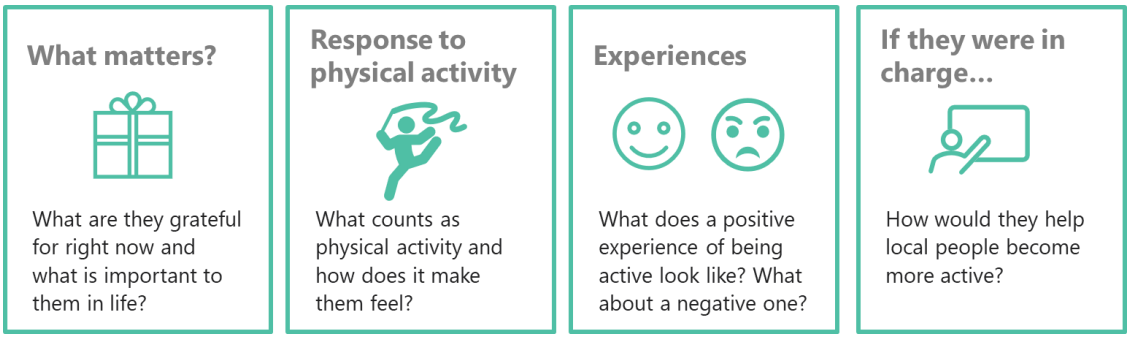
A wide range of potential LTOs were contacted and subsequently 15 were recruited to partner with Active Cheshire and MSP on this work. These cover a diverse range of audiences who typically experience health inequalities, including older people, young people, parents, disabled people, people with long-term health conditions (physical and mental), working adults, unemployed people, people receiving social care, and diverse communities. Some LTOs conducted more than one face to face engagement, meaning in total 19 sessions were held, with 191 people taking part. A full list of LTOs who supported the work can be found in Appendix 5.

A guidance document (Appendix 6) was developed to support LTOs to host research discussions with a group of the people they support. It included step by step advice to guide them through the process, including how to organise a research session, ensuring informed consent, facilitating a discussion, what to ask (Figure 3), how to collect information and share it back, and how to maintain confidentiality.

Questions were intentionally structured to begin with a more open discussion of participants' values and priorities. This allows subsequent responses to be framed in that context and acknowledges that physical activity may not be a priority for everyone. The guidance also took into account best practice guidance from the Sport England Creative Engagement Toolkit.[6]

This guidance was trialled with a pilot organisation who provided feedback to ensure the process was fit for purpose. On agreeing to support the work, each LTO was briefed by a member of the Active Cheshire or MSP team, using the guidance document to structure the briefing.

Figure 3: Topics covered in Public Engagement



Sessions were then arranged by each LTO with an appropriate group at a time convenient to them and to their audience. All discussions took place between 11th April and 27th May 2022. LTOs were provided with a template to share back a summary of what was discussed.

3.5 Phase 2 Considerations

This piece of work has engaged with a broad sample of individuals within our principal target audience and provided some valuable learning for consideration. It should be taken into account when reading the findings however, that the sample was not designed to be representative of all potential audiences in Cheshire and Merseyside who experience health inequalities. It was also not intended to answer every question about what the public needs and wants, but rather was aiming to act as a start point for continued engagement with key target audiences.

Potential LTOs were initially selected purposively to cover audiences of interest, and this involved a subsequent degree of self-selection by those organisations who were in a position to support. Some possible LTOs lacked capacity within the timescale, for example, several LGBTQIA+ organisations. Self-selection was also a feature within groups due to the voluntary nature of participation. Those who are not currently engaging with any community services would also not be represented.

There is a further small risk of bias stemming from the LTOs themselves as gatekeepers to the data provided. The fact that they work closely every day with the target audience gives them a unique perspective and an existing trusted relationship, but also inevitably means LTOs will have their own set of views and concerns around what is important for their audience.

Any bias, however, has been minimised by the detailed guidance and briefing provided and it is apparent from the richness of information which has been shared that participants have been fully engaged in the process. Working in this way has also cultivated the foundations of some key relationships to continue engagement into the future, including with those organisations who were unable to take part on this occasion.

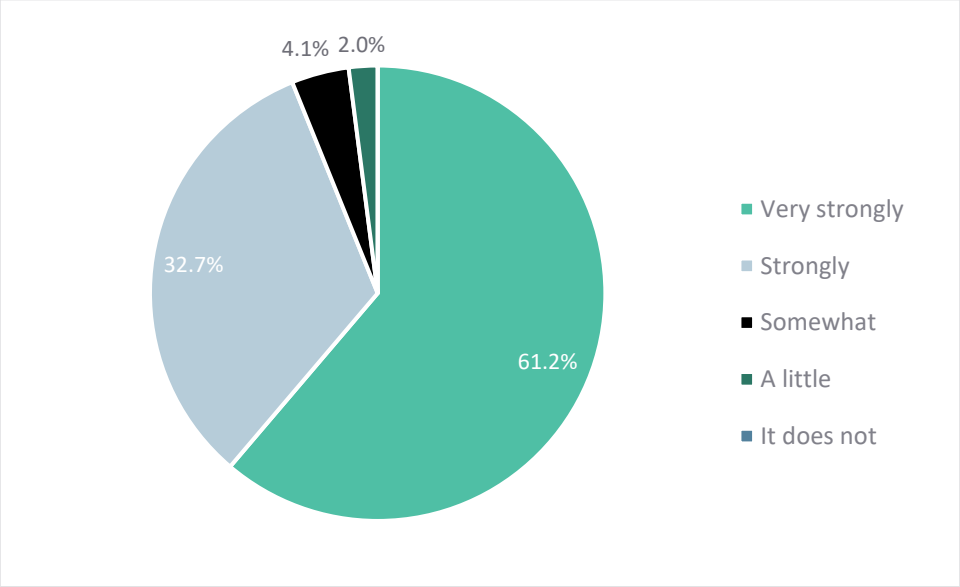
4. Phase 1 Findings: Stakeholder Engagement

The findings which follow are aggregated from quantitative data generated by the online survey, and qualitative conversations through the stakeholder workshops and interviews. They are broadly presented against the aims set out for Phase 1.

4.1 Overall support for a regional Physical Activity Strategy for Health and Social Care

In general terms, strong support was found for a unifying strategy for physical activity across Cheshire and Merseyside and for adopting a whole-system approach. Amongst survey respondents, more than 90% agreed that the overall strategic approach aligned with that of their own organisation (Figure 4).

Figure 4: Extent to which the overall strategic approach aligns to the outcomes survey respondents are trying to achieve



There was support for targeting those with greatest need, applying the principles of proportionate universalism, and for supporting mental health as a central feature; particularly in light of the detrimental impact of the pandemic on mental health and wellbeing.

The fragmented nature of current practice around the use of physical activity in health and social care was acknowledged by stakeholders; however, there was also recognition of the many excellent people and initiatives that are thriving in this space. There was an appetite to ensure that any strategy is building on these strong foundations, sharing learning and connecting good work which is already happening.

Linked to this, the importance of the strategy retaining sufficient flexibility to allow a bespoke approach in each of the nine Cheshire and Merseyside local authorities was repeatedly emphasised. Even within individual local authorities, the hugely different needs of different towns and neighbourhoods was felt to need considerable attention.

"We've got issues just across the borough because our main service centres are all just so different. When you've got Crewe that is so deprived and then the likes of Alderley Edge. What we're trying to achieve in terms of the infrastructure in those locations is so different."

This also meant that local ownership of delivery and outcomes within each of the nine LA areas was deemed critical to the success of the strategy. Ultimately, change needs to be owned at a local level, and so it was felt that the strategy must support the priorities and needs of local practitioners, as well as offer a clear plan which enables collaborative working towards shared aims. As one stakeholder put it:

"I think it would be useful for it to be explicitly agreed as a priority in each of the nine places, because then organisations are held to account for delivering something against this strategy. I think that's really important as there are lots of priorities at the moment…Part of that then, for the next step…is a really clear plan in terms of what it actually is that we're going to deliver against this strategy."

The time allowed for the process of strategy development, as well as the aspirations for ongoing engagement with both stakeholders and communities were seen as further positives to ensure the strategy would truly reflect local need. Ongoing community engagement in particular was cited by a number of stakeholders as fundamental to success.

To do this effectively, it was emphasised by several people that physical activity is not a top priority for all Cheshire and Merseyside residents, including many of the people who might benefit most from an active lifestyle. This means a creative approach to community engagement will be required, and a desire to understand what really matters to both communities and health and social care professionals (HCPs), before looking at how physical activity could support those priorities.

Aligned to this, the language and presentation of sport and physical activity was raised several times as a barrier to engaging the least active. It was felt the strategy presented an opportunity to set the tone for how being active is talked about across the region, presenting a more inclusive perspective, which promotes moving in a way that suits individuals. One stakeholder, for example, highlighted that:

"There are barriers and misconceptions…even golf - people go to the driving range but fear the course, imagining everyone is Tiger Woods, and not realising there is a whole rainbow of skills, from 'none' to 'some'."

There were a number of other broad concerns raised too. Several people pointed to previous attempts to embed strategies and to galvanise local investment in physical activity, posing the question of '*why is this time different*?' Related to this, the need for funding and resources to support the strategy was flagged and a number of interesting discussions on this topic emerged in workshops.

The need to not only have investment, but also invest differently was acknowledged by many workshop participants. One VCSE partner told us:

"With that hat on [delivery hat] I'd be like, is there any money so we can deliver things. But on the wider scale, I think if I was being completely honest with things, we're not going to reach the people who fall through the gaps."

At the same time, the potential for referrals into the community sector was widely acknowledged; however, capacity is felt to be lacking for organisations to accept these referrals.

"Social prescribers or others are trying to push people on you, but I've got to pay staff, I've got to pay overheads, I've got to run it like a business… Not that you'd turn anyone away, or you're trying not to turn anyone away, but you come to a point where you're like, if you offer me just to cover my overheads, cover my staff, I'll find a place for you, but I'm only ever 6 months away from going under, so I can't provide what you're asking."

Longer-term funding was also felt to be a more effective way to achieve system change, than short-term grants, with suggestions that consistent funding was more valuable than large amounts.

"[if you have] a 6-week programme, or even a 12-month programme, what's going to happen after those 12 months? Is that person going to maintain an active lifestyle, or are they going to drop-off and we're going to have the same problem again?"

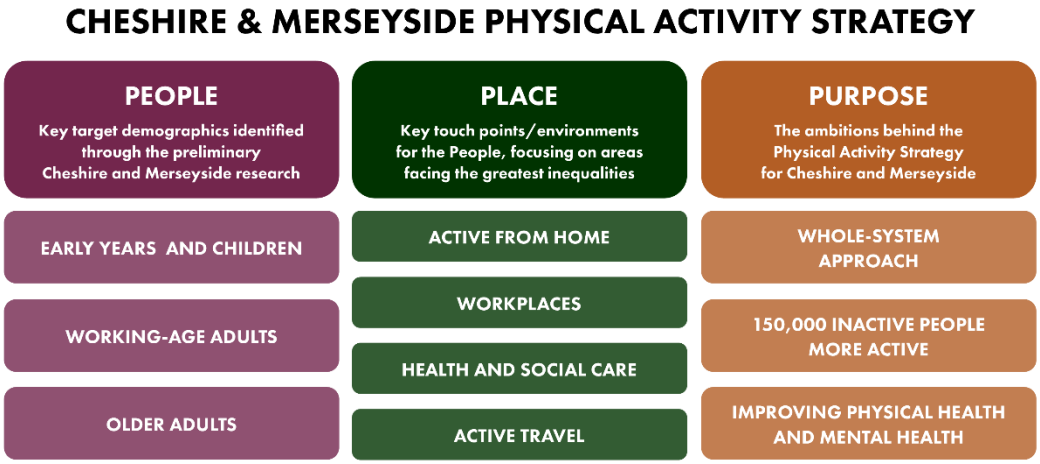
At present, however, only limited funding and resource is committed to the system approach and to the lifecycle of this strategy. Securing commitments in these regards therefore needs to be a focus for those driving the system.

Taking a broader view, there were also several concerns raised about taking a solely intervention based approach. In the spirit of a whole-systems approach, stakeholders wanted to see a shift away from focusing only on changing individual behaviours towards more work to tackle systemic issues which shape the environment and detract from an active lifestyle. This lends itself to more informal activity as part of day to day life and links to the earlier point about reimagining the way we present and talk about active lifestyles.

4.2 Overall reflections on draft strategic themes

As part of the engagement process, stakeholders were introduced to a draft set of strategic themes which had emerged as important through initial research and local mapping. These themes are shown in Figure 5. Stakeholders were asked for their initial reflections on this structure.

Figure 5: Draft Strategic Themes



Overall, there was support for the People, Place, Purpose model as it was felt to be simple and easy to understand. There was an appetite though to see more detail behind each of the themes to understand how this might translate into implementation. Linked to the earlier point, there were also some concerns that this presentation could exacerbate the focus on an intervention

only approach, rather than wider system influences, by requiring any programme of work to have a 'who' and a 'where.'

Having the ambitions of the strategy featured prominently as Purposes was considered helpful to keep them front of mind, although again, raised questions around a need for further detail. One stakeholder felt that simply stating that a whole-system approach would be used was too vague and that the purpose needed to encapsulate something of what an effective system might look like. Another suggested it would be useful to articulate the potential cost savings to the health and social care system of using physical activity as a tool in prevention and management. A third noted that the term 'health inequalities' was currently missing from the purpose and should be incorporated to keep it front and centre.

A number of stakeholders discussed challenges around measurement in relation to the purposes. In particular the importance of finding appropriate methods to identify and track the 150,000 inactive people. One stakeholder challenged the origin of this figure and highlighted the need to consider what degree of progress this represented, compared to that being achieved within the system as it stands. There was general agreement that any metrics should be evidence-led, and that community engagement would play a major role in measurement in addition to local population statistics.

The explicit reference to both physical and mental health was widely welcomed, as the potential benefits of physical activity to health were almost universally recognised, with stakeholders identifying big roles in prevention, in rehabilitation, and in ongoing management of long-term health conditions (LTHCs).

It was felt though, that to really exploit these opportunities, particularly for rehabilitation and LTHCs, physical activity needed to be embedded within wider patient care pathways and that training and support for HCPs was essential to give staff the confidence to introduce these approaches and make them a true part of individual care. As one stakeholder put it:

> *"Lots of health staff know the scope of their role, they know the scope of their practice and they're not comfortable to step outside of that scope. So, in terms of activity and promoting it, they might make general comments to people, but unless they feel comfortable to, sort of, talk further about that, they're not going to do that...for a lot of staff they would be saying 'where is my specific training'."*

Some stakeholders also highlighted that, the physical health benefits of being active were felt to be widely understood by the general public, but the benefits to mental health were not always so well accepted. There was a feeling that more education in this space could be of value. There were also pockets of support from specialists for education on the specific types of activity that are beneficial for particular conditions (e.g., strength and balance for falls prevention; higher intensity exercise for neurological conditions).

Importantly, it was acknowledged that *"knowing something is good for you 'rationally' or factually, isn't enough to stimulate behaviour change"* and so simply promoting the health benefits was not considered to be sufficient. The wide evidence base for promoting the social and enjoyment elements of physical activity was discussed as an effective way to encourage new behaviours. Emerging research also supports this, presenting the significant role which emotion plays in decision-making around physical activity behaviour.[7]

4.3 Feedback on audiences

Amongst survey respondents, almost 90% felt that the strategic People themes resonated with them (Figure 6).

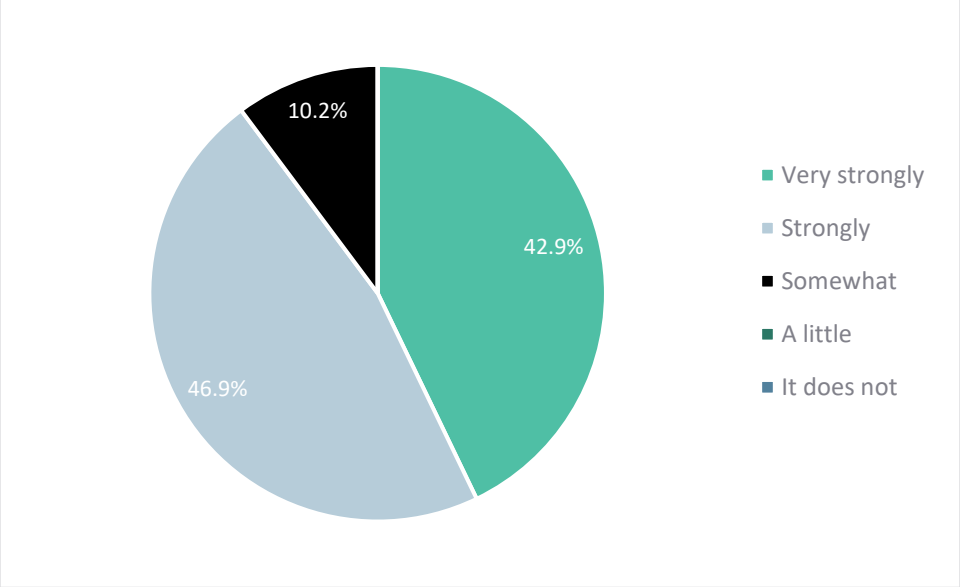
The majority of stakeholders responded positively to using a life-course approach, suggesting this was a good way to capture every stage of people's lives *"from cradle to grave."* There was a significant minority, however, that felt that this approach lacked focus.

> *"Whilst they do [align with our priorities] in the sense that we often use the life-course method to structure our priorities, in the context of a physical activity strategy it is far too broad. You're basically saying everyone is a priority."*

The importance of allowing for intersectionality was well understood, and participants could see how the life-course approach achieved this in one respect. Nonetheless, there were fears that key audiences experiencing most need could be overlooked by this approach.

> *"There are a few groups who are continually raised as being considered with higher rates of inactivity than others, like people with LTHCs...BAME, people with disability. I was just wondering…does the demography breakdown give you enough to go on and focus it in?"*

Figure 6: Extent to which the strategic People themes resonate with survey respondents



Indeed Marmot (2010)[1] highlighted the social gradient which exists within health, with those living in the poorest neighbourhoods in England expected, on average, to die 7 years earlier than those in the richest. The 17 year difference in disability free life expectancy between these audiences is even more stark. There are significant regional differences too, with the North-West and North-East demonstrating the lowest life expectancy across England in both 2010 and 2021.[2]

Within this, there are specific groups who are consistently disadvantaged in terms of education, housing, work and wider societal opportunities, including ethnically diverse communities, disabled people and those with LTHCs, carers, lone parents, refugees and asylum seekers and homeless people. LGBTQIA+ people also experience significantly worse outcomes related to mental health.

One stakeholder felt that, whilst the life-course approach ought not to be lost from the strategy, it might be better positioned as part of an overarching vision for health and social care. This would allow room to identify the audiences with the greatest health needs under People, and place greater emphasis on where physical activity could have the most impact on the region's Marmot indicators (See Appendix 7).

Early Years & Children

This was universally accepted as an important audience, particularly given the life-limiting implications for health which can arise from a poor start in life. Approaches which target children directly (e.g., through education institutes) but didn't take into account wider influences, however, were considered to have limited reach.

To counter this, there was strong support for family-based approaches, to ensure family members could act as positive role models. Further to this, it was felt that to not take advantage of the opportunity to influence health behaviours across all generations would quite simply be "*missing a trick."* Another stakeholder commented that it was important therefore not to focus only on education settings, but on all the places children and young people might get active.

There was also a lot of positive discussion around the role of holiday activities, these being seen as a way to ensure continuity for children throughout the year, as well as a further touchpoint to engage with families. In the spirit of proportionate universalism, there was an appetite to see these schemes expanded beyond children who received free school meals, to see broader benefits to communities, facilitate positive social development, and to reduce the risk of stigmatisation for those children taking part.

The major gap identified in this audience was for young people, although there were wide ranging views on the definition, with age ranges proposed from 12 up to 25 year olds. Regardless of the exact age, there was a general sense that this is an audience that is not well catered for by current physical activity provision and one which needed specific attention. This is particularly in light of the known teen drop-out from sport and physical activity.

Working Age Adults

Of the three audiences proposed this was the one which was least well received. Many people felt it was too broad and encompassed a wide range of audiences who might have vastly different needs. One stakeholder noted that:

> *"Thinking about what's relevant to me and what's relevant to my parents that's very different, but we'd still fall both within that category."*

The use of the terminology *working age adults* in itself produced some confusion. Some stakeholders felt that the inclusion of the word *working* could inadvertently exclude those not currently working, for example those currently seeking work or those unable to work due to ill-health. Even where they were considered, this group were felt to have entirely different lifestyles and needs to those in work.

> *"I think another category might be unemployed adults maybe, because they have totally different lifestyles...Working age adults their daily routine, to somebody who doesn't work, or someone who can't work, maybe because they're a carer or something."*

Further discussion related to this audience largely centred around workplace initiatives and is covered in section 4.4.

Older Adults

Older adults were seen as the major user of health and social care services; hence it was felt that even small reductions in the level of support required for this audience could deliver not only improved patient quality of life, but also significant cost savings to the public purse.

In particular, deconditioning was highlighted as a major issue, especially in light of the pandemic. This was seen as one of the most obvious means to generate short to medium term cost savings across the whole strategy. Under this umbrella, strength and balance are viewed as key to

re-establishing pre-lockdown levels of mobility and a route to support people to maintain independent living for longer. Strength and balance could also significantly contribute to falls prevention, which in itself is a major cost through both treatment and ongoing aftercare.

Stakeholders also highlighted social isolation as a growing problem amongst this audience, which impacts in particular in primary care. A report from the Social Prescribing Network in 2016 suggested that 1 in 5 GP appointments are for a problem which is primarily social and not medical[8], with loneliness and social isolation forming a large proportion of these. Significant opportunities were thought to exist here to link in with local communities and the VCSE sector. Although, of course, whilst being mindful of the earlier point around the need for adequate funding to underpin the necessary capacity for these routes.

Much of the discussion for this audience centred around supporting those receiving social care and other support at home. Many of those in receipt had less mobility and thus were more at risk from deconditioning; this presented an opportunity to introduce physical activity during regular contact with HCPs.

There is also a considerable overlap between this audience and those with a disability or LTHC. In 2017, Sport England estimated that 70% people with a disability or LTHC were over the age of 50[9]. This should be taken into account as part of any implementation planning for this audience.

One notable gap in stakeholder feedback, across all methodologies, was in relation to care home settings. This may reflect the makeup of those who chose to engage in the process, therefore further engagement with this sector may be wise.

Other gaps in audiences

Beyond what has already been covered, there were a number of other important audiences who received frequent mention and who were felt to be at risk of falling through the cracks. These were people from ethnically diverse communities, disabled people and those with LTHCs.

For all these audiences, current sport and physical activity provision was seen as often ill-equipped to offer supportive and welcoming environments. The priority here felt less on transforming traditional leisure settings into more inclusive spaces, and more on linking with alternative community settings. This may reflect a degree of cynicism, as traditional sport development has been battling to engage diverse audiences in traditional settings for many years; but regardless of the reason, this call for alternative community provision very much aligns with the strong desire for local flexibility and more local provision highlighted in section 4.1.

For disabled people in particular, one subject matter expert cautioned against the use of the word *disability* as a catch-all descriptor, due to the diversity of potential impairments and also the fact that many people with a disability simply don't identify with the term.

> *"I think you need to be careful with the term disability, because…if somebody has a health condition and they said 'we've got a disability advisor here for you' they'd say 'I'm not disabled'…So I think…I would err on the side of not using disability as a term. Because dis-ability means no ability...I would prefer to use the term health."*

> *"If you go to the car park and you find the disabled parking, what's the first thing you see? You see somebody in a wheelchair. Well, you've got hidden disabilities, that you can't see, it's this again thinking of the health aspect."*

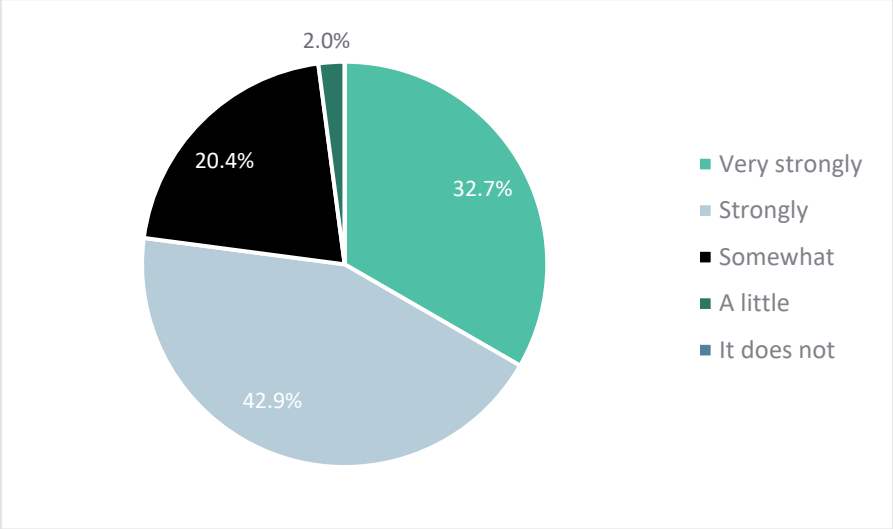
4.4 Feedback on places

Whilst overall support for the Place themes amongst survey respondents was strong, the alignment was not as strong here as for the People and Purpose themes, with just over three quarters feeling the Place themes strongly resonated with them (Figure 7).

Nonetheless, identifying Places as key touchpoints in people's lives was thought to be useful, to provide tangible points of interaction where interventions might be targeted. Stakeholders were also able to draw connections between the different People and Place themes to consider who might best be influenced in which Place.

As has already been discussed, there is a risk though that identifying Places as strategic themes supports a traditional intervention only approach and wider opportunities for system change are missed.

Figure 7: Extent to which the strategic Place themes resonate with survey respondents



At Home

Broadly speaking *At Home* was considered to be a crucial environment for physical activity, especially for older people and disabled people who may be less confident going out or have additional support needs that make going out a more challenging experience. These factors were felt to have been exacerbated by the pandemic, with many of the people our stakeholders engage with still expressing reluctance to leave their homes and mix with others, particularly in crowded settings.

This linked with the deconditioning point highlighted above in relation to *Older Adults*, with *At Home* felt to be a crucial touchpoint to address this, not least for those receiving social care. It was also thought to be a crucial environment for people with neurological or severe mental health conditions.

Workplace

Another consequence of the pandemic for a majority of stakeholders was that, for many people, the home had become synonymous with the workplace, with large numbers of people working from home full-time, or adopting flexible working practices.

> *"The impact of home-working on people's physical activity levels is going to be quite stark. The walk from your bedroom to your kitchen, or wherever you're working, is a lot shorter than it was...a lot of physical activity has been drawn out of our days since lockdown."*

Whilst the need to offer better support for staff to build movement into their home working lives was clearly endorsed, there was little sense that employers had really established how best to do that yet. A small number of examples of offering online classes or encouraging daily walks were mentioned, but these were against a backdrop of concern about constant video conferences and meetings scheduled over lunchbreaks.

With regards to workplaces more generally, whilst there was agreement that employers had a responsibility to support and encourage staff wellbeing, including physical activity, there was a sense here too that the best way to do this isn't yet clear. One stakeholder noted:

> *"How many workplace programmes have there been? Probably in every borough, in every Active Partnership, in every area, and, you know, we're still targeting that, there's something why it's not working. So, are we learning from what's actually gone before, and from what's currently happening and are we going to build on that?"*

Healthcare Settings

These were felt to be a crucial touchpoint for introducing physical activity, especially for treatment, rehabilitation and condition management. It was felt that patients have trust in the advice of HCPs and are more likely to consider adopting a new behaviour on this basis.

As with other themes, this one was highlighted to be extensive, covering primary care, secondary care, social prescribing, private and community support services. A more focused approach was felt to be needed to identify who is coming into contact with which services and when; and what is the best way to build in physical activity. As already discussed in section 4.1, HCPs don't always feel confident in giving advice on physical activity in terms of what to do or where to go; more training and support is therefore thought to be essential, with positive references made to existing initiatives such as Making Every Contact Count (MECC).

Alongside this, the overwhelming pressure which has been born by HCPs throughout the Covid-19 pandemic was acknowledged. It was felt that, whilst many in the health and social care sector might welcome opportunities to build physical activity into patient care, this needed to be done empathetically and in partnership with HCPs, to be sure not to add to the burden. Additionally, there was a need for more straightforward referral pathways into suitable community settings, which HCPs could signpost patients into with confidence (further discussed below).

Linked to the *Workplace* theme, it was also noted that health care settings in themselves are a potential target for workplace interventions, with HCPs often having limited time for physical activity and other forms of selfcare due to long hours and shifts.

Active Travel

There was a lot of positivity around more being done to encourage active travel, although one astute stakeholder did note that *Active Travel* is not really a place, rather a type of activity. The role for active travel in addressing a number of social challenges, including climate change, physical inactivity, mental health and wellbeing and community cohesion made it a particularly attractive theme. Attuned to this, the requirement for collaboration across multiple disciplines, including transport, planning, disability advocacy groups, leisure and local communities, was highlighted by a number of stakeholders.

Many felt that whilst cycling was important, there was a particularly large role to be played by walking in positively influencing health. This was due to its low barriers to entry for almost anyone and the ease with which it could be fitted into everyday lives. This could even involve multiple short bursts for those with limited mobility or those who were time poor. Aligned to this, some felt that the term *active travel* only really captured functional walking and cycling, however leisure walking has just as big a part to play, including dog walking.

It was also noted to be important to consider how active travel could benefit those in rural communities and even urban areas with limited local amenities; perhaps as a way to re-establish local community services, such as banks, post offices and cafes, which are currently under threat. This could also be a significant tool to tackle social isolation in rural communities, and links well to many bodies of work around walkable neighbourhoods, 15-minute cities or similar.[10,11,12]

Other gaps in places

There were two notable gaps in the Place themes which recurred across all engagement methodologies, those being education settings and community settings. For young people especially, the environments included in the draft Place themes were expected to make up only a minority of the places they might choose to get active. Education and community settings were believed to be crucial as this audience increasingly search for safe spaces in which to exert their independence.

Community settings were the most mentioned gap across the entire stakeholder engagement, and could be broken down further into outdoor settings, leisure settings and other community settings; with the VCSE sector seen as a key partner. These are seen as essential to be able to offer local opportunities which overcome some of the structural and practical barriers to accessing physical activity, such as transport.

> *"One thing that struck me in the places part, it doesn't really jump out at me, the role of the wider community...I'm thinking the local groups, allotments, walking groups...I might look at that and think, there's not really a role for [our community organisation]."*

They are likewise crucial for some of our most vulnerable audiences, including disabled people, those with LTHCs (especially those with mental health conditions) and ethnically diverse communities, who may not feel comfortable in traditional physical activity settings. Additionally, as noted earlier, they are a critical referral partner for health and social care settings, including social prescribing, and adequate funding is needed to ensure capacity.

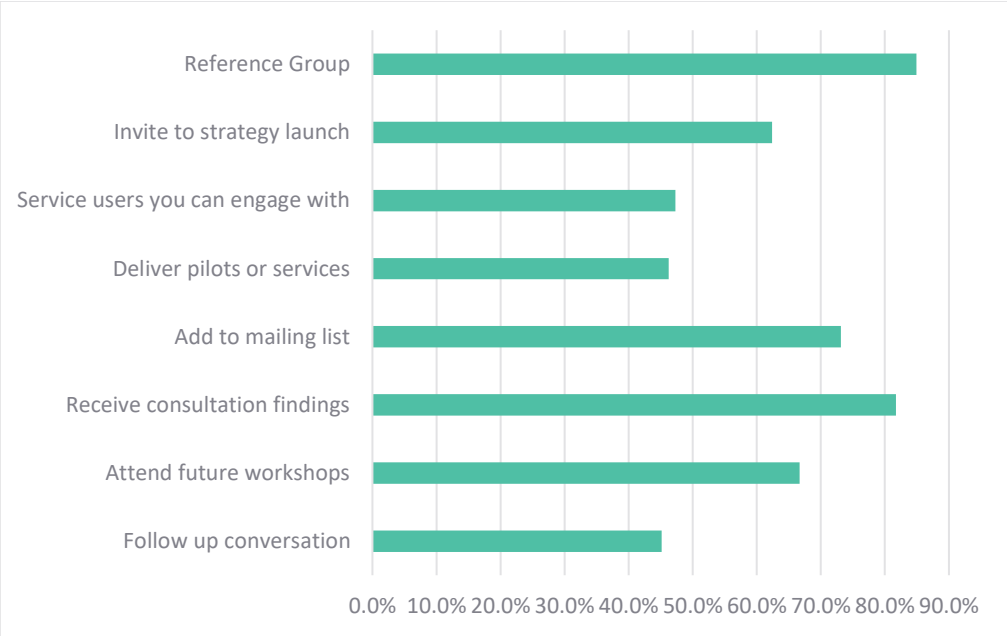
Interestingly, one stakeholder felt that the absence of community organisations in itself wasn't an issue if the aim was for places to represent the places where people are. Instead, it was suggested that an explicit reference to the role of partners and partnerships was needed in the strategy, which would include community organisations.

4.5 Appetite for future involvement in the strategy

All stakeholders who engaged with Phase 1 were asked about how they would like to continue to be involved in the strategy development and implementation going forward. There was significant enthusiasm for further involvement, with local ownership seen as a central pillar for the success of the strategy. Figure 8 shows the range of ways that stakeholders wanted to be included in the future.

Particularly pleasing was that almost half of stakeholders who responded said that they would want to be part of delivering pilot projects or future services. A similar number said they would be willing to help by connecting Active Cheshire and MSP with their service users, to maintain the voice of the public in ongoing work.

Figure 8: How stakeholders want to be involved in the strategy development and implementation



There were also many discussions of the challenges of implementation. Stakeholders recognised the complexity of improving local health outcomes and tackling health inequalities, where physical activity is only one tool amongst many. They highlighted that the challenges are not easy to solve, and that solutions may look different in different geographical areas. Nonetheless, there was a positive commitment to work collaboratively to find solutions, adopting a test and learn mindset.

Some of the challenges that stakeholders wanted to come together to tackle were:

Prioritisation

- Understanding the right role for physical activity to play in health improvement, given the wide range of urgent health, social and economic needs in local communities.
- Identifying and supporting those most in need, whilst offering a universal service.
- Supporting and training the workforce to feel valued, competent and empowered by this opportunity, not that it is just one more thing to fit in; this is particularly important for HCPs and the VSCE sector but applies to all aligned sectors.

Keeping things local

- Agreeing specific priorities and approaches for each of the nine Cheshire and Merseyside local authority areas.
- Translating the strategic themes from a regional level to a local authority level and down to a neighbourhood level; local authority level was felt to be more manageable, but there was greater uncertainty about how to instigate actions at a level that would feel relevant to individual communities.
- Ensuring that good work and expertise that already exists is not lost, but rather built on, grown and joined up.
- Ensuring a seamless service for individuals, which takes account of their wider situation and doesn't leave them feeling passed from one service to another; co-location was mentioned as one useful tool here.
- Ensuring community involvement, ownership and co-creation at every stage.

Measurement

- Tracking progress towards both an effective system, and the quantitative goal of 150,000 inactive people more active; this was seen as a challenge in terms of defining what *inactive* and *more active* mean, as much as it was in monitoring activity levels.
- Ensuring alignment and complementarity with other local aims, measures and reporting.
- Ensuring measurement didn't focus only on hard metrics, but also about how the quality of people's lives was improving.

Learning

- Ensuring learning both from what has been done before, and from any new programmes of work; especially from what hasn't worked and why.
- Finding ways to share learning which are easy to apply on a day to day basis.

4.6 Priorities for Phase 2 public engagement

Workshop and interview participants were asked for their advice on what should be the focus of Phase 2 public engagement, in order to take us beyond a basic understanding of conventional barriers and enablers, which are already well understood.

Who to talk to and what to ask?

In addition to key demographics discussed earlier in this report, such as disabled people, those with LTHCs and ethnically diverse communities, stakeholders identified a range of audiences who would be important to reach in Phase 2. These included carers, nursing home residents, economically inactive adults and parents.

Various lines of questioning were proposed, including how different types of delivery might be received by users and how they might be adapted; exploring opportunities to be active with others in social settings, and understanding what people thought sport and physical activity should look like.

How to ask

Stakeholders also offered some useful advice about how to approach conversations with the audiences of interest. There was support for working with local trusted organisations (LTOs), as stakeholders felt that many of the people they engage with might not speak with a third party who wasn't known to them.

Stakeholders also highlighted the importance of starting from what was important to people, which in many cases wouldn't be physical activity at all. One stakeholder spoke about the Good Life Project in St Helens, which asked the public what they felt contributed to a good life.

> *"Physical activity didn't feature in that conversation. It was very much around making sure there are facilities for people to become debt free...healthy eating, access to healthy and affordable food, stuff around the built environment, housing and the quality of housing people are living in, so PA didn't feature as a topic. What did feature was being connected in the community, accessing our green spaces more (which was probably the closest we got to any kind of activity)."*

Related to this, the use of language was again highlighted, particularly when engaging inactive or less active people. Even the terms *sport* and *physical activity* could be off-putting, and some stakeholders felt it was better to talk about *movement* or *opportunities to connect with others*.

Lastly it was also acknowledged that, for many vulnerable audiences dealing with multiple stressors, additional cognitive capacity is rarely available. In these cases, support workers can offer a valuable proxy to gain insight into the needs of these audiences.

> *"You've got to be realistic as well, if your life is literally, you don't know how you're gonna feed the kids today and with everything that's just coming down the line with price rises and all that, you're just not gonna be on their radar, they've just not got the headspace."*

A full summary of suggestions for Phase 2 public engagement was provided to Active Cheshire and MSP alongside the interim report in April 2022. This was used to inform Phase 2 planning and, whilst it has not been possible to incorporate all ideas in this round, due to the limited time available, all suggestions have been retained and will continue to feed future engagement.

5. Phase 2 Findings: Public Engagement

The findings which follow are based on thematic analysis of summaries provided by local trusted organisations (LTOs) from each of their research discussions with the audience they support. Note that, where quotes are included, some of these were provided verbatim from participants, whilst others have been paraphrased by the LTO. Where this is the case, it has been made clear in the attribution.

5.1 What is important to priority audiences?

The decision was taken to start on broader topics to ease participants into the discussion. Exploring what matters to the audience also allowed the role of PA to be positioned in their overall lives. Participants were asked about what they were grateful for right now to give a view of immediate priorities, before moving on to talk about what is important to them in life overall.

There were some overlaps between these categories, with friends and family featuring heavily in both. In this regard, gratitude centred around spending time with loved ones, particularly following the various lockdowns during the pandemic. Supportive relationships were also a feature, whether this involved direct support from family and friends or being part of supportive social groups.

> *"Grandparents support has made it possible for me to go back to work and not pay extortionate nursery fees."*
>
> *Participant, new parent support group*

> "*I'm grateful for FriYAY group, being able to connect on Zoom. It saved my life, kept me sane, meeting new people and connecting with others."*
>
> *Participant, employment support group*

This extended to gratitude for upcoming events, such as holidays and birthdays, which often gave further opportunities for time with loved ones. Many were also grateful for regular social interactions through recreational activities, such as being part of a choir, volunteering, treating themself to a manicure, or playing sports. Physical activity did crop up for some but was not a consistent theme.

In all groups, the overall importance of family was referenced by the majority of people, both in terms of what family meant to them and also in terms of wanting to do right by their family.

> *"My sons. They are the most important thing to me. I just hope I can support my youngest with his speech therapy and provide him with the best quality of life."*
>
> *Participant, ethnically diverse community support group*

Health was not necessarily front of mind for everyone, although it did come up for a significant minority. It was particularly important for older people and for those who had experienced a recent health scare, either their own or a loved one. For example, one recent stroke survivor expressed that they were grateful "to wake up," whilst another participant expressed gratitude at a parent's recovery.

> *"I am just glad that [participant's mum] is okay. She fell and broke her leg over the Easter weekend and after having her break her hip a couple of years back I was really worried for her."*
>
> *Participant, ethnically diverse community support group*

Interestingly, mental health was rarely explicitly mentioned, with instances occurring mainly amongst participants from a mental health support group. There were however numerous

mentions of gratitude for better weather and opportunities to be outdoors which alluded to a general sense of *feeling better*.

> *"The weather is getting better and it's a Bank Holiday, so we are getting out more - we feel more inclined to do more outside"*
>
> *Participant, community health support organisation*

The other major area which was discussed was gratitude for opportunities and the importance of specific goals. Career goals, opportunities for further study, personal development or learning new skills were important to people. For users of a refugee support service, the opportunity to learn English was particularly important.

Notably, the importance of being included was cited by disabled people, those with long-term health conditions and older people in particular.

> *"One lady said her own independence was the most important thing in her life and without her independence she would be 'lost'."*
>
> *Discussion leader, assisted living programme*

Related to this, financial independence and the current cost of living crisis was mentioned only a small number of times; however, this could be due to the positive framing of the questions. It is likely had we asked what people were most worried about, this topic may have arisen more.

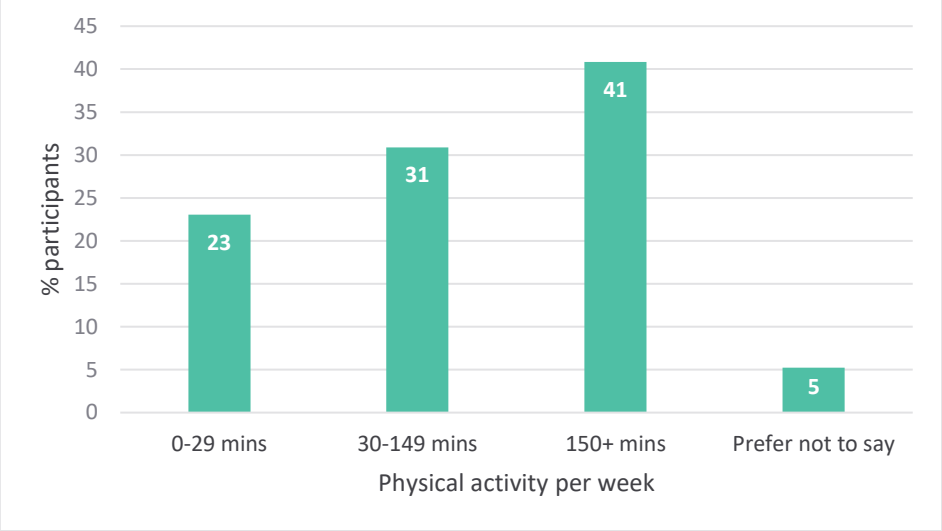
5.2 Understanding of physical activity

The next section of discussions sought to understand what people perceive as physical activity and 'what counts' towards improved health. This question found a wide definition of physical activity, with day to day activities, household tasks and walking mentioned, if anything, more often than more traditional forms of activity such as team sports, running or attending a gym. A number of people also referenced general medical definitions such as "anything that raises the heart rate" or "anything that gets you moving." Figure 9 summarises the activities referenced.

Figure 9: Activities which are believed to 'count' as physical activity

Within our sample, and based on this wide definition, we found a broad mix of activity levels, as shown in Figure 10.[2]

Figure 10: Self-reported activity levels of public engagement participants



The Chief Medical Officer recommends that adults (19-64 years) should undertake 150 minutes of moderate intensity activity (such as brisk walking or cycling).[13,14] In spite of the broad definition applied by our participants, more than half of our sample are not undertaking the recommended minimum amount of physical activity, which broadly reflects the ratio of active versus inactive people we see across the region in the Active Lives Survey.

5.3 What makes a positive or a negative physical activity experience?

When reflecting on their experiences, participants expressed a wide range of emotions which were triggered for them by being active, or the idea of being active. As you would expect, this was a mixture of both positive and negative, with a high number of people articulate *mixed feelings* about being active. The feelings expressed are summarised in Figure 11.

Figure 11: How physical activity makes participants feel

[2] Note that this data is based on self-reporting. Participants were asked: In a typical week, how much physical activity do you normally do? They were reminded to include things like walking and any time they spend being active at home or at work; however, they were not provided with a formal definition of physical activity, as per the Chief Medical Officer's Guidelines.

Positive Experiences

In the majority of groups, those who identified positive feelings associated with physical activity talked broadly about *feeling great*, *having fun*, or *feeling happy*. For those who were more specific, this tended to relate to one of three main areas.

1. Feeling better: In almost every group there were people who spoke about *improved mood*, *feeling uplifted*, *stress relief, having more energy or sleeping better*. Whilst very few people made explicit reference to it, it is clear that for these individuals, being active is having a positive impact on mental health.

> *"Even when I feel like I'm lacking the energy required to participate in the physical activity, the release of endorphins that it stimulates always lifts my mood."*
>
> *Participant, mental health support group*

Around a third of groups also mentioned physical health improvements; however, this was most common for older people, and people with a disability or LTHC. Here symptom reduction or improved condition management were often mentioned.

2. Sense of achievement: More than half of groups also talked about *taking on challenges* and *learning new skills* as part of being active, and how this helped to build *pride* and *self-confidence.* The nature of the challenge itself, however, was varied. For some, for example, it was completing a marathon, for others a short walk, and for some simply moving every day.

> *"If I don't move my body or do some physical activity during the day, I feel like I haven't achieved anything."*
>
> *Participant, employment support group*

3. Personal importance: In a handful of groups people referenced physical activity as holding great personal importance and being part of their identity, with one participant in a parent support group describing it as "*a necessity".* However, there was no noticeable pattern as to the types of people who identified in this way.

When discussing memories of positive experiences of being active, it is notable that much of what people described when asked what was good about the experience relates to the things that they had discussed earlier as being most important to them, and to the stimulation of the positive emotions described above.

People talked about social interaction with friends, family or teammates; and about the sense of achievement that they got from a particular task or activity.

> *"I once went for a walk with my friend and her baby. I enjoyed that. We chatted and I didn't realise how far we'd actually gone."*
>
> *Participant, parent support group*

> *"My sister in law took me [to Zumba], It was so much fun. It is pay and go so you don't have to commit long term, but we laughed so much, and we tried our best."*
>
> *Participant, community health support organisation*

For some achievement was about specific rewards, such as winning, scoring a goal, or getting a medal; but for many it was more about enjoying the challenge, personal improvement or simply getting to the end. There were also a couple of groups where feeling comfortable and included was discussed, in relation to the environment of a particular activity and the attitudes of the other people there.

In health terms, many again spoke about an activity which left them feeling physically and mentally better, but with very few mentions of long-term health gains, such as pain management or losing weight. In relation to mental health, people also referenced having time for themselves, a break in the day, or a sense of freedom.

In terms of the activities people described as enjoyable, these were as wide ranging as the overall definitions of physical activity which participants had already offered. Walking and being outdoors were particularly popular, however there were equally mentions of traditional sports activities (e.g., football, badminton, golf and boxing), traditional exercise (e.g., gym, running or exercise classes) and other leisure pursuits (e.g., swimming, cycling, yoga, gardening).

Negative Experiences

For those whose first thoughts and feelings towards physical activity were negative, there were similarly some who struggled to articulate beyond *"I don't enjoy it," "it's not for me,"* or *"it's boring."* Those who were more specific generally spoke about three main areas:

1. Pain/discomfort: This came up in more than half of groups, including for many people with LTHCs, where people's main associations with being active were that it was tiring, physically painful and that it had the potential to make symptoms of LTHCs worse.

> "*I count getting up as movement. I have been diagnosed with Fibromyalgia. Exercise to me means pain, try to move as best I can but find it a balancing act."*
>
> *Participant, employment support group*

> *"To me exercise means torture...Lockdown and losing my mum 2 years ago hasn't helped my physical health and I've since been diagnosed with COPD."*
>
> *Participant, employment support group*

2. Too difficult: Many also talked about feeling physically incapable of taking part, whether that be due to physical limitations (e.g., not being able to do as much as they could when they were younger), due to technical inability, or due to a general lack of confidence and feeling *left out*.

"[I feel] upset because I cannot exercise on my own without 1:1 support as I cannot use my legs."

Young person, college for disabled students

"The group discussed how it makes them feel at length and confidence seemed to be the key theme, with them not knowing what they can and shouldn't do."

Discussion leader, assisted living programme

3. Anxiety: The final category related to people feeling nervous, self-conscious, frightened or stressed by the idea of physical activity. For some this linked back to the idea of it being too difficult for them, but for others it was more about social comparison.

> *"I am overweight, and I would feel self-conscious if I went to a gym."*
>
> *Participant, parent support group*

Moving on to talk about specific negative experiences of physical activity, once again, many of the things that people described aligned with stimulation of the negative feelings described above. These included pain from existing ailments or the creation of new ones, not being fit enough, feeling they were worse than everyone else, or feeling like they didn't know what to do.

> *"One lady said after attending a line dancing class she felt stupid, as didn't know the steps and no one showed or helped her"*
>
> *Discussion leader, assisted living programme*

For some there was a sense of fear, often created by a past injury or feeling of inadequacy. In the latter case, this commonly stemmed from the environment itself and the attitudes of others in the environment, including where activities were felt to be too competitive. For disabled people this was a particular problem, with challenges related to the venue and to levels of staff knowledge, in addition to the environment of the activity itself. A few people also mentioned being put off by bad weather.

> *"I had an accident on a bike so been scared of trying to ride a bike since."*
>
> *Participant, working adults' discussion group*

"Four participants said that when they have attended sessions within the community, they were ignored by other people and even the instructor, which put them off not only attending them sessions but not wanting to do anything else."

Discussion leader, assisted living programme

Importantly, there was also talk in more than half of groups about mixed feelings towards physical activity. These generally centred around not enjoying the activity itself and seeing it as a chore but knowing they would feel good once it was over.

"3 out of the 5 women within the group said that the idea of physical activity is 'exhausting' and 'it feels like a chore but once do it, I do feel good'

Discussion leader, assisted living programme

For some this further manifested into guilt when they didn't have the time or the energy to take part. For others still it depended on the activity.

"Some said they 'hated' the thought of going to the gym or for a run, however they did enjoy their garden so have spent a lot of time cultivating it."

Discussion leader, community health support organisation

Notably, the activities which people referenced as providing a poor experience, whilst still highly varied, tended to centre around traditional forms of physical activity, including running, gym, swimming, cycling, competitive sports and exercise classes. Past experiences of PE were also mentioned several times by adult participants, as were household tasks.

5.4 How would participants support their community to get more active?

In the final section of the discussion, participants were asked what they would to help the people of their local community to be more active if they had the power to do so.

The two overwhelming things people talked about were having more local activities and more free or low-cost activities (with these often mentioned together).

"Have an outreach service in the community so people can have classes with friends - we don't want to go to somewhere we don't know."

Participant, disabled people's support group

"An 'after school club for parents and children was widely discussed as parents would not have to worry about childcare and they could do activities together. However, this would have to be a free provision as the cost of living is also having pressures on residents."

Discussion leader, social housing residents' support

The benefits around these two themes were quite extensive: enabling people to access physical activity without a car, minimising transport costs, building social connections and enabling opportunities for community support. People were also keen to see local assets better used, in particular parks and greenspaces.

Support for walking came up in a number of guises, including improving walking routes and infrastructure, and establishing more walking groups. There was advocacy for more audience specific sessions: for women only, for disabled people, older people, young people or for weight loss. There were numerous mentions of family-based activities, whether that be mother and baby, whole family sessions, or intergenerational activities, and also a strong advocacy for the provision of childcare to allow parents of young children to take part.

"I would have felt more comfortable if there was a gym just for the people of the weight management programme or at least 'ladies only.'"

Participant, new parent support group

"People are willing to give anything a go as long as it's the right level for them. So, it's important to consider their abilities, health conditions, support network before introducing any activity."

Discussion leader, care home residents

Building on the desire for social interaction referenced in earlier parts of this report, a number of people suggested building physical activity into wider social offerings, such as picnics or family events. This was particularly supported by older people in our sample.

Awareness of opportunities to take part was cited by some groups, particularly those with a disability or LTHC, and it was felt better promotion of opportunities could help. Accessibility also came up for this audience, in terms of venues, inclusive sessions pitched at the right level and the need for appropriate staff training in how to support people with disabilities or LTHCs. Two people spoke about being excluded from activities by cost, due to having to pay membership for their personal assistant.

"Make sure that what people offer is fun and not too hard."

Participant, mental health support group

These themes have been prevalent in other recent community engagement work, both within the Cheshire and Merseyside area and around the UK; they also reflect themes raised in the stakeholder engagement work described in section 4.

Only a small number of groups linked physical activity directly to healthcare and healthcare settings, and those that did were most likely to be disabled people or people with LTHCs. The majority of these referenced social prescribing of physical activity, although there were also specific mentions of physical activity as a tool to combat loneliness, and of better support for disabled people to be active in general.

It is notable that the ideas in this section were mainly focused on community sessions and opportunities, as opposed to the wider range of places proposed for the strategy. Working adults did make some suggestions around workplace initiatives, such as stand-up desks, cycle to work schemes and exercise bikes in office spaces. Beyond the references to walking and cycling above, active travel was not further referenced and there was only one mention of support for activity at home.

Whilst it could be viewed as disappointing that participants did not offer a wider view of how they might change the physical activity system, it should be born in mind that they were only given a short time to consider the challenges. These were also the first conversations in what is hoped will become an ongoing process of engagement. With more opportunities to reflect and build contextual knowledge about what already exists and what systemic barriers might need to be tackled, these conversations can flourish into productive opportunities for co-creation.

5.5 Implications of public engagement

The findings from the public engagement help us to begin to understand the ways in which our audiences experience physical activity. Much research on physical activity behaviour focuses on how people cognitively appraise physical activity, leading only to consideration of the benefits and disbenefits. A decision to be physically active, or not, however, is one that we take over and over again throughout our lives, each time an opportunity to do so is presented. These in the moment decisions are grounded in the emotions, associations and past experiences we have, and in our values, much more so than they are in our understanding of the logical reasons to take part.

Notably, when we frame the questions in this way, people rarely talked about more conventional barriers, such as cost, being local and easy to access, or being short and convenient, in relation to either positive or negative experiences. They also rarely talked about long-term or extrinsic motivations, such as reducing health risks or weight loss. Where these were mentioned, it was often as an addition to other intrinsic motivations.

"The low impact exercise class gave me a sense of achievement. It's enabling me to move and walk further. It's increased my mobility, loosening up my muscles, and helped me to manage my pain."

Participant, LTHC support group

This understanding of people's experiences and how they connect to positive or negative attitudes and perceptions underscores the overall importance of creating positive environments which support being active in a way which enhances intrinsic motivation. Whilst structural and practical barriers remain real and often insurmountable issues for many, and work to remove these should continue, the removal of barriers alone is rarely enough to stimulate behaviour change.

This whole section also highlights that appealing to people at the point of these in the moment decisions requires a different language and narrative than that used when talking to professionals. The language and evidence of health and clinical outcomes is crucial for HCPs to help them know when physical activity is appropriate for patient care, however something different is needed to provide individuals with positive expectations of being active.

As an additional benefit of this process, an array of relationships has been established with organisations who support those who face the greatest health inequalities in our area. A number of individual participants have also put themselves forward to become part of an ongoing engagement conversation. Taking advantage of these relationships and the opportunities they present will be key in further development and implementation of the strategy.

6. Strategic Considerations

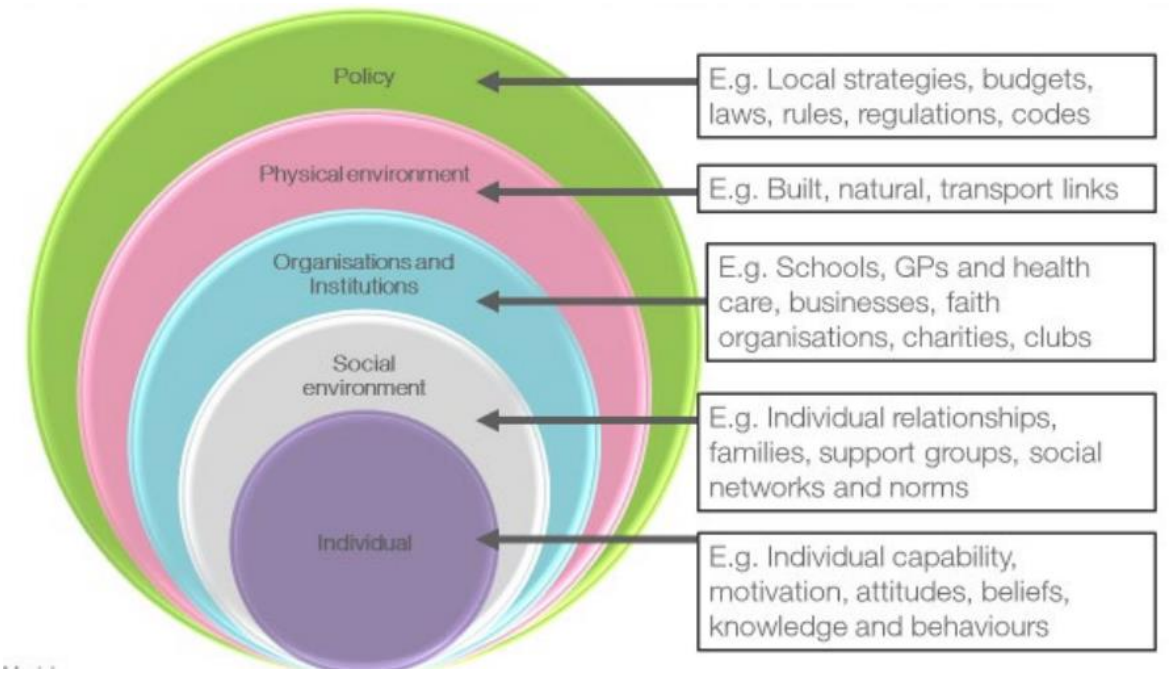
6.1 Overall strategic intent

Phase 1 engagement demonstrated widespread support from a range of stakeholders for establishing a unifying strategy for physical activity in health and social care in Cheshire and Merseyside, which improves overall population health, incorporates both physical and mental health, and has a positive impact on people's lives. Public engagement also highlighted the important impact that being active can have on mental health and wellbeing.

Further to this, stakeholder engagement emphasised the desire to use physical activity in tackling health inequalities, wherever this was possible, with support for the Marmot approach[1] of a universal offer, but with greatest investment in those who could benefit most (Proportionate Universalism). Inherent within this aspiration is the need to understand which audiences experience the greatest health inequalities within the region, where they are, and how they want to engage. Marmot discusses[1,2] the social gradient in health extensively and, whilst this does not account for every person who experiences health inequality, those who live in the poorest neighbourhoods represent a major proportion of inequality. This is therefore a valuable indicator when determining the distribution of resources within the strategy.

Additionally, stakeholders exhibited a significant appetite for a whole-systems approach to be adopted, which will engage with all levels of the system (Figure 12), including policy and culture. There was a keenness amongst local partners to avoid the more traditional intervention approach, which has been used in the past, and relies too heavily on changing individual behaviours without considering the overall environment in which people are choosing those behaviours.

Figure 12: Levels of influence on behaviour[6]



To fully work in this manner, it is necessary to map the system in a number of ways. Whilst these will vary for different systems and places, they generally include for the target behaviour: consequences, causes, stakeholders & influencers (known as network analysis), current actions

and their impact. Once a clear view of the current system is established, you can then move to identify future actions intended to improve the system.[15] The role of the strategy might be seen as capturing these actions, rather than seeking to represent the whole-system. This will enable the targeting of resources most effectively, whilst the combination of the system maps and strategy together will support visibility of what to measure to understand the difference the actions are making.

Related to this, it is important that aims are set for all aspects of the desired system change; these will fall under improved population health, reduced health inequalities, and establishing a more effective system. Stakeholders acknowledge that this will require both process and impact measures, and that these should be both qualitative and quantitative. This will enable not only an understanding of the end goal, but how that has been achieved, and how the system has been altered.

Aims should also take account of the time and resources available. One stakeholder cautioned against setting targets which are not strongly grounded in evidence and may ultimately be unrealistic and unachievable. They noted, for example, it was important to assess what percent of inactive people in the region is represented by 150,000, what percentage change this would be over the time period, and how this compares to the current rate of change.

> *"Before finishing the strategy, you need a sense of the activities and policies you've got in that strategy and what proportion of that 150,000 are they going to be delivering. I did it myself, my first job in [area of work] was writing a physical activity strategy, and if I look at the list of activities now, it is laughable that I thought it was going to result in a measurable increase in physical activity."*

The choice of actions should be very much aligned to the priorities of those who will own delivery of the strategy, those who will sign-off on the strategy, those who will provide resources, and those who will drive the wider system change. For this strategy it will therefore be important to consider the priorities of the C&MHCP, but also other potential investors of time and funding, including the new Integrated Care System (ICS; see section 6.2 for further details).

In choosing the actions, when deciding where the greatest impact can be made, there are a number of questions for consideration by C&MHCP.

1. **LEAD v INFLUENCE:** Which parts of the system fall within the direct remit of C&MHCP and require them to own any action – this will likely reflect all levels of the system (Figure 12) and may involve greater levels of delivery. Conversely, which areas impact on their aims but fall outside of their direct control (e.g., transport). These are areas where C&MHCP's actions will seek to exert influence. They are likely aligned to higher levels of the system model. Consideration of alignment with other local strategies will be helpful at this stage to understand what other system partners are doing. For example, local health priority planning, such as the local place-based plans[16]; related local policies, such as Local Authorities' Local Cycling and Walking Infrastructure Plans (LCWIPs); and the upcoming strategies for Active Cheshire and MSP.
2. **HEALTH v WIDER SOCIAL OUTCOMES:** There has been discussion by stakeholders throughout Phase 1 about physical activity for a range of functions, including its use to address social outcomes outside of health improvement. This brings questions of how far reaching the strategy should be. Is it a vision for realising all possible benefits, health or otherwise, of physical activity for the region? Or does it intend to remain focused on health improvement? If the latter, since wider social outcomes align with the social determinants of health these still need consideration; however, C&MHCP must ensure actions are achievable within the time and resource available, as discussed above.

3. **PREVENTION v TREATMENT:** There is real support from stakeholders for physical activity as a preventative health measure, in addition to its integration within patient care pathways for treatment. As above, C&MHCP should consider how best to distribute resources to incorporate prevention in a way which supports those who will benefit most. Lessons should be taken from past programmes to avoid unintentionally diverting resources to those who already advocate for healthy living and whose risk of poor health outcomes is low.

Consideration of the above questions will allow C&MHCP to focus their overall strategic ambitions in light of this stakeholder input. This will support them to make difficult choices about what should be included and what should not, in order to have the greatest impact on health inequalities in the time available. It will also enable them to talk honestly with stakeholders about the reasons for some things being included whilst others, at least for now, are not.

6.2 Implementation

Once the overall purpose of the strategy is clear, structures of governance will need to be established for both the system and the strategy operating within the system. System leadership best practice[17] advocates that anyone can be a system leader, however an effective system still needs to be championed. This includes people who are advocating for and guiding the system approach itself (using input from wider system partners), in addition to those delivering actions.[12] A typical system requires:

- A core team to guide the day to day and maintain the system's momentum
- Senior support & advocacy who can influence policy and resource allocation
- A network of system leaders who have a stake in the system and who make a commitment to something that contributes to its success.

Throughout the stakeholder engagement there has been significant appetite to collaborate, with significant numbers of stakeholders keen to support strategic planning, community engagement and translation into implementation plans (see section 4.5). A key role for the core team and C&MHCP Physical Activity Sub-Group over the coming months will be to harness this energy and guide it towards an effective network. Maintaining ongoing engagement with this network will be crucial, but also resource intensive and this needs to be factored in.

Place-based flexibility to operate within the strategy framework in a way which meets local need has also been cited repeatedly by stakeholders throughout the engagement process to date. As the work evolves senior champions within each place will need to be identified who can extend the capacity of the regional level core team and galvanise further support in their place. This will establish dual ownership at both regional and local levels, such that commitments can be made and held to account.

Related to that, it has been noted that the funding and resources committed to this strategy and to the overall move towards systems working are currently limited. A further critical role for the core team and senior supporters, therefore, will be to secure these commitments from the wider system. This means much of the work of these teams will need to be focused on relationship building, advocacy and influencing in the coming months.

With the Integrated Care System (ICS; NHS Cheshire and Merseyside) coming into force on 1st July 2022 and with CCGs ceasing to exist, it will be important to understand the flow of funding from the ICS to the new Place-based Partnerships which will come into operation within each of the nine areas[18]. It will also be important to understand the relationship between the ICS and C&MHCP.

In addition, there is potential for additional funding to flow into the region via Sport England's place-based work. Given *Connecting with Health and Wellbeing* is one of Sport England's 5 big issues in its *Uniting the Movement* Strategy[19], a bid which specifically focused on health could be well received.

The final area of critical importance to the success of the systems approach and the strategy will be ongoing community engagement. It has been referenced earlier in this report and needs to be built into every stage of activity. The public engagement to date has also given us valuable insight into the values of those who experience the greatest health inequalities, and how they feel about and experience physical activity. This suggests that two vastly different approaches are needed when engaging with professionals (where the focus is improving long-term health outcomes) and communities (where the focus is improving day to day lives and experiences).

7. Conclusions and Recommendations

7.1 General conclusions

Overall support for the value of physical activity to health, wellbeing and healthcare has been apparent throughout this engagement process. There is a clear aspiration to integrate physical activity opportunities more closely with healthcare settings and move beyond a traditional sport and physical activity intervention approach to tackle some of the systemic issues which influence physical activity behaviours in the day to day lives of local residents. Community settings, including support services, outdoor settings and existing physical activity environments are seen as vital referral routes for the health and social care sector.

There is a high degree of support for flexible, locally-owned, place-based approaches aligned with other local strategies and aims. It is especially important to stakeholders to build on and join-up existing good work and ensure learning from what has not worked.

There is enthusiasm to contribute, which should be leveraged, from the majority of stakeholders who took part in Phase 1 engagement. One notable gap in engagement at this stage, however, is with frontline health and social care professionals. This should be prioritised both to establish support and buy-in, but also to understand the day-to-day realities being faced and ensure workable plans are taken forward.

Ongoing community engagement and local ownership are additionally seen as cornerstones necessary to achieve success. In particular frequent engagement with those experiencing the greatest health inequalities is seen as essential, with opportunities for local ownership and co-creation to be prioritised. The relationships established with local trusted organisations (LTOs) in Phase 2 of this work will be invaluable in this pursuit.

As part of a whole-systems approach, there is recognition of a need to move beyond an intervention only approach towards programmes of work to tackle the environments which shape everyday behaviours. This requires a broad definition of physical activity and a public presentation of inclusivity over competition or elitism. Some of the challenges of establishing and operating within a systems approach have been detailed in section 6, however the benefits are generally felt to be worth the investment.

Inevitably, the matter of funding and resources is seen as a major challenge, and whilst the strategy should be ambitious, it needs to be achievable within the constraints in which it must operate. This will need to include adequate training, support and capacity building for the workforce to avoid overburdening in an already stretched climate.

7.2 Strategic framework

Overall, there was support for the draft strategic themes presented, with stakeholders feeling they are clear and easy to understand. Concerns have been raised though that the current presentation of the themes, particularly the People and Place themes, lack the detail required to translate into local implementation. They might also encourage an intervention-based approach; and may not allow room to tackle wider system change.

The life-course approach taken in the People themes resonated well in the sense that good health is crucial at all ages for a healthy life. However, more detail is demanded to ensure appropriate targeting can be achieved, and avoid key audiences experiencing health inequalities, such as ethnically diverse communities and those with LTHCs, falling between the cracks.

This could be achieved within the current framework by adding further detail of the major health challenges to be addressed for each life stage and where this links to place. Alternatively, one stakeholder suggested that the life-course approach sits better as a vision, allowing more specific audiences to be identified within the strategic themes.

Whether the framework is retained in its current form, or the key elements evolved in an alternative representation, it will be important for C&MHCP to consider what value inclusion of each element contributes to the overall strategic intent. This will avoid a reactionary approach which simply describes the system, by including every audience and environment, but fails to provide focus and clarity.

Nonetheless, specific gaps in the themes were highlighted by stakeholders as:

- People: Young People, Non-working Adults, Families
- Place: Community Settings, Education Setting
- Purpose: What does an effective system look like?

7.3 Summary of key recommendations

Whilst the findings of this report should be reflected on in full, we present here some key recommendations for Cheshire & Merseyside Health & Care Partnership to consider.

1. Reflect on the strategic considerations (Section 6) to refine the overarching strategic purpose and vision for the strategy, reflecting the appropriate role for C&MHCP, its partners, and the newly formed ICS. Evolve the People, Place, Purpose model to provide *a plan on a* page which summarises the core strategic purpose.
2. Give frank and honest consideration to the likely funding and resources available to ensure strategic aims are ambitious, but achievable.
3. Ensure priority audiences who experience the greatest health inequalities are explicit within the strategy and consider where physical activity is and isn't well placed to support progress against the Marmot Indicators (Appendix 7).
4. Design-in actions to tackle systemic and environmental issues which limit movement in day to day life, including public perceptions of physical activity and sport.
5. Commit resource to mapping and guiding the system, progressing the strategy, securing funding, and building the network of system leaders.
6. Capitalise on stakeholder energy, by convening opportunities to work collaboratively, especially at a place-based level, to translate the strategy into local plans and address key challenges (including those identified in section 4.5). Ensure flexibility and place-based leadership is embedded in everything.
7. Engage with health and social care professionals (including care homes) to understand what is realistic and what will be supported in healthcare settings, in particular in the wake of the pandemic.
8. Incorporate the significant role to be played by community settings as a formal or informal referral pathway to support HCPs; and seek to support capacity building.
9. Build in explicit and frequent points for community engagement to all future iterations of both the strategy and implementation; including actively seeking opportunities for co-creation with both communities and HCPs.
10. Consider the different language and approach required to engage a professional versus community audience in physical activity.

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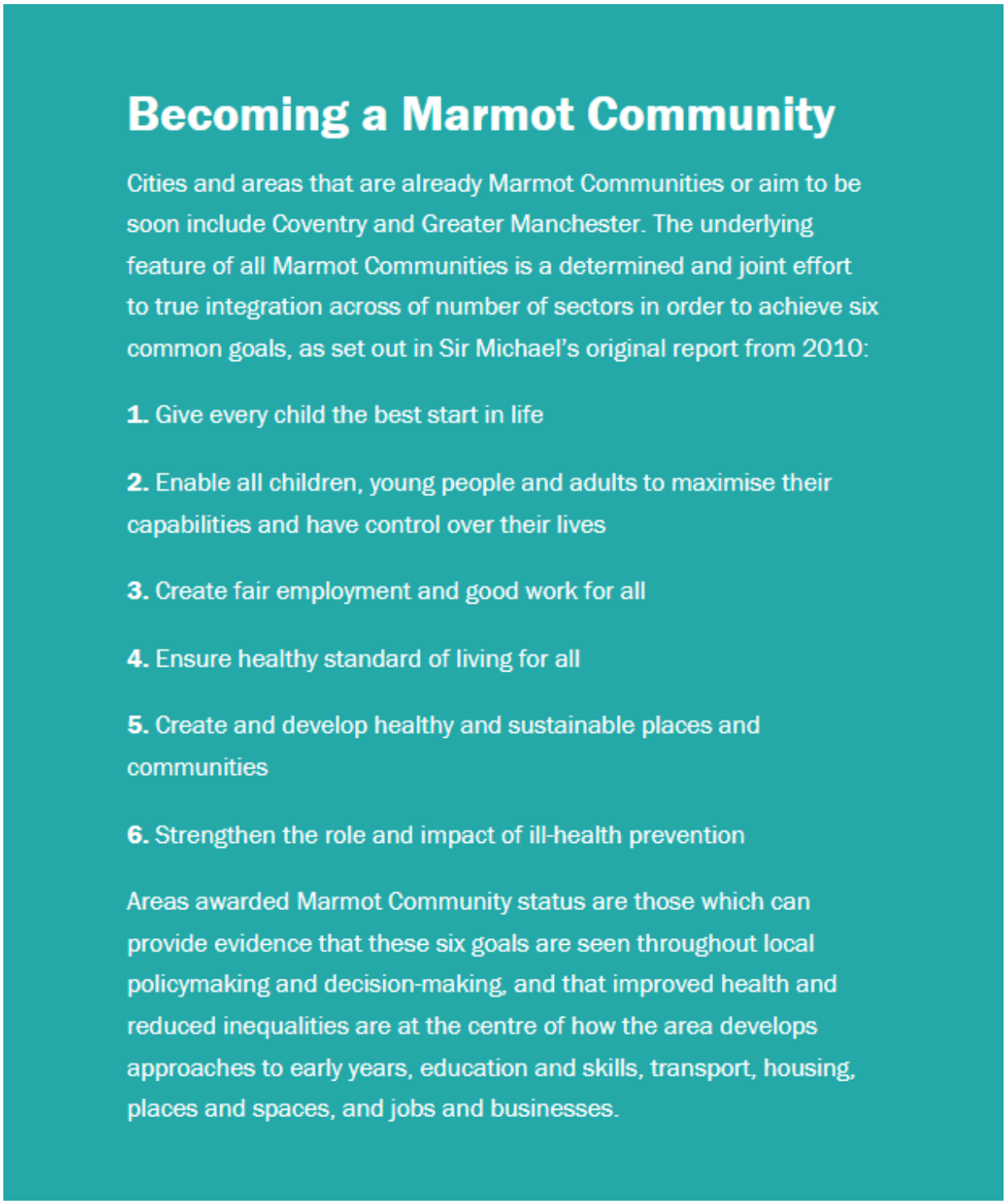
9. Appendix 1 – Marmot Principles



From Becoming a Marmot Community - Cheshire & Merseyside Health & Care Partnership (cheshireandmerseysidepartnership.co.uk). Accessed 05/07/2022.

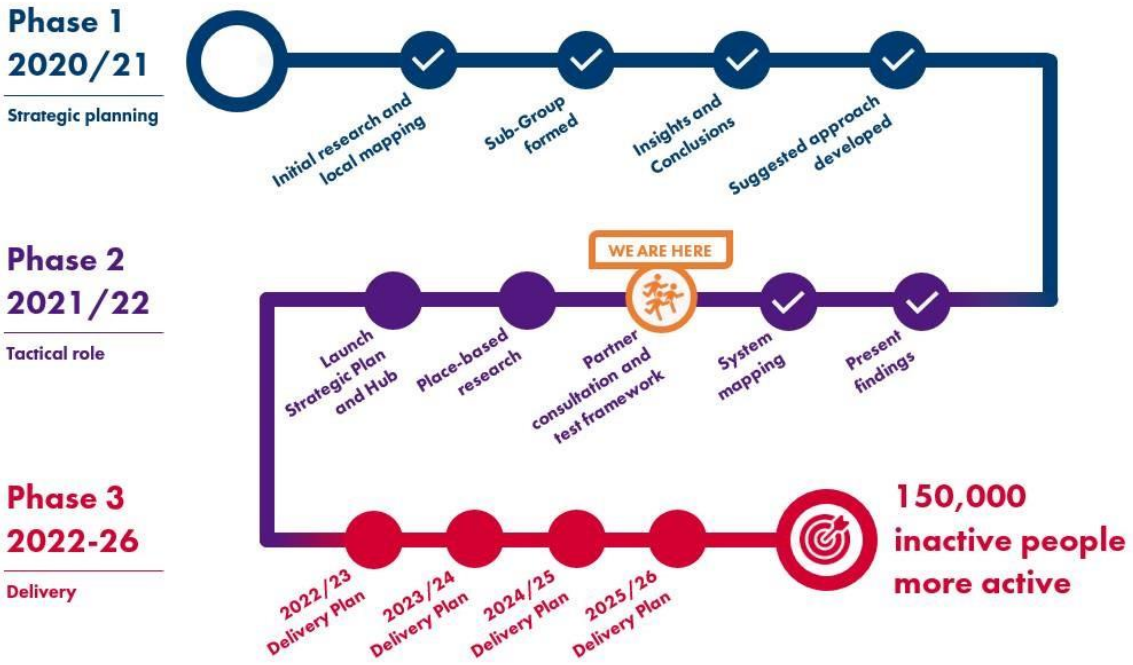
In December 2020, two additional goals were added following the onset of the pandemic.

7. Tackle racism, discrimination and their outcomes.
8. Pursue environmental sustainability and health equity together.

10. Appendix 2 – Roadmap of work to date

Key milestones towards the strategy development, prior to this round of stakeholder engagement, included:

- Undertaking initial research to ascertain needs and opportunities across the region
- Establishing, chairing and consulting with the C&MHCP Physical Activity Subgroup
- Developing a draft strategic framework and strategic themes to be tested with stakeholders
- Presentation of findings to key stakeholders (e.g., C&MHCP Population Health Management Board, and the 9 Local Authority Directors of Public Health)
- Producing a System Map which has informed the development of a stakeholder map



11. Appendix 3 – Stakeholder Survey Questions

1. How strongly does the proposed strategic approach link to the outcomes your organisation is trying to achieve?
    a. Very strongly
    b. Strongly
    c. Somewhat
    d. A little
    e. It does not

Please provide any details about your answer:

2. Do the three strategic people themes (Early Years & Children, Working-age adults and Older Adults) resonate with you? [Please answer even if your organisation does not cover all three themes].
    a. Very strongly
    b. Strongly
    c. Somewhat
    d. A little
    e. They do not

Please explain how these strategic people themes link into your organisation's work, or if there are any gaps?

3. Do the four strategic place themes (Active from Home, Workplaces, Health and Social Care and Active Travel) resonate with you? [Please answer this question even if your organisation's work doesn't cover all four themes].
    a. Very strongly
    b. Strongly
    c. Somewhat
    d. A little
    e. They do not

Please explain how these strategic place themes link into your organisation's work, or if there are any gaps?

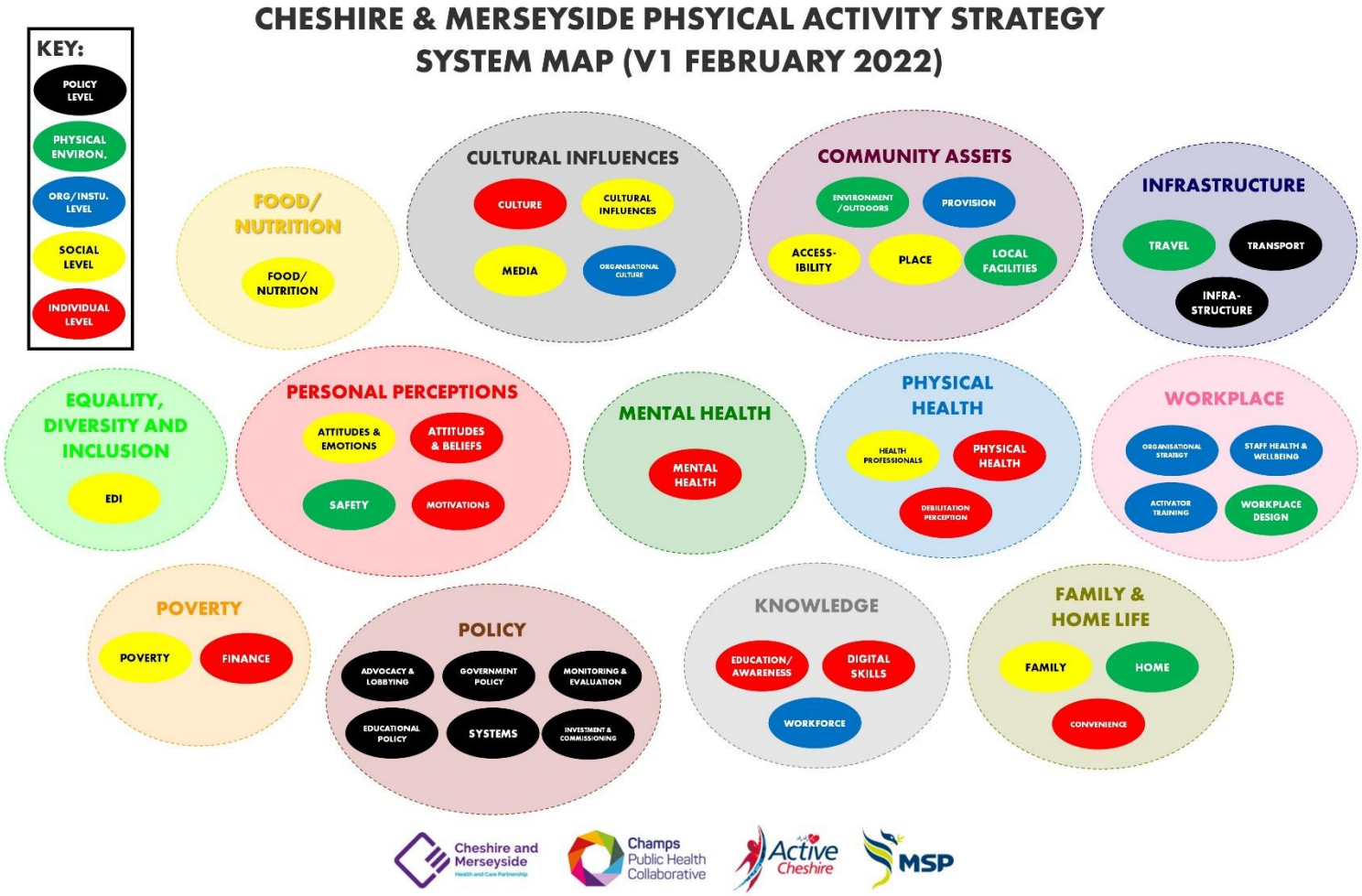
4. What do you feel are the top three enablers or barriers for the people that you support to being more physically active?

    Biggest

    Second biggest

    Third biggest

12. Appendix 4 – Cheshire and Merseyside Physical Activity System Map



13. Appendix 5 – Local Trusted Organisations (LTOs) who supported Phase 2 Public Engagement

In total 26 organisations were contacted as potential LTOs and 15 were able to support the work during the required timeframe:

Organisation		Consultation				
Organisation Name	Purpose	Who they spoke to	No. consultees	Activity Levels (per week)		
				0-29 mins	30-149 mins	150+ mins
Age UK Wirral	Working in the community to support older people, their families and their carers	Older Adults (50+)	18	2	8	6
Asylum Link Merseyside	Help asylum seekers learn about and make connections in their new community.	Asylum Seekers (18+)	11	1	1	6
CRH Trust	Care Home Provider	Care home residents (70+)	12	12	0	0
Disability Positive	Providing services, opportunities and advocacy for people with a disability or LTHC	People with a disability or LTHC and their parents	9	3	6	0
Edsential	Providing a range of services to the education sector	Primary age children and parents	13	0	4	9
Greenbank School	High school & college for 11-18 year olds with SEN	Students with disabilities (16-25) and Powersport clubs members (16-50)	31	4	15	12
Healthwatch Cheshire	Local consumer champion for health & social care	Carers and older people (18+)	7	2	3	2
Hut Group	Local business	Working age adults in a call centre (18+)	14	0	3	11
Irish Community Care	Provision of support, information & guidance for all Irish, Irish Gypsy and Traveller communities	Irish, irish gypsy and traveller community members (40-50)	2	0	0	2
Stroke Association	Helping stroke survivors and their families live fuller, happier lives	Stroke survivors (18+)	7	0	2	5
Transform Lives Company	Supporting people back into work and employee wellbeing programmes	Unemployed people (18+)	6	0	2	4
Tongue Tie Northwest	Supporting new parents with feeding and tongue tie issues	Parents of 0-5 year olds (18+)	11	3	3	5
Torus Foundation	Charitable arm of the affordable homes provider. Investing profit into community projects e.g. H&W, financial advice, employment support	Residents in social housing	5	2	2	1
		Residents in social housing (under 60)	15	6	4	5
		Residents in Extra Care sheltered housing (55+)	15	5	3	2
		Residents in sheltered housing (55+)	5	2	1	2
Wirral Deen Centre	Mosque and community centre for the whole community	Muslim family members (18+)	5	0	0	5
Wirral MIND	Mental health support	Adults experiencing mental health issues (18+)	5	2	2	1
TOTALS			**191***	**44**	**59**	**78**
		*10 people preferred not to provide their activity levels				

Largely due to pragmatic reasons, Active Cheshire and MSP were unable to secure participation in this specific phase of engagement from all audiences within the Cheshire and Merseyside region who were identified through earlier system mapping work as facing health inequalities. Nonetheless, relationships have been forged with a number of organisations who support those cohorts who have not yet engaged, and their participation will be prioritised for future rounds of public engagement.

14. Appendix 6 - Phase 2 Public Engagement: Guidance for Local Trusted Organisations (LTOs)

Phase 2 LTO Engagement Guide.pc

15. Appendix 7 – Marmot Indicators

Life expectancy		Frequency	Level	Disagg.	Source
1	Life expectancy, female, male	Yearly	LSOA	IMD	ONS
2	Healthy life expectancy, female, male	Yearly	LA	IMD	ONS
Give every child the best start in life					
3	Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development)*	Yearly	LA	NA	DfE
4	Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception)	Yearly	LA	FSM status	DfE
Enable all children, young people and adults to maximise their capabilities and have control over their lives					
5	Average Progress 8 score**	Yearly	LA	FSM status	DfE
6	Average Attainment 8 score**	Yearly	LA	FSM status	DfE
7	Hospital admissions as a result of self-harm (15-19 years)	Yearly	LA	NA	Fingertips, OHID
8	NEETS (18 to 24 years)	Yearly	LA	NA	ONS
9	Pupils who go on to achieve a level 2 qualification at 19	Yearly	LA	FSM status	DfE
Create fair employment and good work for all					
10	Percentage unemployed (aged 16-64 years)	Yearly	LSOA	NA	LFS
11	Proportion of employed in permanent and non-permanent employment	Yearly	LA	NA	LFS
12	Percentage of employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter***	-	-	-	NHS, local government
13	Percentage of employees earning below real living wage	Yearly	LA	NA	ONS
Ensure a healthy standard of living for all					
14	Proportion of children in workless households	Yearly	LA	NA	ONS
15	Percentage of individuals in absolute poverty, after housing costs	Yearly	LA	NA	DWP
16	Percentage of households in fuel poverty	Yearly	LA	NA	Fingertips OHID
Create and develop healthy and sustainable places and communities					
17	Households in temporary accommodation****	Yearly	LA	NA	MHCLG / DLUHC
Strengthen the role and impact of ill health prevention					
18	Activity levels	Yearly	LA	IMD	Active lives survey
19	Percentage of loneliness	Yearly	LA	IMD	Active lives survey
Tackle racism, discrimination and their outcomes					
20	Percentage of employees who are from ethnic minority background and band/level***	-	-	-	NHS, local government
Pursue environmental sustainability and health equity together					
21	Percentage (£) spent in local supply chain through contracts***	-	-	-	NHS, local government
22	Cycling or walking for travel (3 to 5 times per week)-	Yearly	LA	IMD	Active lives survey

** Children achieving a good level of development are those achieving at least the expected level within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.*

*** Both the Progress 8 and Attainment 8 scores are proposed for inclusion. Progress 8 scores at local authority level demonstrate that schools with a negative average score require systematic intervention. Attainment 8 shows the percentage achievement of school-leavers and is a more sensitive measure of annual change within schools.*

**** These indicators will require the NHS and local authorities to establish new data recording and collection methods. We have factored the social value indicators into the 2022/23 work programme to align with the rollout of the Anchor Institute Charter. It will also require definitions of "local" in both the local supply chain and employment. All contracts, direct and subcontracted, should be analysed and included. This should be reviewed after the first year of implementation. Collecting ethnicity data related to employment should also be reviewed after the first year of implementation.*

***** To be used to demonstrate annual changes, interpretation to factor in population changes.*

- Active Lives Survey states the length of continuous activity is at least 10 minutes.

From Marmot (2022) All Together Fairer – Health Equality and the Social Determinants of Health in Cheshire and Merseyside

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