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Citation:

Ingle, L and Rivett, M and Long, JA (2010) Cycling and Health Innovative Pilot Projects (Executive summary). Project Report. Cycling England (led by the Directorate of Public Health, East Midlands and the Carnegie Research Institute).

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Cycling and Health Innovative Pilot Projects

Executive Summary 2011

Conducted for Cycling England (led by the
Directorate of Public Health, East Midlands)
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May 2011



Executive Summary

The Cycling and Health Innovative Pilot Project (CHIPPS) provided cycle training for adults in Nottingham and Northamptonshire from 2007 to 2010. The Primary Care Trusts in each area have delivered these projects in collaboration with partners. In Nottingham collaboration with Ridewise delivered the Cycling for Health Project that aimed to involve people from deprived communities and employees of the Primary Care Trust; in Northamptonshire the Easy Rider project delivered via Age UK was also aimed at those living in deprived areas and middle-aged people. Throughout the three years the initiative was evaluated by the Carnegie Research Institute of Leeds Metropolitan University. Those taking part completed questionnaires at the outset, at the end of their training, three months later and finally after a year. In addition, a mix of one-to-one interviews and focus groups were conducted with policy makers, those delivering the projects and participants (including those who dropped out).

Key Findings

The projects benefited from regular meetings that allowed goals and targets to be reviewed in the light of project monitoring reports and feedback from the researchers' evaluation.

It was known from the outset that these projects would not involve large numbers of people and targets were set accordingly. In the event, the programme was delivered to 261 people in Northamptonshire and 228 in Nottingham. More generally, the projects recruited more women than men (65% in Northamptonshire and 75% in Nottingham) and were effective in reaching minority ethnic communities.

Level 1 of the CTC scheme is too advanced for some and an entry level, like that offered by these projects, is needed through which those who have never ridden can learn to ride. Classes then need to be graded, starting on enclosed areas offroad, then on near deserted roads (like an industrial estate on a Saturday morning before moving onto quiet roads).

As hoped, the projects did have an impact on participants' confidence (see Table 1). For example, in Northampton two thirds said they had gained confidence in light traffic, and in Nottingham a majority even said they had gained confidence in complex road environments.

Cycling competence	Gained confidence		No change		Lost confidence	
Level 1 – basic control	60%	54%	18%	43%	22%	3%
Level 2 – light traffic	66%	52%	14%	48%	20%	0%
Level 3 – complex roads	46%	55%	29%	29%	25%	16%

In Northamptonshire participants showed a small but significant increase in participation from their starting point. Time spent cycling was greatest at three months after finishing the training; although it then declined it was significantly

greater after 12 months than at the outset. Although participants in Nottingham showed greater increases in time spent cycling these changes were not statistically significant because there were fewer people involved.

The stage of change model assesses people's orientation to (in this case) cycling from those who are not even thinking about it to those who have relapsed into nonactivity. In both PCT areas those in the active categories of action and maintenance increased markedly through the project (from 44-60% in Northamptonshire and from 51-72% in Nottingham), but then declined again beyond that, though still remaining above baseline.

However, in neither Northamptonshire nor Nottinghamshire was there any real change in general activity levels, as measured by EPIC categories, because most people were already in the moderately active or active category.

We have no hard data on the success of these projects in attracting people from more disadvantaged backgrounds though Ridewise instructors observed a more mixed set of participants than they would otherwise be working with. In Northamptonshire qualitative data suggest that while participants initially came from more affluent areas that gradually changed through the course of the project.

The projects in both PCTs had success in recruiting guided ride leaders but whereas Northamptonshire also managed to train some people as trainers, Nottingham found this more difficult.

One of the goals of the Northamptonshire project was for participants to 'graduate' to local cycling clubs, however there are no casually recreational clubs for them to become a part of, most cycle clubs require a pace and distance beyond graduates of these projects.

Good Practice

The CHiPPS projects have shown the importance of an adequate investment phase to get appropriate procedures and practices established. Short term funding inhibits this; the third year of funding for CHiPPS allowed models to be developed and momentum to build up as more people progressed through the system and alliances were developed.

The experience of Nottingham in particular has emphasised the value of an integrated referral network and of being able to use cycling enthusiasts rather than health professionals who may not have the necessary skills or interest to promote cycling.

In Nottingham the problem of ensuring a regular supply of bikes has been successfully addressed in part by teaming up with *Framework*, a social enterprise that recycles bicycles.

Both projects established that although some 1:1 attention may be necessary at the outset group classes are not only more efficient but also provide a valued social element and a chance to establish support networks.

Learning Lessons

As with many projects before it, the experience of CHiPPS emphasised the importance of allowing sufficient time to set sound foundations for the project. Equally, the third year of funding was important in allowing the projects to be refined to address need and to secure their legacy.

As expected, it was indeed hard to recruit people from target groups that might be seen to be on the 'wrong' side of the health divide. This type of engagement might best be achieved through community development approaches and the use of trained intermediaries recruited from their peers in the local community.

The training itself needs to be differentiated according to the experience, skills, confidence and even personality of the participants. Beyond the training the challenge is to embed cycling in people's everyday lives to ensure participation is sustained and health benefits maximised. Apart from training a cycling project needs bikes. The CHiPPS projects developed various approaches including linking with others repairing and recycling bikes, bike hire schemes, a bike library and making bikes available at community facilities.

However good the systems might be the right individuals need to be in place to ensure success. The programmes are better delivered by cycling enthusiasts rather than health professionals who may not have the necessary skills or interest to promote cycling, and a champion is needed in policy circles.

Experience from the CHiPPS projects suggests that what is needed to make a successful project is:

- Establishing an integrated referral network with pathways from a range of professionals both within and outwith the health service
- Sufficient trainers – training the trainers to increase capacity
- Properly resourced – a bike “library” with a varied resource pool
- Providing maintenance skills – keeping bikes on the road and safe
- Social engagement – fostering conviviality, camaraderie, team and safety
- An exit strategy to maintain cycling activity

What Next?

The cutbacks in public funding do not come at a good time for securing the future of these initiatives. However, both projects report hopefully on the possibilities of social enterprises linked to GP referrals as well as opportunities that may accrue from greener transport policies. Whatever emerges in the wake of CHiPPS will have to negotiate the upheaval from the demise of PCTs and the opportunities offered by the transfer of public health responsibilities to local authorities.

There is a need to make sure that initiatives to promote cycling are fully synchronised with efforts to increase physical activity; i.e. people should be offered the opportunity most likely to get and keep them active.

Instead of asking 'What do we need to do to get people cycling?' the approach adopted here invites a series of questions by recognising the different stages involved in changing behaviour:

- What can we do to get people's attention?
- Having got their attention how can we persuade them cycling might be for them?
- What will it take to get them actually cycling?
- How can we encourage them to make it part of their 'normal everyday lives'?
- What will it take to keep them cycling once our intervention is withdrawn?

Moreover, it recognises that there are very different types of people in any local authority area with very different attitudes to physical activity.

The data from this evaluation also demonstrate the need for something to be in place to prevent the loss of hard won gains between 3 and 12 months after participation in initial training.