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## **Linking Physical Activity & Health Evaluation to Policy: Lessons from UK Evaluations**

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### **Jim McKenna**

Jim is Professor of Physical Activity and Health and the 12-year head of the Centre for Active Lifestyles at Leeds Beckett University, following almost 20 years' service at the University of Bristol. He has accumulated an extensive portfolio of PhD completions, grants and peer-reviewed papers. Beyond being an award-winning academic, Jim works with underserved groups, like hard-to-reach men, that others get their daily PA running away from! He is currently learning about the neuroscientific basis of learning and behaviour and is leading the evaluation of the BattleBack Centre programme for service personnel, funded by The Royal British Legion.

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## **Abstract**

Evaluation is an important component of contemporary physical activity (PA) interventions. In this chapter, we provide a series of peer-review case studies that we have been involved. We comment on a number of issues and debates on the role of evaluation in PA policy and interventions. The case studies selected originated in local and or national policy. To identify these cases, we applied two key criteria set elsewhere (*Pringle, Hargreaves Lozano et al., 2014*): (I) Credibility: Cases represent real world illustrations of the place of evaluation in a policy context. (II). Impact: Cases identify their effects. The case studies provide applied, insightful, contextual and practical examples of partnership evaluations in both PA intervention and policy. Emerging from these case studies are a number of lessons for how evaluation is performed. We share this learning so it may shape future evaluation practice in PA and public health.

## Introduction

Evaluation is an important component of contemporary physical activity (PA) interventions, although it is a relative newcomer on the policy scene. In this chapter we comment on a number of issues and debates on the role of evaluation in PA policy and interventions, based on our experiences of assessing the impacts and outcomes of PA-led interventions that originated in local and or national policy. Mostly these accounts are available in the peer-review literature, making them readily available for independent scrutiny. At the risk of being accused of collective self-promotion, we agreed on this approach from the outset because we want to contribute an account that only we could. As cases, they provide applied, insightful, contextual and – hopefully – informative, practical examples of partnership evaluations in both PA intervention and policy. To identify them, we applied two key criteria, set elsewhere (Pringle, Hargreaves Lozano et al., 2014): (I) *Credibility*: Cases represent real world illustrations of the place of evaluation in a policy context. (II). *Impact*: Cases report their effects. Notwithstanding the differences that the technological era brings to daily life, many of these themes appear timeless, i.e., they recur. For that reason, we hope that sharing them will inform current and future practice. Therefore in this chapter we discuss:

1. Key examples of evaluation linking to PA policy.
2. Key lessons for PA evaluation

### **1. Key Examples of evaluation linking to PA policy.**

We start by looking at key examples of evaluating PA interventions and their link to policy. Position of the evaluator is an important consideration (Gattenhoff, 2017) and it is important to consider the different evaluation designs. For example, external contracting involves independent evaluation specialists who perform all aspects of evaluation work. In contrast, within in-house evaluation designs, this responsibility lies with deliverers. Finally, partnership evaluation designs combine specialist evaluators working alongside programme staff (Pringle, Hargreaves, Lozano et al., 2014). These designs are popular for a number of reasons. First, a scarcity of resources, means PA providers have to make existing funds stretch further. Second, many deliverers have pre-existing alliances with local evaluation

partners, such as consultants and local Universities. Third, in the case of the latter, some of these partners have a strategic agenda to support local professional communities of practice and the communities where they operate. Central to decisions to intervene on PA and PH issues are a series of questions. (i) What is the problem?, (ii) Why is action needed? (iii) Who is responsible? (iv) Who is generating pressure to act? (v) When does this need to happen? (vi) How can the problem/issue be best addressed?

Responding to these questions and using frameworks from the literature, we provide a suite of partnership evaluation case studies as examples. They illustrate interventions with foundations set in policy for PA and/or health improvement. In doing so, we discuss how monitoring and evaluation interact with policy across two different scenarios.

- I. Evaluation used to inform policy and policy decisions
- II. Evaluation leading to policy formation and the case for intervention

#### I. Evaluation used to Inform Policy and Policy Decisions.

Evaluation can be used to inform policy which supports investment in PH resources. In our first case study, and being mindful of our point that many themes here are recurrent, we refer back to 2004-05 and 'Choosing Activity (CA), a PA Action Plan' (Department of Health, 2005). CA was a subsidiary of the 'Choosing Health (CH)' the former PH white paper. CA set out government plans to encourage and co-ordinate the action of a range of departments and organizations to promote increased participation in PA across England (Department of Health, 2005). The CH white paper reported intentions to establish evidence on which interventions were effective in increasing PA. This was achieved through commissioning the Local Exercise Action Pilots (LEAP) (Department of Health, 2007; Pringle, Marsh, Gilson et al., 2010).

LEAP was a national programme and evaluation of PA interventions; it is useful for our account, not least because it spans different forms of PA, different methods of delivery and local political agendas. Findings from the LEAP programme were intended to inform how £50.7 million, (set aside for PA and nutrition promotion through CH), could be used most effectively and efficiently. In its own right LEAP was a £2.6 million Government funded intervention and was a seminal programme as one of England's first multi-site evaluations

of community interventions aimed at increasing PA levels. Centred in local communities, LEAP subsumed a suite of PA interventions delivered in 10 primary-care trusts (PCTs), with at least one pilot site in each of nine NHS regions of England (Sport England, 2006, Pringle, 2011). Pilots aimed to develop primary-care led approaches for PA promotion to secure outcomes for health care priority areas and groups previously detailed in key health policy documents, including the then, National Service Frameworks (NSF) (Department of Health, 1999a; 1999b 2000). With no obvious awareness of the scientific standards that this would require – in terms of deploying randomised controlled trial designs - the Department of Health (2007 p.1) reported that LEAP aimed to establish:

*“...the most effective types of interventions for getting the general population, including people from priority groups to initiate and maintain regular moderate intensity PA, and to reduce the numbers of sedentary adults and children...”*

To pursue this aim, an independent evaluation was commissioned which set out to:

*“Evaluate both qualitatively and quantitatively the overall effectiveness of the LEAP programme and individual pilots at increasing PA levels of both the general population and target groups”* (Department of Health, 2002 p.2).

There are conflicting reports on the effectiveness of LEAP. Pringle, Marsh, Gilson et al., (2010) reported that LEAP interventions had a positive impact on PA levels within an initial intervention period. Conversely, Bagot (2013) suggested that the LEAP pilots had little impact on PA, but provided a useful test-bed for PA interventions. In implementing both LEAP interventions and the evaluation, a number of substantial challenges were encountered and reported in the evaluation reports (Department of Health, 2007, Sport England, 2006). These provide important guidance on conducting the evaluation of PA interventions; many remain relevant today.

To ensure that the widest audience is exposed to research outcomes, dissemination is typically achieved through multiple methods and channels (Eldredge et al., 2016). Thus, it is important to link evaluation to policy so that policy supports and informs subsequent provision. Even though LEAP included a final evaluation report published on the commissioners websites (Department of Health, 2007), publication of a summary of findings

(Sport England, 2006), a major launch event supported by Government Cabinet Ministers and their Departments, as well as dissemination at five Regional PA Networks, it is not clear how it was used to inform specific decisions in the white paper. This is important because £50m had been set aside in CA for PA and nutrition, - arguably '*a raison d'être*' for implementing the LEAP pilots (Department of Health, 2002). While we are not aware of any co-ordinated evaluation which subsequently assessed how findings from LEAP informed policy formation for PA across all PCTs, there are many examples of influences on local policy for PA promotion and subsequent investment decisions. For example, in Nottingham, East Midlands, one of original LEAP pilots, where PH officials invested in activities and intervention designs based on the outcomes of the evaluation. Resources and responsibility was devolved to community-facing agencies who could reach local populations, including the Nottingham YMCA community motivators programme (Carnegie Research Institute, 2010). While in Kirklees, West Yorkshire, once effectiveness of LEAP had been confirmed, staff in the pilot charted an early course to subsume PA interventions in four priority areas in local PA provision (Department of Health, 2007). Sustainable programmes reflected a strategic fit based on locally identified health priorities and needs. Moreover, on-going interventions were underpinned by local partnerships and resourced by mainstream budgets recommended in national and (Sport England, 2006) and the PH literature (Eldredge et al., 2016).

Findings from this case study suggest that monitoring and evaluation did inform the direction of local PH and PA promotion. At the same time, and perhaps because of the diffuse nature of the LEAP pilots, its three-year time-scale and the inevitable changeability of PH policy, it remains unclear which, if any, evidence from it was most influential for directing future policy decisions and investments. This means that, using LEAP, commissioners of subsequent programmes will remain unsure of how to use local level evaluation to inform national level policy.

## ii. Evaluation Leads to Policy Formation and the Case for Intervention

In this scenario, evaluation of the intervention leads to the generation of policy which (i) supports decisions to invest within interventions and (ii) the production of policy guidance on how interventions should be implemented, so they are effective. For illustration, we



refer to the role of professional sports clubs as settings for local-based health improvement (Baker, Loughran, Crone et al., 2016; Lewis, Reeves and Roberts, 2016). and specifically our experience of evaluating a bespoke men's health improvement service within professional football clubs (Zwolinsky, McKenna and Pringle, 2016). Research across the 27 European member states, identifies men's health as a PH concern; this supports calls for a co-ordinated political and strategic approach for improving men's health (European Commission, 2011). Yet, *'despite overall improvements in life expectancy, rates of premature male mortality, particularly for men in areas of socioeconomic deprivation, remain an important issue of concern in the United Kingdom'* (Robertson and Baker, 2016 p.102). There is a particular need to identify how best to engage those men who are unhealthy by conventional standards, but who don't see themselves as unhealthy; this scenario leaves them unresponsive to conventional approaches aiming to connect with these men over their health and lifestyle behaviours (White, de Sousa, de Visser, et al., 2011; Robertson, Woodall, Henry et al., 2016). In response, sports clubs, recreation groups, workplaces and religious settings all represent non-traditional channels with the potential to reach the many men at the wrong end of the social gradient of disease (Curran, Drust, Murphy et al., 2016; Zwolinsky, McKenna, Pringle et al., 2016). While these men did not routinely use Primary Care services (Pringle, Zwolinsky, McKenna et al., 2013 a b, Zwolinsky, McKenna, Pringle et al., 2016), these non-traditional channels reflected their powerful pre-existing interests and hobbies reported elsewhere (Lozano, Pringle, McKenna et al., 2016; Curran, Drust, Murphy et al., 2016). Capitalising on these pre-existing behavioural pathways is regarded as a key strength of sport-led health improvement provision (McKenna, Quarmby, Kime, et al., 2016, Martin, Morgan, Parnell et al., 2016).

With football and PH leaders making the case for the power of professional football in connecting previously unresponsive groups to health interventions (Martin, Morgan, Parnell et al., 2016) we discuss *Premier League Health* (PLH). PLH was a three-year programme of men's health promotion delivered through 16 English Premier League football clubs (Zwolinsky, McKenna, Pringle et al., 2016). Interventions were delivered by professional football club's Community Trusts alongside their local health partners. Partners included Primary Care Trusts, local authorities and local charitable organisations. Interventions were

led by Health Trainers, allied health professionals with specific training and education in behaviourally-based health improvement (Pringle, Zwolinsky, McKenna et al., 2014).

In line with specific policy guidance (NICE, 2007) and the extant literature (Eldredge et al., 2016), PLH interventions addressed the needs of local men even though this varied club-by-club. Activities were typically PA-centred and for many – but not all - clubs, football was at the heart of the programmes (Pringle, Zwolinsky, McKenna et al., 2014; Zwolinsky, McKenna and Pringle, 2016). PLH interventions reflected the CDC (1999) classification of informational, behavioural and social change approaches based on three modes of delivery, (i) match day activities (ii) regular weekly classes and (iii) outreach work (Sinclair and Alexander, 2012; Curran, Drust, Murphy et al., 2016).

Also in line with PH guidance (NICE, 2007) an independent evaluation was commissioned - at the same time as the clubs were selected. Here the aim was to assess the impact and processes that generated programme outcomes (Eldredge et al., 2016). The resulting multi-method evaluation (Pringle, Zwolinsky and McKenna et al., 2014; Zwolinsky, McKenna, Pringle et al., 2016) identified that the programmes were effective in reaching and encouraging men to adopt health improvement interventions (Zwolinsky, McKenna, Pringle et al., 2016). Moreover, the process evaluation helped to identify which components worked more effectively than others (Arends, Bode, Taal and Van de Laar, 2017, Pringle and Zwolinsky, 2016). The evaluation – based on a pre-post design - identified an array of improvements in CVD risk factors and other health outcomes within an initial intervention period (Pringle, Zwolinsky, McKenna et al., 2014; Zwolinsky, McKenna, Pringle et al., 2016). As men's awareness of health issues can incubate over time (Lozano et al, 2016) the PLH programme focussed on issues and solutions, as defined by men themselves, an important ingredient of effective health improvement with this group (Robertson, Woodall, Henry et al., 2016). Importantly, this signalled the potency of maintaining a specific delivery approach rather than of specific programme content. Partly because PLH actively recruited hard-to-reach groups, the evaluation outcomes informed (i) *the case for future investment*, (ii) *the development of policy on men's health improvement in football settings* and (iii) *PH guidance on how interventions could be implemented to be effective* (White, Zwolinsky, Pringle et al., 2012, Zwolinsky, McKenna and Pringle, 2016).

An evaluation report (White, Zwolinsky, Pringle et al., 2012) supported the case for further rounds of funding for similar football-led health interventions, including interventions with men (Curran, Brook, Lozano et al., 2015; Lozano, Careless, McKenna et al., 2016). Subsequently, funding was made through charities (Curran, Brook, Lozano et al., 2015), statutory services and the charitable arms of football including the Premier League's 'Creating Chances' programme within the specific 'Health' theme (Pringle, Zwolinsky, and McKenna 2013 a b). Creating Chances uses positive associations with the football 'brand' to support the health improvement of individuals and communities (Premier League, 2011; Pringle, Zwolinsky and McKenna, 2013; Zwolinsky, McKenna, Pringle et al., 2016) in line with policy objectives for health improvement (DH, 2011).

In line with the literature on evaluation (Eldredge et al., 2016; Estabrooks et al., 2016), findings from the PLH evaluation also provided programme guidance of how best to implement interventions delivered by professional football club Community Trusts. With those considerations in mind, three criteria for supporting investments were especially important (i) demonstrating an impact on health profiles and behaviours (ii) working strategically with local health partners to part fund interventions and (iii) demonstrating an exit strategy to sustain activities once start-up funding had expired.

As a result of these strong outcomes, evidenced by the PLH evaluation, community foundations and charities increasingly operate within professional football clubs to deliver on the PH agenda (Martin et al., 2016). This, in part, reflects steps in the right direction of a shift in the policy and intervention context, toward providing acceptable, affordable and accessible (Fineberg, 2012) health improvement opportunities for men at the local level (Robertson and Baker, 2016). That said, reflecting the on-going challenge of making the case for PA and PH resources more generally, our recent review of health improvement provision across the second tier of professional football - the 72 clubs outside the Premier League - has identified difficulties in persuading local policy makers through the Community Commissioning Groups (CCGs) to invest in longer term provision of men's health interventions. Being unable to anchor these programmes in local health plans has meant that funding has been reduced or even cut completely (Pringle and Zwolinsky, 2016).

On a different track, and reflecting post-recessionary policy and thinking, we next report the more contemporary case of *Leeds Let's Get Active* (LLGA). Building on the evidence which supports the role of 'sport' to engage those who are least active, Sport England initiated the Get Healthy Get Active Fund in 2014. This approach was grounded in one of the core notions of PH policy; do more to help the least healthy. With the distinctive power of addressing inactivity - the best returns for PA programmes are often found when improvements are achieved in these least active groups (Blair Kampert, Kohl et al., 1996) - engaging inactive individuals became an on-going PA and PH priority (Department of Health, 2011).

In LLGA the aim was to improve the evidence base for the role that 'sport' can play in engaging inactive people, i.e., those undertaking <30 minutes of PA per week, and to generate evidence that is sufficiently compelling to support further Public Health commissioning (Gardener, 2014). LLGA emerged as part of a national programme (macro) to encourage people who do not do any physical activity to do at least 30 minutes of PA, once a week (Leeds City Council, 2015). To achieve this aim, recruits were provided with free citywide (meso) access to unused leisure centre and community sport provision within a supportive and welcoming environment. LLGA provided around 150 separate hour-long gym and swimming sessions free to registered participants at 17 different venues across the city at a variety of times each week. In addition, a parallel 'community' offer provided a range of group- and family-based activities in local community venues and parks.

In the 20-months since launching, LLGA recruited and captured baseline data from over 64k participants (Zwolinsky and McKenna, 2015). Almost half (48%) of these recruits were classified as inactive and 87% were not meeting the current PA guidelines, suggesting the potential for effective targeting of this group. These powerful recruitment figures were supplemented by intentionally promoting engaging and enjoyable individual/group experiences, and encouraging participants to share these experiences with other potential recruits. These seem to be fundamental approaches for realising successful interventions, especially among previously inactive individuals (Pringle, Zwolinsky, McKenna et al., 2013a, 2013b). Importantly, intervention data revealed substantial increases in PA levels (Zwolinsky and McKenna, 2015), suggesting the importance of powerful induction experiences for sustaining involvement. Using automatic registers of attendance, over a quarter of a million

visits to leisure centre gym and swim sessions were undertaken by LLGA participants; over 135k were made by participants classified as inactive at baseline. Crucially, over 80% of participants who provided follow-up data that were classified as inactive at baseline were no longer inactive at follow-up.

Based on these findings, LLGA was able to secure further PH funding, to examine the potential of the programme for impacting wider lifestyle behaviours. In Leeds alone, a considerable proportion of the adult population failed to achieve the current PA recommendations. Combined with a poor diet, smoking and excessive alcohol consumption, these lifestyle risk factors (LRFs) are the most proximal risk factors for non-communicable diseases, (Mozaffarian, Wilson and Kannel, 2008). These behaviours account for a 14 year gap in life expectancy between those presenting all four LRFs compared to those with none (Khaw et al., 2008). Although many Leeds residents were likely to harbour multiple concurrent LRFs, little was known about how these behaviours co-occur and many residents – typically those who are most at risk – were reached by this new approach whereas existing approaches had left them (mostly) unreached. Indeed, widespread, community-focused promotion of LRFs is consistent with calls to shift societal attention toward successful and sustainable ‘health systems’ and away from ineffective and unaffordable ‘health care systems’ (Fineberg, 2012); removal of the word ‘care’ is used to denote how health is a universal concern, whereas health care lies in the orbit of medical professionals.

Data from N=13,579 participants revealed that 90% did not do enough PA for health each week, 82.3% did not consume enough fruit and vegetables each day, 19.3% currently smoked and 45.7% reported hazardous and/or harmful alcohol consumption. Moreover, 87% of all participants reported two or more of these LRFs in combination. Insufficient physical activity combined with a lack of fruit and vegetables was the most prevalent cluster. Nevertheless, at follow-up, there were significant improvements in PA levels from baseline to follow-up; participants were doing the equivalent of an additional 30 minutes each week. Follow-up data showed a 60% relative reduction in the number of inactive participants and a 50% relative increase in the proportion of participants achieving the PA guidelines. Moreover, a quarter of participants improved their LRF profile and there was a reduction in the proportion of participants reporting LRFs in combination. There were also

beneficial changes in smoking levels and alcohol risk status, even though neither was a target within LLGA (Zwolinsky and McKenna 2016).

LLGA highlights the need for continued physical activity and lifestyle improvement opportunities across Leeds. Based on UK health recommendations, these data showed the alarming prevalence of LRFs and how these risks cluster in specific combinations. Nonetheless, LLGA was able to reach a large proportion of health-needy individuals whose social status had left them unreached by other services and interventions. None of these services had the aspiration to intersect multiple behaviours. Yet, LLGA helped to improve and stabilise several of the most important lifestyle behaviours impacting mortality and morbidity. These findings highlight the potential benefits of LLGA-type approaches, supported by an imaginative approach to delivery and to evaluation, to provide a rationale for its integration into long-term sustainable programmes. These programmes can clearly help to prevent and manage the foundational risk factors for non-communicable disease incidence (Zwolinsky, McKenna, Pringle, Widdop et al., 2016).

To achieve this, LLGA foundations were set in localism, aiming to meet the needs of local communities across the city. Local policy aspires for Leeds to be an active city and LLGA offers value for money by using spare capacity in local authority sports and leisure provision. In post-recessionary times, these are powerful policy-related issues. Interventions with similar aspirations for targeted effectiveness are most likely to do so when they can be built into the philosophies and cultural practices of the targeted communities. Crucially, they must form part of on-going community activities that incrementally and discreetly mould norms and values.

## **2. Key lessons for PA evaluation**

While evaluation frameworks are helpful, they are guidelines. Real life is different. Our experience of performing evaluations of interventions at the local and national level leads us to two firm conclusions. First, for a host of reasons, evaluation is not always possible, which proposes the idea of *evaluability*. Evaluability refers to the capacity and amenability of an intervention for monitoring and evaluation (Wholey, Hatry and Newcomer 2004). Second, evaluations can only rarely be delivered in the ways anticipated by stakeholders.

While guidance routinely recommends ‘good practice’ (Dugdill and Stratton, 2007, Dugdill, MRC, 2008, Dugdill Stratton and Watson, 2009; NOO, 2012, Eldredge et al., 2016), a number of factors can conspire to impact on evaluability.

To understand these points, it is helpful to refer to evaluation definitions. For example, the CDC (2011) refer to evaluation as the *systematic investigation of the merit, worth or significance of an object* (Scriven, in CDC, 1999 P.3). In our experience many organisations undertaking evaluation fail with the first word – systematic. Their institutional habits, and therefore those of their agents, are wholly more reactive than pro-active and planful. This makes anything systematic unlikely, yet they still assume evaluability. Why? Responses depend on the stakeholders’ foci, but here are a common set of problematic assumptions we have encountered (DH, 2007):

- Evaluation is simple and uncomplicated with few steps
- Organisations house ample numbers of staff with the skills and resources to do it
- Existing staff (and/or volunteers) will want to do an evaluation and already know how and when to do it
- Existing staff (and/or volunteers) will actually do it alongside higher priority tasks.

Collectively, and worryingly, these assumptions confirm that the inherent nature of human behaviour change is poorly understood in these organisations. This is ironic given that the interventions focus on changing PA behaviour in clients and participants.

At any stage, it is unwise to assume that every programme can be effectively evaluated. Indeed, this is something that should be explored with key stakeholders and confirmed both at the outset and during the evaluation process (Dwyer, Hansen, Barrera et al., 2003; Chapel and Lang, 2009; Eldredge et al., 2016). This is particularly the case in partnership evaluation designs, where specialist evaluators and programme deliverers collaborate to work on shared tasks (Pringle, Zwolinsky, McKenna et al., 2014). Given that health researchers, investigators and funders place importance on collaboration between communities and academic institutions (Corbi-Smith, Bryant, Walker et al., 2015; Simmons, Klasko, Fleming et al., 2015) it is important to get this approach right from the outset (Eldredge et al., 2016; Pringle, 2011).

Indeed, Pringle, McKenna, Whatley et al., (2006) and Pringle, Hargreaves, Lozano et al., (2014) have suggested that those tasked with implementing evaluations will require personal and collective *commitment*, *capacity* and *capabilities* while undertaking and completing evaluations. Using these notions to guide our discussion, *Capability* refers to the skills and expertise that stakeholders can deploy while performing evaluations, including tasks associated with the design, implementation, analysis and dissemination of evaluations. *Capacity* refers to the resources - human or financial - that stakeholders can use to complete evaluation tasks. *Commitment* refers to the strength and direction of motivation that stakeholders have for implementing specific evaluation tasks. In the understanding that stakeholders have other important and concurrent roles, it will come as no surprise that performing the evaluation will be low on most deliverer's list of priorities (Department of Health, 2007). Referring to our previous point; what applies to behaviour change in clients is just as likely to apply to the behaviour change of deliverers (Kok et al., 2015; Eldredge et al., 2016), when it applies to the new behaviours accompanying evaluation. Part of the success of LLGA and the attendance behaviour it helped to identify was that all that data captured was automated, contrast this with the manual processes deployed in the National Evaluation of LEAP, (Pringle, 2011).

It is also important to address the experiences of researchers who have completed detailed and informative evaluations. Often they report feeling frustrated that their research is neither been applied to the health promotion context (Blinkhorn and Gittani, 2009) nor translated into practice (Ballhew, Brownson, Haire-Joshu et al., 2010). On the other hand, this is hardly surprising; evaluators have been criticised for providing health promoters with more problems than solutions (Blinkhorn and Gittani 2009; Eldredge et al., 2016); our experience in the LEAP programme often drove that point home (Department of Health, 2007, Pringle, 2011). Indeed, evaluations are often seen by practitioners as lacking real-world utility (Wilson, Basta, Bynum et al., 2010), which has given rise to concerns to progress under the aegis of a new 'implementation science' (Lobb and Colditz, 2013; Kok et al., 2015; Eldredge et al., 2016).

Instrumentation is a recurrent problem area. Using instrumentation that is not only inappropriate for the setting (Learmonth and Griffin, 2007; Pringle, Zwolinsky, McKenna et al., 2014), but also for the groups with who they are performed (Judd, Frankish and



Moulton, 2001) seem widespread. Instead, addressing all notions health literacy – not least because it so often subsumes shortfalls in literacy – should be standard practice for developing evaluation instruments. Assessing any paperwork for readability and for using plain English is helpful in all cases (Pringle, Zwolinsky, McKenna, et al., 2014).

Criticism is not only reserved for evaluators, but also for commissioners who procure evaluations, including the procuring government departments (Chambers, 2009; Whitehead, 2009). Moreover, it is not uncommon for political influences to impact on decisions about whether or not to commission evaluations (Benzeval, 2009; Evans, Hall, Jones et al., 2007, Pringle, 2011), as well as the type of evaluations that are procured (Sowdon and Raine, 2008). Like evaluators, commissioners have also been criticised for failing to appreciate the practicalities associated with implementing evaluations, including those undertaken in community settings, where diverse factors impact on intervention delivery and outcomes (Kryiaccou, 2009; South and Phillips, 2014). Indeed, such factors play out even more during evaluations located in the community settings (McKenna, Davis and Pringle, 2005; Donaldson, Patton, Fetterman et al., 2010), including those in areas of high health need and low SES (Hind, Scott, Copeland et al., 2010; Curran, Drust Murphy et al., 2016). With those thoughts in mind, we propose five considerations aimed at facilitating evaluability in partnership evaluation designs, where specialist evaluators work with delivers to evaluate PA interventions. These considerations are intended to contribute to the body of guidance and evidence on performing evaluations (Pringle, 2011).

- Partnerships Require Early, Timely and On-going Dialogue

Green and Tones (2010) and Eldredge et al., (2016) recommend that stakeholders are engaged in dialogue with evaluators at an early stage in the planning process. Such activities generate agreements on evaluation matters, including the choice of instrumentation and roles and responsibilities for evaluation (Dugdill, Stratton and Watson, 2009). Agreeing on the measurements that manage participant burden while also assessing population and programme attributes, stakeholders should be mindful that compromise may be a key consideration when confirming evaluation arrangements (Bauman, Phongsavin, Schoeppe et al., 2006, Wozniak et al., 2016). This is a particular issue within PA promotion where the many divergent, and potentially conflicting, messages that may be promoted; think of the

possible combinations between the elements of the exercise prescription (frequency, intensity, time and type) overlain by programme themes such as ‘do less sitting’, ‘walk more’, play sport, exercise at work and so on and the complications become clear.

Further, when stakeholders commit to early dialogue they send powerful messages about the nature of partnership working and of future intentions (Parnell, Pringle, Widdop et al., 2015; Zwolinsky, Pringle, McKenna et al., 2015; Eldredge et al., 2016), as well as enhancing the quality of the evaluation design (Wozniak et al., 2016.) Moreover, these pre-emptive actions aimed at identifying potential issues and realistic solutions (Wozniak et al., 2016) are a more effective and efficient use of resources than those actions centred on salvaging and recovering a fractured partnership at a later date (Pringle, 2011). Dissatisfaction is likely when one group, or key individuals within a group, assumes superiority over others or when these dominant agents demonstrate unexplained mission creep for the project, the evaluation or both. Studies confirm that with the right course of actions, damaged or malfunctioning partnerships can be repaired (Moldon and Finkel, 2010; Pringle, 2011), but the resources required can be substantial.

- Partnerships Require Effective Planning and Clear Goals.

With partnership evaluation arrangements being relatively commonplace (Lozano et al., 2016, Zwolinsky McKenna and Pringle., 2016), we set out a series of considerations for facilitating evaluability and then being more effective in doing evaluations. This now shifts our attention from ‘knowing that’ to ‘knowing to’; this has much to say about routines and practices around day-to-day evaluation. Problematically, ‘know that’ is often rated as more important than ‘know to’ in many organisations; our experience is that both are needed in equally high amounts and that organisational habits have much to do with the problems that surround even the most elegant evaluation approaches.

Green and Tones (2010) and Eldredge et al (2016) recommend that partnerships need to plan, set out and work to clear aims and objectives. However, we have often found that mission creep can affect commissioners as much as deliverers and/or evaluators. This can be helped by establishing a written plan, which becomes reference point for charting progress and activity; it is especially helpful for identifying loss of momentum (Eldredge et al., 2016). Often this loss of focus occurs mid-evaluation.

By combining the efforts of the key constituents, anticipated problems can be identified and potentially offset before they become harmful. By viewing strengths and difficulties together and straightforwardly, potentially, this makes another statement of intent for future working arrangements. It can help to create events where stakeholders repeatedly confirm their commitment to evaluation (Chapel and Lang, 2009, Eldredge et al., 2016). Further, with different perspectives, evaluations can become truly bespoke; this can be important because stakeholders attach different levels of worth to evaluation (Blamey and Mutrie, 2004; Deehan and Wylie, 2010), and hold different ideas on how evaluation should be performed (South and Tilford, 2000; Green and Tones, 2010). Consistent with our experience, the CDC (1999) evaluation framework identified that coming together around the evaluation can help ameliorate some of the inherent challenges it brings (Pringle, Zwolinsky, McKenna et al., 2014; Eldredge et al., 2016).

- Partnerships Require Common Agreements.

Agreement between partners provides a powerful signal that partnerships are centred on building effectiveness (Green and Tones, 2010; Parnell, Pringle, Widdop et al., 2015). It has been recommended that individuals and teams within the community must engage around collectively negotiated aims (McDonald, Viehbeck, Robinson et al. 2008; Pringle, Parnell, Zwolinsky et al., 2015) and procedures. Too often procedures are overlooked in the pursuit of more lofty aspirations (Pringle and Zwolinsky, 2016). As noted previously, decisions around evaluation instrumentation and timing are key areas that are most contested by stakeholders in partnership evaluations (Pringle, McKenna, Zwolinsky, 2013; Parker, Meiklejohn, Patterson et al. 2006). Timely appointment of evaluators will help prioritize key tasks, such as developing a workable evaluation design and securing ethical approval, where necessary (Eldredge et al., 2016). It will also help to ensure that the evaluation instrumentation is piloted and ready for use when the programme begins (Zwolinsky, McKenna, Pringle et al., 2016). Without that, many participants will be excluded from the evaluation; burdensome evaluations can ‘signal’ that programmes are unappealing to target audiences. This mistake can be fatal for change-oriented programmes relying on evaluations examining pre-post differences. Collectively, these avoidable evaluation mistakes can undermine claims that programmes meet policy aspirations. That they continue to happen offers an indication of how far there is to travel to ensure that evaluators, commissioners

and respective stakeholders work to develop and then use evaluation outcomes to improve on-going programme performance.

- Partnerships Should Prioritise Key Tasks.

Evaluation partnerships become more effective when they prioritise activities that are the linchpins of what produces programme outcomes (Pringle, Parnell, Rutherford et al., 2016). This should not only include those who deliver, but also those who evaluate and commission programmes (Benzeval, 2009). While commissioned evaluations may be prominent in any level of policy documentation, only rarely does this assure evaluability (Pringle, 2011). Instead, commissioners may focus on the planning or publicising the programme, even though longstanding (CDC, 1999) guidance recommends developing evaluations alongside interventions. An unfavourable start to an evaluation can contribute to accumulating dissatisfaction between stakeholders over a host of seemingly mundane and ordinary issues (Pringle, 2011). Moreover, such feelings may develop long-term enmities that add difficulty to what is already challenging (Pringle, 2011).

- Choosing Evaluation Instrumentation

Evaluation is often poorly performed, using methods for collecting data that are seen locally as inappropriate to the intervention and the context (Nutbeam, 1998; Freeman, 2009; Glasgow, 2009; Green and Tones, 2010; Eldredge et al., 2016). Dugdill, Stratton and Watson, (2009) provide a useful framework for considering instrumentation for evaluating PA interventions. Debates and disagreements often arise over the different yardsticks being used to assess effectiveness of interventions (Pringle, 2011). Tensions can arise between preferences for adopting non-validated 'quick and dirty' methodologies that count heads and ask people what they liked and for using validated instrumentation, in its fullest form, but which lacks relevance to the local setting and people. Indeed, evaluations conducted in interventions in areas of high health need and low SES can be difficult (Sport England, 2006; Department of Health, 2007; Hind, Scott, Copeland et al., 2010). Issues regarding literacy and concerns about civil 'surveillance' have been commonly reported (Pringle, Marsh, Gilson et al., 2010, Pringle, 2011). Unresolved sensitivities about specific evaluation tools – even specific questionnaire items - can end with a general rejection of the evaluation and poor working relationships (Pringle, 2011). Because of these issues, it is important that timely

discussions are held between evaluators, deliverers and participants to select and to pilot instruments, and to plan the timing of data collection, submission and review (Dugdill, Stratton, Watson, 2009; Eldredge et al., 2016, Wozniak et al., 2016). In unreached communities, the issues that prick such sensitivities may be subtle and unfamiliar to many evaluators, so responding to local knowledge and insight is important. The engagement of key stakeholder throughout the evaluation is fundamental (Eldredge et al., 2016), not least when enhancing preparedness and building capacity to deliver evaluations (Pringle, Zwolinsky, McKenna et al., 2014; Zwolinsky, McKenna, Pringle, 2016; Wozniak et al., 2016).

### **Conclusion: Implications for future PA policy and practice related to the chapter topic**

Our experience is that enacting and then evaluating policy is complex and it is wise to acknowledge this. This complexity is inextricably linked to the interconnectedness of influences between policy, evaluation, delivery, politics and the people and constituencies involved in these domains. Even so, simplicity can be found beyond this complexity and an array of useful frameworks and guidance are available for putting order around how policy can be enacted and assessed in evaluations. It is rarely mentioned, yet still helpful, to acknowledge that this complexity may parallel the behaviour change that underpins becoming more active. That justifies paying closer attention on the people involved with any of these activities; they are different to the people who engage with programmes and what seems easy (or difficult) from the outside can be seen very differently on the inside.

The recurrence of familiar themes suggests that learning about them – including those affecting evaluation - is often temporary and ephemeral. This underlines why it is important to emphasise the important messages that can be drawn both from current and historical examples. Yet, the difficulties and challenges of executing evaluations are often left unexpressed even though timely and open dialogue of what worked, and didn't, can be a substantial resource in its own right. In any organisation where evaluation is likely to be an on-going issue it makes good sense to maintain a record of in-house learning. We have learned that it is unwise to assume that positive evaluation habits exist, let alone prevail, in any organisation. Neither are resources (human, material or financial) readily or willingly deployed to support evaluation.

The many powerful practices – and shortcomings - we report have been seen while delivering evaluations of community programmes in single and multiple locations, with varying PA content and with distinctive target groups. The powerful practices are replicable and shortcomings are (mostly) recoverable. For reasons of effectiveness and efficiency there is considerable advantage in revisiting and reconsidering them throughout every evaluation. Crucially, it is the behaviours of evaluation staff and their partners – not what they ‘know’ or claim to know to do – that makes any evaluation work, or not. These are the behaviours that are imperative for generating better PA policy.

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