

ESDN Symposium Sheffield

Beyond 2012 – what next for sport and physical activity?

Proposed Paper

Sport, Physical Activity and the establishment of Health and Wellbeing Boards in Nottingham and Nottinghamshire

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Abstract

This paper will examine the emergence of Health and Wellbeing Boards in Nottinghamshire and the City of Nottingham and explore the implications for sport and physical activity.

At the time of writing the transfer of responsibilities for Public Health and the establishment of Health and Wellbeing Boards in both the City of Nottingham and within Nottinghamshire County Council are considered to be relatively advanced by the Strategic Health Authorities, the respective local authorities and by the boards of the two Primary Care Trusts. “Shadow” Health and Wellbeing Board have been established in both authorities and they have been meeting regularly for several months. Public health and commissioning staff have also been successfully relocated and new strategies and priorities are starting to emerge.

Nottingham and Nottinghamshire have traditionally acknowledged the role of sport and physical activity to the wider determinants of public health and given a relatively high priority to the contribution that sport and physical activity can make to their preventative health and early intervention agendas. This paper will look at the transition to Health and Wellbeing boards to assess how the role of sport and physical activity may be changing and to identify opportunities for its’ contribution to policy and practise in the future.

It will examine both the theory and practise behind the emerging governance arrangements, the strategic objectives and priorities, and the developing evidential base for future policy and delivery within the two areas.

Topic Area: Health and Wellbeing.

Interest/benefits to researchers or practitioners: To help researchers and practitioners understand the changing policy environment in which they have to operate.

Symposium themes: Physical activity, health and wellbeing

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Introduction

The Health and Social Care Act 2012, *inter alia*, encourages better integration between health and social care and transfers responsibilities for Public Health at the local delivery level from Primary Care Trusts to local authorities. To facilitate and implement these developments it proposes the establishment of Health and Wellbeing Boards as the primary multi-organisational governance arrangement to oversee delivery, public reporting and accountability. The Health and Social Care Act received royal assent in March 2012 and the proposed Health and Wellbeing Boards assume their responsibilities from April 2013.

The Act requires the new Boards to encourage health and care commissioners to work together to advance the health and wellbeing of the people in its administrative area. Although the provisions of the Act will commence in April 2013, NHS organisations, local authorities and other key stakeholders, to a greater or lesser extent, have been actively preparing for the changes, since the proposals were first introduced in the governments White Paper entitled "Equity and Excellence: Liberating the NHS" in December 2010 (DoH 2010).

This paper will examine the background and experience of the emerging Health and Wellbeing Boards in Nottingham City and Nottinghamshire County Councils, and in particular will explore the implications for Sport and Physical Activity. Nottingham and Nottinghamshire have traditionally recognised the role that sport and physical activity can play in the wider determinants of public health and have previously invested in sport and physical activity as part of their preventative health and early intervention programmes. At the time of writing the transfer of responsibilities for Public Health and the establishment of Health and Wellbeing Boards in both the City of Nottingham and within Nottinghamshire are considered to be relatively advanced by the Strategic Health Authorities, the respective local authorities and the two Primary Care Trusts. "Shadow" Health and Wellbeing Boards have been established in both authorities and have been meeting regularly for some months. Public health and commissioning staff have also been successfully relocated and new strategies and priorities are starting to emerge.

By undertaking this exploratory research within two areas previously acknowledged for their innovation and good practise, it is anticipated that some recommendations and advice can be developed for both policy and practise and help to optimise the contribution that Sport and Physical Activity can make to the public health agenda and to the health and wellbeing of citizens and communities. The following research question and sub-questions were therefore adopted to focus the project.

What is the potential role of sport and physical activity in the new public health system envisaged by the Health and Social Care Act 2012?

- a) What is the nature and scope of the Health and Wellbeing Boards role within the emerging public health system?
- b) What is the nature and scope of the Health and Wellbeing Boards role in practise as emerging in Nottingham and Nottinghamshire?

- c) What is the potential role for Sport and Physical Activity within these scenarios?
- d) What lessons can we draw for Sport and Physical Activity in terms of future policy and practise?

Background, context and literature review.

- a) What is the nature and scope of the Health and Wellbeing Boards role within the emerging public health system?

In order to be able to advise on the optimisation of the strategic positioning and practical contribution that Sport and Physical Activity can make to this new agenda, it is necessary to understand the policy and legislation and the theoretical and practical landscape in which it is developing. This is particularly important in relation to both Health and Wellbeing Boards as eventually formulated by the Act and for Sport and Physical Activity because In both of their cases, their recent antecedents have included some theoretical and conceptual confusion, although the research shows considerably less confusion in practise as developed in Nottingham and Nottinghamshire.

As eventually formulated the provisions of the 2012 Act in general and the proposals for Health and Wellbeing Boards in particular can best be interpreted or understood through the Public Value or new Public Service Theory that has developed since the mid-1990s originally in the USA but increasingly in Europe, Australia, North America and the UK (Moore 1995, Kelly et al 2002, Blaug et al 2006, Mulgan 2009 and Bennington and Moore 2011). However during its early development in the UK there was considerable confusion with some of the earlier proposals and interpretations from the Department of Health and the Department of Culture Media and Sport appearing to emphasise Public Choice Theory and New Public Management concepts particularly in the recent white paper (DoH 2010) and in the publicity and debate generated by the unprecedented and extensive “Listening exercise” (DoH 2010a). Similarly although some early policy for the development of Sport and Physical Activity from the last government was based upon early application of Public Value (Cabinet Office/DCMS 2002) later policy tended to be theoretically confused with both policy and delivery increasingly dominated by the London Olympics.

Public Health policy, the development of Health and Wellbeing Boards and the role of Sport and Physical Activity however clearly have their recent policy and theoretical antecedents in the wider determinants of health agenda and the development of inter-organisational collaboration for addressing complex community issues (sometimes referred to as “wicked issues” because of their persistence and resistance to single agency resolution or amelioration) of the 1999 Health Act through to the 2007 Local Government and Public Involvement in Health Act.

The World Health Organisation defines “health” as “a state of complete physical, mental and social wellbeing...not merely the absence of disease or infirmity” and in the UK the term health and wellbeing has increasingly been used to describe this more holistic view of our ambitions for individuals and local communities. However since the 1980s in parallel with this desire to see longer and healthier lives there has been consistent evidence of unacceptable and continually increasing health inequality within the UK (Black 1980, Whitehead 1987, Acheson 1988, Barton and Grant 2006). This culminated in the last government commissioning the Marmot review of health

inequalities (Marmot 2010) which provided the evidential background and momentum for the subsequent public health white paper (DoH 2010) and the most recent Public Health Outcomes Framework (DoH 2012). The local evidential base for improving public health and reducing health inequalities had already been established by the statutory Joint Strategic Needs Assessments (JSNAs) of local areas required by the 2007 Local Government and public involvement in health Act (NHS Confederation 2011, DoH 2012a).

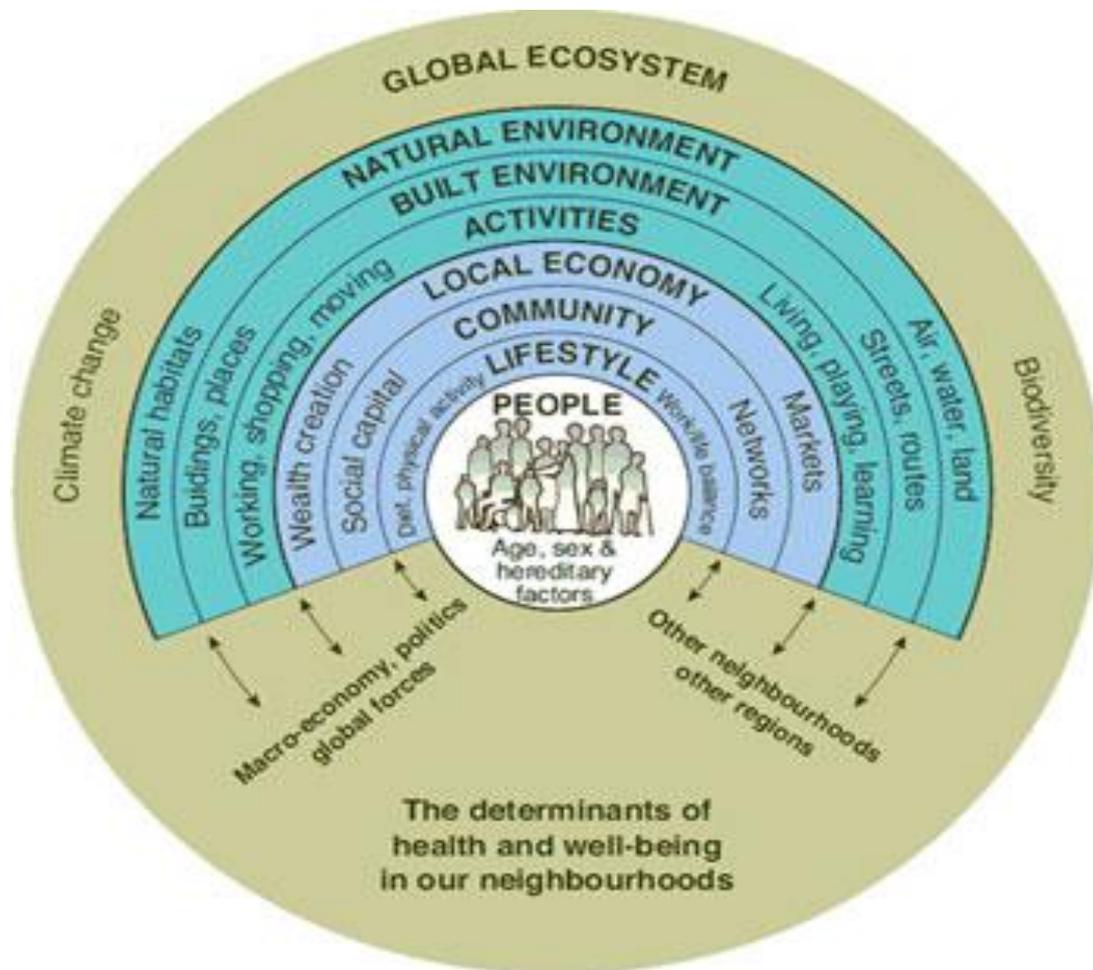


Figure 1. The wider determinants of health and wellbeing
Source. Barton and Grant.

The recent development of inter-organisational collaboration for addressing complex community issues has its origins in the 1998 Crime and Disorder Act, the 1999 Health Act and the 1999 Local Government Act, with the latter introducing the concept of best value and the requirement for local authorities to facilitate the continuous improvement of local public services. Various collaborative partnerships for tackling deep rooted “wicked” issues were gradually developed and these were generally facilitated under the umbrella of Local Strategic Partnerships (LSPs) who subsequently established their policy and priorities and then co-ordinated their delivery activity through 3-yearly Local Area Agreements (LAAs) negotiated with the government. For the purposes of this paper it is useful to note that health issues, objectives and targets featured prominently in all forms of the LAAs and in the parallel strategic partnerships for Children’s and Adult Services. Not surprisingly Sport and Physical activity therefore featured just as often in the Health and Social Care theme or “block” of

the LAA as it did in the Children's Services block. At the time of the 2009 LAA refresh 82 out of 149 LSPs had included targets around National Indicator NI8 "the percentage of adults engaged in sport and active recreation" and most LSPs (adopting the emerging nomenclature of the wellbeing agenda) had developed Health and Wellbeing Groups or sub-committees to co-ordinate the relevant parts of the LAA often under the leadership of the Primary Care Trust.

Methodology and Methods

This paper is based upon exploratory research rather than evaluative or analytical research to which the author has adopted a critical realist perspective. The focus has been on two inter-related case studies for both theoretical and practical reasons which are explained below.

The Nottingham and Nottinghamshire case studies

An examination of the successive versions of the two Local Area Agreements for the areas (LGID 2012 – formerly known as the IDeA), together with the two JSNAs (Nottingham City Council and Nottingham City NHS 2012, Nottinghamshire County Council and Nottinghamshire NHS 2011), the corporate and service plans and documents and external inspection reports under CPA and CAA (Audit Commission 2012) demonstrates that Nottingham and Nottinghamshire have traditionally acknowledged the role of sport and physical activity to the wider determinants of public health and given a relatively high priority to the contribution that sport and physical activity can make to their preventative health and early intervention agendas. This was confirmed by a comparison with the equivalent documentation for the other seven LSP/LAA areas of the East Midlands undertaken as part of this research. In addition they compare very favourably with the latest national good practise advice issued by the Department of Health (DoH 2012a) and the former Improvement and Development Agency which is now known as Local Government Improvement and Development (IDeA 2010 and 2011). Their respective Directors of Public Health have been actively involved in the Department of Health's public health policy development, and they are recognised within health community for good practise and innovation with both receiving numerous awards for their work in this area, most recently in the 2012 British Medical Journal Awards. (BMJ 2012).

Nottingham City is a core city with a unitary local authority while Nottinghamshire has a two tier system of local government. Both received particularly challenging budget reductions in the coalition governments Local Government Financial Settlement 2010-2014 with significant reductions required in their annual budgets. The councils have Health Overview and Scrutiny committees for their individual areas and a shared joint Health Overview and Scrutiny Committee that, *inter alia* scrutinises the activity of Nottingham University Hospitals Trust, which is the fourth largest Acute Hospital Trust in the country, and Nottinghamshire Healthcare Trust, which is one of only three Mental Health Trusts in the country that provides the full range of mental health services.

From the more practical viewpoint of facilitating the primary research and access to key documentation and personnel, Nottingham City NHS and Nottinghamshire County NHS were chosen because the author is a Non- Executive member of both of their NHS boards and is a member of the board of the Nottinghamshire PCT cluster.

The methods adopted for the research therefore included participant observation and enquiry, together with document and website reviews and a series of interviews with key participants from both PCTs, both Local Authorities and other key stakeholders.

Findings.

- b) What is the nature and scope of the Health and Wellbeing Boards role in practise as emerging in Nottingham and Nottinghamshire?

It was clear that in both case study areas the emerging Health and Wellbeing Boards were being established to take the central role in overseeing and driving the public health agenda in their respective areas. Both Councils have been early adopters of the need for action and have reacted to the opportunities and challenges of the transfer of responsibilities, well in advance of the royal assent being given to the act. In both cases the Board is being Chaired by a senior member of the political executive and, in addition to the “shadow” Director of Public Health, both of the councils Chief Executive Officers and Deputy Chief Executives have been closely involved in advising both the transition projects and the emerging Boards. Both Directors of Public Health will report directly to the CEOs and both councils have adopted a “building not re-inventing” attitude to the emerging governance arrangements effectively dissolving the former Health and Wellbeing committee (or equivalent) of the LSPs and appointing the core of these bodies to the new shadow boards with new chairman. The new Chief Operating Officers and clinical chairs of the emerging Clinical Commissioning Groups have been included in all cases together with the CEOs of the Nottingham Universities Hospital Trust and the Nottinghamshire Healthcare Trust. Both the transition groups and the shadow boards have met on a number of occasions with terms of reference, working protocols, delegation arrangements and other governance infrastructure being rapidly put in place with regular reporting to the parent PCT Boards.

Good progress with these practical arrangements does however disguise the different policy positions of the two councils. For very understandable political reasons, Labour controlled Nottingham City Council wished to maintain a public policy position of opposing many of the provisions of the 2012 Act and therefore did not wish to formalise any of the practical preparations until the passage of the act was assured. However at the same time it took a very practical view of the need for advance preparations if (contrary to their preference) the Act was passed rather than abandoned. Their position was therefore explicitly communicated to the Primary Care Trust and the Public Health team from the very start, and this research confirms that good informal and formal working relationships were maintained throughout the period of the coalition governments “listening exercise”. As and when the Act was passed the informally agreed arrangements were rapidly formalised and progress with the transition programme has remained on schedule to meet the requirements of the Act.

Conservative controlled Nottinghamshire County Council were, in contrast, strong advocates for the proposed changes from the date of their first publication, and wished to expedite the changes and, in effect, act as a local pathfinder for the new arrangements. They therefore established a very challenging timetable to their transition project at the very start, with the Leader of the Council chairing and leading the transition group. They also formalised preparatory arrangements as soon as possible. However they also took a very pragmatic view of the interconnectedness of the two health communities and the need for the exporting organisations (and the new clinical commissioning

groups) to be in a suitable position to effect the transition. As a consequence all parties, Councils PCTs and key stakeholders have maintained open communications and mutually supportive positions to their respective transition programmes throughout the process to date. They also have been assiduous in keeping the Strategic Health Authority and the emerging NHS Commissioning Board informed of their respective policy positions and with progress “on the ground” and at the time of writing, the potentially contentious transference of budgetary provision has not as yet been a source of any significant dispute.

The reason both areas were able to achieve this was attributed in the primary research to the strong relationships developed between PCTs and the Local Authorities in the previous Local Strategic Partnerships, Children’s Trusts and Safeguarding arrangements. This was evident in the robust reciprocal challenge and scrutiny (accountability) arrangements that had developed in the two areas allied to mutual respect (between officials and between acknowledged political opponents) and individual and collective acceptance of responsibility. In particular respondents from all parties repeatedly drew attention to the overlapping health scrutiny arrangements that had been developed across the two councils and PCTs under previous legislation, which complimented the individual internal scrutiny arrangements of the individual councils but also embraced many of the same health service providers such as the secondary care providers, the mental health providers and the community service providers.

All members of both emerging boards and their principal advisors interpreted the health and wellbeing responsibilities that they were obliged to develop and implement in characteristic Public Value or New Public Service Theory terms, in that they saw their organisations pursuing public strategies rather than organisational strategies which conform to the Mulgan’s definition of “the systematic use of public resources and powers by public agencies to achieve public goals or objectives” (Mulgan 2009 p 20). They also saw their programmes being implemented by a collective community of interest or network of responsible public agencies rather than an individual organisation. In theory and practise both boards are developing strategies and programmes on the evidential base of their recently refreshed JSNAs (DoH 2012a, NHS Confederation 2011, 2011a, 2011b) and they are building directly on the policies, objectives and priorities of the former sustainable community strategies of the previous LSPs such as the Nottingham 2020 Plan (One Nottingham 2012). In particular both give central prominence to the community wide goal of continuing to reduce health inequalities across their respective communities, and the Quality, Innovation, Productivity and Prevention (usually known as QIPP) challenge of the Department of Health and the NHS (DoH 2010, Murphy 2012).

The areas that the research identified as potentially needing clarifying, improvement and/or reinforcing in the new arrangements tended to be around external structures and parties. Respondents were concerned at the potential loss of common external auditors following the abolition of the Audit Commission, the forthcoming relationship with the new Local Office of the NHS Commissioning Board and whatever arrangements would emerge for the new local and national Healthwatch organisations intended to replace the existing Local Involvement Networks (LINKs). It was clear (and universally accepted) that external and robust scrutiny arrangements were essential to the future operation of the boards but respondents wanted to see a mutually supportive and innovative relationship develop, explicitly with public service improvement and the dissemination

and promotion of good practise at its core, rather than a top down monitoring and compliance culture developed in the past by some regulators.

c) What is the potential role for Sport and Physical Activity within these scenarios?

In theoretical terms the potential for sport and physical activity to contribute to health and wellbeing, and to various other objectives in the Community Strategies, Local Area Agreements and local service delivery plans initiated by the previous government was significant and wide ranging. As well as contributing directly to Sport, Leisure and Cultural Service objectives and targets, the potential range and scale of the contribution that both sport and physical activity could make is indicated by their inclusion in all four blocks or themes of the various generations of the LAAs. An example of their interdependence and potential contribution to other agendas , in this case the Adult Social Care agenda, is shown in Figure 2 taken from an IDeA report (IDeA 2010).



Figure 2 Culture and Sport and Adult Care contributing to each others improvement
Source IDEA 2010

Sport and physical activity featured in almost as many Children's and Young Peoples programmes (not least because of school sports proposals), as they did in Health and Wellbeing themes, and their

contribution to the “Safer and Stronger Communities”, and “Economic Development and Regeneration” themes was widespread (LGID 2012). In practise however few academics or practitioners would argue that this potential was fully exploited, despite the sometimes heroic efforts of the former Improvement and Development Agency and others to gain greater awareness and recognition for their potential contribution (IDeA 2010, and 2011, Scottish Government 2004).

At the local level in Nottinghamshire, however the potential contribution of Sport and Physical Activity was recognised in all versions of the Nottingham City and County LAAs and in both of the JSNAs from their inception, and they retained this high profile throughout. Both of the JSNAs contain specific sections with detailed evidence dedicated to Physical Activity and both LAAs had stretching targets for National Indicator NI8 (the level of adult participation in sport and active recreation). Sport and Physical Activity featured prominently in both community strategies and there is considerable evidence of programmes of activities and initiatives within local government and health, to help meet their aims. This compares favourably to the national profile where 82 out of 149 LAAs contained a stretch target for NI8. However, despite this relative prominence, the research for this paper revealed a very consistent message of an opportunity missed to fully appreciate and exploit the potential of sport and physical activity to the wider wellbeing agenda. There was a consistent view that the sector could have achieved more in terms of setting and meeting priorities and targets and this contributed to a pronounced and disappointing pessimism about future prospects in the new era of austerity. It should however be noted that the field research for this paper was undertaken prior to the London Olympic games, and any feel good factor which may alleviate this pessimism.

Current Concerns and Future Prospects.

The principal issues or concerns about prospects for the future could be identified, and were generally fairly consistently referred to across respondents from the local authorities, the health service commissioners and providers, and the key public and third sector stakeholders. They ranged from very high level issues such as the quality and prominence of sector leadership, and the scientific academic culture of clinicians within the NHS; to very detailed issues such as the quality of evaluative techniques used in the JSNAs and the (hopefully short term) flight of key human resources from the Public Health Service to other parts of the NHS caused by the 2012 Acts reforms. Any conclusions drawn from this evidence must of course, be highly provisional not only because of the exploratory nature of this research but also because of the small number of case studies from which it is drawn. However it may suggest some potential directions for further inquiry.

One of the most consistent concerns was the nature and level of leadership support and advice for the sector from the national level. The DCMS was not viewed as having adequately supported or promoted the sector or the wellbeing agenda under the previous government when greater resources were available. Its priorities were seen as focussed on the Olympics and the role of the national governing bodies of sport, had been emphasised over the role and potential contributions of local authorities in terms of the delivery of local community needs and aspirations. The loss of the improvement infrastructure provided by the IDeA, the Cultural Improvement Partnership East Midlands, (CIPEM) and others, was highlighted by the leisure and sports community, and the discretionary nature of sport and leisure services was seen as a potential weakness in the current era of austerity when the distribution of public resources would be inevitably more limited and

contested. Few respondents felt the DCMS fully understood the needs of the future wellbeing agenda nor how to support practitioners in delivering it, although they were also critical of support provided under the previous government. Respondents did acknowledge that both the Department of Health and the NHS Improvement and Innovation Trust, were aware of and appreciated the contribution that Sport and Physical Activity could make to health and wellbeing, but they recognised that this could never be a key or prominent part of their role, either in the past or the future in view of the sheer size and range of their interests and responsibilities.

A second “high level” issue identified was the nature, effectiveness, focus and level of scrutiny that the services would be subjected to in the future. The current government through its localism agenda has been committed to reducing the level and detail of external scrutiny over public services. This research found a major concern over the potential reduction of external scrutiny, the potential effectiveness of scrutiny so that it could easily fall to a level below what was considered appropriate. All parties accepted the need for scrutiny of public services and clearly preferred robust informed and positive scrutiny and feedback that supports improvement rather than compliance checking and the tick box mentality, by which it is sometimes characterised. There was however a real concern over the professional resources available within the Care Quality Commission (and Monitor) and concern over the lack of information about the operating model for the new national and local Healthwatch services that are due to become the champion of the patients and public voice in the NHS and replace the existing low key Local Involvement Networks (LINKs) established in 2008.

The third major concern, was the potential loss of resources from the Public Health Service to other parts of the health service or to other services within the Local Authorities portfolio. This arose from two principle considerations. The first concerned the potential loss of clinicians, allied professionals and support staff from Public Health to other parts of the NHS essentially because other parts were either going through the NHS reforms at an earlier stage, where clearly remaining within the NHS (with less perceived effect on future job security, pensions, promotions etc), and would not be subject to the close political control that is evident in local authorities. This had resulted in a demonstrable loss of staff in both Public Health Services in Nottingham and Nottinghamshire including the loss of the highly experienced and well regarded Director of Public Health for the city. Public Health professionals were generally viewed as being primary responsible for driving the preventative health agenda, where Sport and Physical activity was widely acknowledged as having a clear role and contribution. A relative weakening of their role and resources available could undermine or under exploit the contribution of sport and physical activity. The second issue, particularly early on in the process, was the concern that some of the Public Health resources to be transferred to the local authority may in the short or long term diverted to other local authority priorities. In the short term this latter concern tended to diminish as negotiations over the transfer of budgets became more transparent and assurances were sort and secured by the PCTs (Nottingham City NHS 2012 Nottinghamshire County NHS 2012). However it was recognised that no long term assurances were capable of being given on this issue.

The final group of issues worth highlighting were widespread concerns around the maintenance and management of the evidential base upon which future decisions would be dependent both locally and nationally. Despite the future of JSNAs being assured within the new reforms (DoH 2012a), and both areas having dedicated and detailed Physical Activity sections in their JSNA (Nottingham City Council and Nottingham City NHS 2012, Nottinghamshire County Council and Nottinghamshire NHS

2012) these concerns persisted. There appeared to be three issues. One was a simple concern over the stewardship, promotion and dissemination of national evidence of good practise and or new discoveries or techniques relating to the sport and physical recreation sector. This was clearly associated with the governments dismantling of the LAA infrastructure, and reductions in the public service improvement infrastructure available to local authorities (such as the Audit Commission Research capacity, the IDeA Knowledge database the IDeA community of interest network and the National Advisory Unit for Culture and Leisure Services), The second was a much more subtle anticipated shift in the nature of research and information and the evidence likely to be collected in the future, together with the evaluative techniques to be adopted to assess this future evidence base upon which decisions would be made. This issue needs a more detailed investigation than is possible in this paper, but in essence the concern was that medical and clinical evidence and judgements were seen as dominated by double blind peer review clinical trials which are by far the most common research methods used in medical research. Similarly the NHS system of assessments of potential interventions based on Quality Adjusted Life Years (QALY) were seen as disadvantaging preventative programmes and interventions using sport and physical activity. Research and evaluations into the short term impact and/or long term effects of sport and physical activities were not seen as routinely utilising these techniques and the knowledge and sophistication of evaluative techniques in the sector was considered underdeveloped when compared to other sectors within the evidence base contained within the two JSNAs. An examination of the seven other JSNAs within the East Midlands confirmed that this was not unrepresentative and the level of use and sophistication of the application of techniques such as Social Impact Assessments (Barrow 2000) or the Social Return on Investment (Scholten et al 2006), which are highly appropriate for epidemiological research was surprisingly under-represented and underdeveloped in all nine JSNAs in the East Midlands..

Conclusions and Recommendations

Although this paper is based primarily based upon exploratory research with all the attendant inadequacies, the primary and secondary evidence suggests that both the theoretical development of the background policy and legislation, and the practical preparation and development on the ground in Nottingham and Nottinghamshire are best understood through the theoretical prism of Public Value or New Public Service Theory (Bennington and Moore 2011). Thus the nature, scope and role of the new Health and Wellbeing Boards within the new Public Health system envisaged by the current Health and Social Care reforms are best understood and their future strategy and operations best anticipated by applying this form of theoretical analysis and interpretation.

In practise both of the Nottingham and Nottinghamshire communities of interest centred around the public health agenda in the local areas have unequivocally adopted a pragmatic approach to the NHS reforms and the new organisational landscape that is emerging. This is clearly being built upon existing policies, objectives, strategies and governance arrangements established under the previous governments system of LSPs, Community Strategies and LAAs, rather than attempting to build wholly new policies and structures. These arrangements emphasize the several and mutual collective responsibility for local public services based upon the centrality of the community or public interest as articulated in a series of public strategies or programmes with the public citizen or the community at the centre rather than the ambitions of individual organisations (Goss 2007, Mulgan 2009 Murphy 2012).

In theory these circumstances should in the past have facilitated sport and physical activity to contribute significantly to the public health and health and wellbeing agendas through various channels such as the Community Strategies, LAAs and local service delivery plans initiated by the previous government, and therefore have allowed respondents to take an optimistic view of the sectors contribution in the future . However the (admittedly limited) research for this paper suggests significant under-delivery against this potential in the past, and considerable pessimism about the sectors potential to command resources and deliver services and impacts in the future. While some of these concerns are clearly speculative, at this stage, the research does suggest some real barriers or inadequacies are developing and that some of these could be addressed or mitigated by the sector if appropriate action is initiated.

Finally it is possible to suggest some recommendations that would facilitate the development of the sectors contribution and enhance the strategic positioning of the sector within the post-Olympic policy environment, the new public health system and the emerging health and wellbeing policy and delivery agenda. Although considerably additional detailed research may be necessary to confirm some of the broad conclusions articulated above, the particular issues highlighted during this research that require attention include, high level issues of national and local policy and leadership; the need for robust and effective scrutiny and governance arrangements; continuous improvements to both the local and national evidential base for sport and physical activity, and the development, use and dissemination of appropriate research and evaluative techniques that not only demonstrate the contribution of the sectors activities, but are also acknowledged and accepted by the health and social care research and decision making structures.

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