National Institute for Health and Clinical Excellence

PH INTERVENTION – PHYSICAL ACTIVITY
Consultation 31 May – 30 June 2005
Comments on the Scope by 30 June 2005

Stakeholder Comments

Please use this form for submitting your comments to the Institute.

1. Please put each new comment in a new row.
2. Please insert the **section number** in the 1st column. If your comment relates to the document as a whole, please put **'general'** in this column

Name:	**Dr Alan Maryon Davis**
Organisation:	**Faculty of Public Health**
Section number Indicate **section number** or **'general'** if your comment relates to the whole document	**Comments** Please insert each new comment in a new row.
General	The Faculty welcomes the opportunity to comment on the scoping document from the National Institute for Health and Clinical Excellence (NICE) which looks at public interventions on physical activity. This response has been put together by members of the Faculty of Public Health' Cardiovascular Health Working Group.
4.1	The Faculty welcomes the choice of the four categories of intervention to be considered, but would like to see a further category included, namely: home-based exercise programmes under supervision (eg. with ongoing telephone support). This approach has been well studied, particularly in the US, and is likely to be one of the approaches used by the new breed of 'personal health trainers' whose role is shortly to be piloted. This could perhaps be brought in as an extension of 4.3.1 (brief interventions in primary care, although some studies have looked at home-based programmes accessed through routes *other than primary care*, eg. via leisure centres, health clubs or targeted community projects).
4.1	The Faculty very much welcomes the attention to be given to the impact of interventions on health inequalities, but would also like the guidance to look at the impact of inequalities on the effectiveness of interventions.
4.4.1	The CMO's recommended level of physical activity does not take into account the psychosocial benefits of lesser amounts of activity, nor the benefits of lesser amounts in terms of improved flexibility for older people. If effectiveness is assessed only on reaching the CMO's standard much of the potential benefit will be ignored. The Faculty would like to see participation rates and

	quality of life scores (where they exist) also taken into the assessment. In addition, we feel that studies emerging from the US and elsewhere regarding the potential benefits of small changes in lifestyle (eg. 200 extra steps a day) should be also be included.
4.4.2	The Faculty accepts that for practical reasons the proposed guidance is restricted to interventions aimed at adults. We welcome the assurance that children's exercise referral schemes will be included in the forthcoming obesity guidance. However, we would also wish to be reassured that other approaches to increasing physical activity in children will also be included in the latter guidance: eg. active play in under-5s, school-based programmes, active travel, community games, etc.
4.6	See comments re 4.4.1 above.
4.7	The Faculty is broadly happy with the nine key questions to be examined. Regarding 4.7.1 (objectives), consideration needs to be given as to whether the outcome being assessed is whether the intervention reached its own objectives, or the CMO's standard. Regarding 4.7.9 (barriers), we would like to see the target group's perceived barriers included (where available), eg. non-participants' attitudes and beliefs. We need to better understand why people do not take up the many opportunities to increase physical activity – socio-cultural evidence. This should include the perceived costs to the potential participant.
4.8	Other target audiences include government departments (particularly DCMS and ODPM), local town and transport planners (even though not specifically looking at activity-conducive environments) and the media. With regard to the media and general public, it is crucial that press statements and the report itself make it very clear that a lack of evidence of effectiveness does not mean evidence of non-effectiveness – merely that more studies are needed.
4.9.2	In addition to QALY-based cost-effectiveness analyses, we would like see to a DALY-based approach (disability-adjusted life-year). Increased mobility and quality of life are important outcomes to include in cost-effectiveness if enough studies are available. Scales such as SF-12 and ED-5Q should be included where available.
4.9.2	Whilst we accept that the effect on co-morbidities such as diabetes, hypertension and obesity are, or will be, covered in other guidance, it is important that the comparator of 'usual care' includes cost of medication for such conditions. The potential for physical activity to reduce the necessity of drug therapy is important to assess. We believe that the totality of the evidence supporting the use of physical activity in supporting people with long-term conditions may be diluted by considering it only in

	guidance concerned with each individual condition. The present proposed guidance may be a missed opportunity to consider these benefits in the round.
General	The analysis of primary-care based interventions (of whatever type) should if possible be presented in a way that links closely to the QOF points scheme (quality and outcome framework) incentivising practices to give appropriate advice re physical activity.
General	The Faculty would like to see future guidance assessing the impact of environmental change on activity levels (eg. town or rural planning). Although we recognise this may not be a job for NICE, we feel that NICE could recommend this to other government departments.
General	The Faculty welcomes the opportunity to comment on this guidance for public health interventions on physical activity. However, the consultation period is extremely short. It is critical that for future consultations information is sent to stakeholders by the most time-effective means. Consultations should be sent electronically and not via post to ensure that the full consultation period is allowed. It would also be useful to receive a pre-alert eg a month or two beforehand – or when work on preparing the scoping document commences, so that stakeholders can plan ahead and incorporate responding to the consultation into their existing work schedules.

Please add extra rows as needed
Contact: physicalactivity@nice.org.uk