

A report on the Department of Health 'Walking Cities' initiative in
Birmingham, Cambridge, Leeds and Bradford, Norwich and
Manchester

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Overview

This report on the five 'Walking Cities' was commissioned by Beelin Baxter, Senior Physical Activity Policy Officer at the Department of Health (DH). The aim was to synthesise the findings from the reports submitted to DH, highlight innovative practice and to enable learning for the future.

This report was written by Sarah Hanson, Research Associate and Professor Andy Jones, both from the Norwich Medical School at the University of East Anglia.

Executive summary and recommendations

The Department of Health funded five 'Walking Cities' in 2013 – 2015 to develop walking initiatives. There was great variety in the projects and evidence of much activity. The aim was also to target the particularly inactive and those who were less well socially situated. Whilst there are useful transferable lessons to be learned from this project, the poor reporting did not allow the assessment of how well aims were achieved. Where baseline measurements were recorded it appeared that participants were already physically active.

Where interventions were particularly successful, they built on 'grass-roots' community assets already in existence which took them to the heart of a community. The use of community based assets was particularly important in accessing those who are harder to reach and hence the learnings from this programme support assessing and utilising the assets in a community. There were attempts to work with health professionals with direct referrals into the walking interventions. This met with very limited success and continues to represent a major missed opportunity in reaching those who are the most inactive and in poorest health.

Due to the poor project reporting the mandated and full use of the Standard Evaluation Framework for Physical Activity is recommended for the future. There was limited outcomes reporting and this limited our evaluation of how successful the programme was at increasing physical activity.

We would make the following two recommendations. Firstly, that the Standard Evaluation Framework for Physical Activity is mandated for future work and that practitioners are trained in how to use it. Secondly, we would recommend that we need to understand the missed opportunity of direct referrals from health professionals; why this is the case and why health professionals do not refer to walking interventions, such as group walks.

Background information

In 2013 DH distributed £1.2 million funding over two years to be divided across the successful City Deal recipients of the Cycle City Ambition Grant (CCAG). Each of the successful CCAG applicants were invited to submit a proposal with costings up to £250,000 to be split equally over two years. The purpose of the fund was to get more people walking.

Underpinning beliefs

DH believes that 'mainstreaming' walking and cycling offers a cost effective way to increase health-enhancing physical activity, relieve congestion and improve the quality of life within a city. DH wants to encourage more people to walk as a more realistic, accessible and inclusive travel mode in order to benefit health.

Funding criteria and principles

DH funding was to be used to get more people to walk more and to support those harder to reach groups.

The revenue funding was offered on the principles of making a strategic case, an economic case, project deliverability, and monitoring and evaluation. It was also expected that each city set out their plans for the end of the revenue funding and how these would be informed by evidence of cost effectiveness over the two years.

Possible Interventions

DH was keen for the funding to be used to focus on sedentary and inactive people who are likely to require tailored and intensive support to become more active. The funding could be used to expand existing programmes or set up new initiatives which show positive outcomes for walking.

Interventions such as walking programmes with referrals from NHS health checks, exercise referrals, community street audits to identify key barriers to walking, practical support for primary care staff to carry out brief interventions, and employer promotion of walking as part of active travel for their staff were all suggested as possible foci.

Suggested partnerships

DH strongly encouraged the engagement and support from organisations that specialise in walking including Living Streets (LS), The Ramblers, Britain on Foot, Sustrans as well as community interventions such as 'Beat the Street' (BTS) run by Intelligent Health.

Overall findings

The plans and outputs for each city

The intended projects and evaluation plans submitted by the five cities in their funding applications are synthesised and presented in Table 1 in the appendices. Table 1 also lists the activities and outputs that were submitted to DH at the end of the funding period. The Living Streets organisation report summarised Birmingham, Leeds and Bradford and Norwich. Norwich also submitted an additional report. There were separate reports from Cambridge and Manchester.

Objective setting

The primary objective for receiving funds was to increase physical activity in those who fail to meet the current Chief Medical Officer's guidelines of at least 150 minutes a week. The justifications of how the walking cities would achieve this were generally explained in broad terms with a lack of specific anticipated outcomes. Where outcomes were numerically specified, it was notable that these were not revisited in the final reports and there were no explanations as to whether outcomes had been achieved and if not, why the projects had failed to meet the targets. Generally, the programmes would have benefitted from a clear theoretical basis to each intervention with the process of change identified. Techniques such as intervention mapping or the use of a logic model would have aided the planning and evaluation process. From this, evaluation tools could have been selected that were appropriate to each intervention. For example, the evaluation of a population event such as a walking festival is different to joining a walking group from an exercise referral scheme.

Evaluation within the schemes

Throughout the programmes there was a lack of objective measure collection or reporting to determine baseline, end of intervention, and follow up physical activity levels. There would have been benefit from independent evaluations of each of the cities' programmes and a co-ordinated evaluation of the whole funding stream. This would have enabled a more effective evaluation plan at the onset, ensured rigorous monitoring and ultimately better highlighted good practice for learning in future schemes. We are aware of independent process evaluations of both the Norwich walking champion scheme and Beat the Street by the University of East Anglia and an independent qualitative study of the Manchester walking scheme. Otherwise whilst potential academic partnerships were raised in the funding bids there was no reference to them in the final reports.

Generally, there was poor use of the Standardised Evaluation Framework for Physical Activity (SEF), despite this being recommended in the funding application. This meant that extrapolating data for the effectiveness of the interventions was problematic and it was difficult to extract learning across the five programmes. It is recommended that the SEF (or other consistent standardised framework) reporting is mandated for future funding. If the SEF is used, it would be helpful for the subtitles and numbers used in SEF to be consistently applied in future reporting.

The impact for each city

There was very limited physical activity outcomes reporting and no physiological or health outcomes reporting. Where outcomes were described they have been listed in Table 2 in the appendices. Table 2 describes the intervention, the data collected and the physical activity outcomes. Generally, across the reports, the tool used to evaluate was not explained, there was poor labelling of time-points, there was a lack of numerical clarity, there were extensive missing outcomes data the reason for which was not explained, there was virtually no collection or reporting of follow-up data, and there was limited use of objective measures.

'Upshot' was the main evaluation tool used by Living Streets to evaluate the three cities (Birmingham, Leeds and Bradford and Norwich) that they were responsible for. This is a monitoring rather than a physical activity evaluation tool. In this case people were surveyed twice with the use of telephone surveys, emails and face-to-face engagements. The sample size was just 297 individuals. From this it was extrapolated that 12,021 people were reached with a walking message, 9,174 took part in a walking activity, 4,587 people walk more (this was based on the assumption of a representative sample and that 50% of those reached with a walking message subsequently walked more) and 4,878 felt healthier. We do not feel these claims can be substantiated based on the information contained in the report.

Case studies were used as useful illustrations. A problem is that often they were quite highly descriptive or anecdotal in nature, lacking information on objective outcomes and a transparent way of reporting findings. We suggest it is desirable to use validated, objective tools to assess the outcomes of physical activity interventions.

The Walking Cities project was delivered to an extremely short timetable – approximately 18 months – which presents a challenge when evaluating the sustainability of interventions. We would suggest therefore that in addition to end of intervention evaluation, future programmes include a longer-term follow-up to assess whether any impact observed is sustained in the longer term.

Sustainability

The short project delivery time meant that all projects were subject to the challenge of making an impact and embedding work to enable sustainability in the longer term. Sustainability was secured in Manchester through the Local Sustainable Transport fund and there was also funding to sustain the Norwich walking champion's scheme until March 2016. Projects would benefit from more or longer term partnership building within localities to help ensure sustainability. In Manchester there is a stated plan to continue to work with partners including Manchester City Council, Salford and Oldham Community Leisure Trusts, local councils, the Ramblers and Walking for Health. In the Cambridge buggy walks, childminders and family workers were trained on how to organise the sessions in partnership with children's centres.

Reaching hard to reach groups

There was a particular emphasis from DH that interventions should support those harder to reach groups and reduce health inequalities. A range of groups were identified from those cities that reported on this, although there was no participant information reported for Birmingham and Leeds and Bradford. Groups considered were:

The physically inactive

Where baseline self-reports were reported, it would appear that the vast majority of participants were already physically active. There were however some interesting case studies of participants for whom a walking intervention was a new experience. This may have translated into more physical activity in everyday living although the evidence presented was only anecdotal.

Socio-economic status

Generally, there was poor reporting of socio-economic status of participants which limits our ability to determine the potential impact of the programmes on socio-economic inequalities. Manchester utilised postcodes to give CACI Acorn classifications and found a propensity for people from 'Affluent achievers', 'Comfortable communities' and 'mature money' to participate. Whilst there was good socio-economic evidence and rationale in all the funding applications there was little evidence that

those typically attending the interventions were those who would be classified as socio-economically deprived.

Ethnicity

Generally, the walking interventions were dominated by those who were white British. It would be useful when reporting attendance levels according to ethnicity that reference is made to the percentage BME levels in that area to enable inference to be drawn in the context of local populations. The walk project in Oldham (part of the Manchester scheme) reported this and had some successes in targeting ethnic minority communities. However, as with other schemes, the majority of respondents, 83%, were White British compared to 75% across Oldham. Just 7% of respondents were Asian Bangladeshi, a similar proportion to Oldham as a whole whilst Asian Pakistani were under represented at 2% of participants whilst accounting for 10% of Oldham's population. There was no reporting of participant ethnicity in Norwich and there was much missing or non-recording of data in Cambridge, although it was stated that 89% of participants were white.

Disability

There was some success in both Norwich and in a scheme in Oldham (part of the Manchester project) in working with established community organisations for people with additional needs or learning disabilities. The Norwich Walking Champion scheme also recruited a walk leader with a mild learning disability who was a strong advocate of the group walks in her community. Manchester reported participants' self-rated long-term health problem or disability for 8 of their schemes with an average 76% of participants declaring themselves as without a disability or long term illness. This broadly equates to the 80.6% reported for Greater Manchester in the 2011 Census. Disability was not known or not reported in either the Cambridge or Norwich reports except for one child with a special educational need in the buggy walks in Cambridge.

Age and gender

The BTS initiative in Cambridge and Norwich was aimed at primary school children, whilst the Cambridge 'Walk to Work' week was aimed at those of working age, in work, and the Cambridge buggy walks were aimed at young parents. Otherwise, general population initiatives tended to attract an older population. In the eight schemes reported by Manchester, 72% of participants were ≥ 45 years of age and 58% ≥ 55 years of age. Some 86% of those who attended the health walks in Cambridge were over 45. Missing data and poor reporting prevents age being determined for the Norwich scheme. Females represented 58% (range of 48-69%) of participants in the Manchester projects and 66% and 86% in the Norwich and Cambridge health walks respectively.

Innovative practice

Examples of innovative practice were given within the reports from each of the five cities. These are presented in Table 3 and represent possible foci for future programmes and areas of research. As with all piloting of innovative practice, it is recommended that activities are planned with evaluation in mind and then rigorously evaluated with both an outcomes and process evaluation to determine effectiveness, value and learning.

Conclusion

The DH funding of the five 'Walking Cities' aimed to increase physical activity by developing walking initiatives, particularly for those who are inactive and less well socially situated. The poor reporting of participant information and baseline and outcomes measures seriously limits the evidence of what has worked well and what lessons can be drawn. Generally, there is weak evidence of an

increase in physical activity but where it was observed it tended to be amongst participants who were already physically active. There is very little evidence within the reports to suggest that the projects were successful in reaching 'harder to reach' groups. The full and consistent use of the Standard Evaluation Framework for Physical Activity for all five cities would have enabled better evidence to have been built. There were examples given in the reports of interventions viewed as particularly successful and those that continue to represent a challenge when accessing the most inactive. Successes particularly consisted of community based interventions that worked well with, and built on, 'grass-roots' community assets already in existence. Attempts at direct referrals into the walking interventions from health professionals were generally less successful and this represents a missed opportunity for reaching those who would likely benefit most.

Appendix (i) Project plans and outputs for the five cities

Table 1: Project plans and outputs for the five cities

City	What they said they would do (As outlined in bid documents)	Evaluation plan and outcomes (As outlined in bid documents)	Activities / What they did (Taken from final reports)	Outputs (Taken from final reports)
<p>Birmingham</p> <p>Co-ordinated by 'Living Streets'</p> <p>£250,000 from DH and £100,000 from Birmingham City Council</p>	<p>Birmingham Walking Revolution</p> <p>Appointment of 'Walk-to' coordinator (LS)</p> <p>Street audits and expert reviews (barriers to walking)</p> <p>Engagement events, including street parties, led-walks, and 'treasure hunts'</p> <p>Walking challenges LS walking challenge, Walk to School and Walk to Work initiatives</p> <p>Promotional activities</p> <p>Lasting legacy</p>	<p>Impact and assessment report</p> <p>Changes in total physical activity</p> <p>Changes in the frequency of walking</p> <p>Changes in the determinants of activity behaviours, such as improving attitudes to walking and increasing knowledge about walking and exercise</p> <p>Anticipated outcomes not numerically specified</p>	<p>led walks to the park for key stage 2 pupils at one city primary school</p> <p>Pledge cards for individuals</p> <p>Themes walks</p> <p>Community Street Audits</p> <p>Small grants fund</p> <p>Walking Champions</p> <p>Social media work</p> <p>Strategic work to share learning</p>	<p>LS tool – Upshot*:</p> <p>Number of people reached with a walking message = 3865</p> <p>Number of people actively participating in a walking activity = 1980</p> <p>Number of people walking more after participating = 990</p> <p>Number of people feeling more healthy after participating = 1010</p> <p>No reported outputs from their activities</p>
<p>Leeds and Bradford</p> <p>Co-ordinated by 'Living Streets'</p> <p>£250,000 from DH and £310,000 from W Yorkshire Combined Authority</p>	<p>Best foot forward project</p> <p>Focus on children and families through engagement with schools, children's centres, third sector and local health providers (GPs)</p> <p>Walking advisor (LS)</p> <p>Street audits</p> <p>Events – buggy walks, treasure hunts</p> <p>Social reward-based initiatives</p> <p>Creation of school curriculum material</p> <p>Small fund pot</p>	<p>Mixed methods</p> <p>School travel data</p> <p>Increase in propensity to walk</p> <p>Interviews – sample of adults – pre and post intervention on attitudinal change</p> <p>Anticipated outcomes: Targeted population 15,000</p>	<p>3 million steps social reward scheme (n=388)</p> <p>Themed walks</p> <p>Community Street Audits</p> <p>Small grants fund</p> <p>Tendering delivery to local community organisations</p> <p>Social media work</p> <p>Strategic work to share learning</p>	<p>LS tool – Upshot:</p> <p>Number of people reached with a walking message = 3544</p> <p>Number of people actively participating in a walking activity = 2762</p> <p>Number of people walking more after participating = 1381</p> <p>Number of people feeling more healthy after participating = 1409</p> <p>No reported outputs from their activities</p>

City	What they said they would do (As outlined in bid documents)	Evaluation plan and outcomes (As outlined in bid documents)	Activities / What they did (Taken from final reports)	Outputs (Taken from final reports)
<p>Norwich Co-ordinated by 'Living Streets' £228,500 from DH and £12,000 from Norwich City Council</p>	<p>Norwich 'Walk to' programme Walking co-ordinator (LS) 'Beat the Street' school walking game with 'Intelligent Health' Personalised travel plans with 'Lift Share' Group health walks with 'Active Norfolk'</p>	<p>Data collection and analysis by delivery partners</p> <p>Anticipated outcomes: Engage with 43,000 people Health walks – 500 participants Travel plans – 2,400 people Engagement events – 10,000</p>	<p>Group walking champions led walks including 1km group walk for people with a learning disability Pledge cards for individuals Community Street Audit Small grants fund Beat the Streets project Social media work Strategic work to share learning</p>	<p>LS tool – Upshot: Number of people reached with a walking message = 4612 Number of people actively participating in a walking activity = 4432 Number of people walking more after participating = 2216 Number of people feeling more healthy after participating = 2260</p> <p>Health walks: 185 walks, 12 volunteers and 154 new participants Beat the Street: 1890 participated Travel plans: not reported 1 community street audit</p>
<p>Cambridge £200,000 from DH £11,000 from Travel for Work partnership</p>	<p>Walk Local Project officer Walk Buggy – young parents and children Walk Health – GP practice based health walks Walk Work – active travel Walk School – 'Beat the Street' pilot in four primary schools Walk Aware - promotion</p>	<p>SEF for all 5 elements.</p> <p>Anticipated outcomes: not numerically specified</p>	<p>Promotion of Walk4Life and WfH campaigns (various media), maps and community walks Walk to work week activities with 17 employers Health walks in 3 surgeries BTS piloted in 4 primary schools Weekly buggy walks / wild play with young parents and children under 5</p>	<p><u>Walk Aware</u> 7 walks with 108 participants £10.87 per participant (does not include cost of maps) Walk local message to 50,000 people <u>Walk Work</u> Participation in 'Walk to Work' week <u>Walk Health</u> Health walks. Total participants n=27 £8,348 = cost per participant £309 <u>Walk School</u> 890 participants (978 recruited) in 'Beat the Street' (3 week intervention) £44,000 Cost per participant of £49 <u>Walk Buggy</u> 230 attendances £5056.83 Cost per participant £21.99</p>

City	What they said they would do (As outlined in bid documents)	Evaluation plan and outcomes (As outlined in bid documents)	Activities / What they did (Taken from final reports)	Outputs (Taken from final reports)
<p>Manchester £250,000 from DH (including 10K for monitoring and evaluation) £145,000 from other sources</p>	<p>Get Active in Greater Manchester Everyday walking such as utility trips Recreational walking – themed and volunteer led walks Structured health walking – via health care services to target high risk</p> <p>Project co-ordinator Community Walking Rangers Led walks (entry level) Promotional events Journey planning Travel choices workshops Marketing and Communications Volunteer support and training Information and social media</p>	<p>Numbers of people engaging with the project Number and frequency of sessions accessed Accessible and inclusive</p> <p>Anticipated outcomes: to get 2,000 people walking more regularly</p>	<p>Eleven projects</p>	<p>Walking Works Personal travel planning advice to 24,000+ households in Greater Manchester Promotion of walking to 400 businesses (280,000 employees) Walking Works newsletter Walking Festival in May 2015 with 100+ health walks</p> <p>Specific projects <u>East Manchester Moving:</u> 1 x Project officer 23 led walks with 163 participants 10 led cycle rides with 96 participants 8 volunteer action days 24 volunteers trained as volunteer walk leaders £40,500 = £248 per participant <u>Tameside Active Outdoors Project:</u> 4 new health walks with 30 participants 18 new volunteer walk leaders 1 new patient from new exercise referral programme 5 new self-guided walking routes in production – Proposed launch in 2016 £26,250 = £875 per participation <u>The Green Corridor Project:</u> 9 led health walks with 91 new participants. 5 volunteers trained as walk leaders £25,240 = £277.36 per participant <u>Salford Ranger team project:</u> 1 new self-guided walking route 11 additional recreational walks with 107 participants 12 volunteers trained as walk leaders 12 led cycle rides with 108 participants £32,454 = £301.31 per participant <u>Active Oldham Outdoors Project:</u> 26 Level 1 health walks with 143 participants 14 new volunteer walk leaders Capital funding from Public health to improve walking infrastructure in 9 parks £20,000 = £139 per participant</p>

City	What they said they would do (As outlined in bid documents)	Evaluation plan and outcomes (As outlined in bid documents)	Activities / What they did (Taken from final reports)	Outputs (Taken from final reports)
Manchester (Continued)				<p><u>Active Trafford Greenspace Project:</u> 20 led walks with 278 participants 23 new volunteer walk leaders 3 GP Surgeries piloting 'walk prescribing' or other methods of promoting walking to patients. 3 Workplace Walk led walks events held 5 new Workplace Walks mapped and promoted £26,903 = £96 per participant</p> <p><u>Greater Manchester Walking Festival:</u> 126 led walks with 1291 participants Planning commenced for GM Walking Festival 2016</p> <p><u>Stockport Walkaday Walks Project:</u> 13 additional walks with 217 participants 4 new volunteer walk leaders £3,100 funding = £14 per participant</p> <p><u>Bridgewater Canal Walks Project:</u> 22 recreational themed walks with 74 participants £1,800 = £25 per participant</p> <p><u>The Salford Trail:</u> 8 new walking routes which join together to create the new 'Salford Trail' New leaflets and maps created for each route New trail added to OS maps</p> <p><u>Trafford Community Leisure Trust:</u> 8 new volunteer walk leaders</p>

*Upshot is an online tool developed by the Football Foundation and used by Living Streets to manage and monitor projects. Data was collated using emails, telephone surveys and face to face engagements. Two waves, October 2014: n=149 and June 2015: n= 166

Appendix (ii) Impact evaluation (where stated in reports)

Table 2: Impact evaluation

City	Intervention	Data presented	Physical Activity outcome
Birmingham		No data presented for this city	No data presented for this city
Cambridge	Walk Health Great Shelford medical centre walks	Baseline (date not given) 1005 minutes walking per week End of project (date not given) 1055 minutes walking per week Minutes being physically active did not change (284 minutes) Sedentary time did not change	Increase in walking in a physically active population No change to overall physical activity
Cambridge	Walk Health Cherry Hinton medical centre walks	Baseline (date not given) 153 minutes walking per week End of project (date not given) 226 minutes walking per week Increase in physical activity of 103 minutes per week Sedentary time did not change	Increase in walking in a physically active population Increase in physical activity in a physically active population
Cambridge	Walk Health Sawston medical centre group walks	Baseline (date not given) 225 minutes walking per week End of project (date not given) 270 minutes walking per week Overall PA remained at 50 minutes Sedentary time did not change	Increase in physical activity in a physically active population
Cambridge	Beat the Street n= 890	Walk or cycle time to school before BTS 9 minutes (n=104) Walk or cycle time to school after BTS 9 minutes (n= 94) Walk or cycle time to school 6 months after BTS 9 minutes (n=106)	No statistically significant increase in time children spent walking or cycling after BTS intervention BTS not associated with an increase in journeys in which children walked or cycled to school Pre-BTS Children met DH PA target of 60 mins on at least 5 days per week and no statistically significant improvement to this
Cambridge	Walk Work week scheme	Comparison between 2013 data (n=8 workplaces) and 2014 data (n=17) workplaces taking part in the Walk to Work week project 9.97% walked in 2013 and 10.2% walked in 2014 Average distance in 2013 6.41 miles and 11.24 miles in 2014	Increase in physical activity in participants who are already physically active

City	Intervention	Data presented	Physical Activity outcome
		<p>Annual travel survey 7% walked in 2013 and 7% walked in 2014 Average distance in 2013 2.63 miles and 2.06 miles in 2014</p> <p>10% of those taking part stated that an employer incentive (cake) was the main gain from Walk to Work week (!)</p>	
Cambridge	Walk aware	No data presented for this project	No data presented for this project
Cambridge	Walk Buggy	No data presented for this project	No data presented for this project
Leeds and Bradford		No data presented for this city	No data presented for this city
Manchester		<p>Baseline data but insufficient respondents for follow-up data Baseline data (grand mean across the 8 SEF reports): 83% > 150 minutes of activity per week 59% > 55 years of age 77% no long term illness or disability</p>	No follow up data from which to ascertain changes in PA or health
Norwich		<p>Health walks: Baseline data 50% of participants PA ≥ 30 mins on 3 days or more (42% response reported) Beat the Street: Number of days in previous week with > 30 mins activity 3 days or less : 45% before and 23% after No days : 19% before and 5% after 7 days before : 9% before and 16% after (Only 35% pre-intervention and 34% reporting for post intervention)</p>	<p>No follow up data from which to ascertain changes in PA or health</p> <p>Unable to assess BTS due to unclear and missing data</p>

Appendix (iii) Innovative practice highlighted in the reports

Table 3: Innovative practice highlighted in the reports

Birmingham	Small grants fund helped to lever out groups that the project might not otherwise have reached.
Cambridge	Encouraged referrals from GPs and provided promotional pads to make signposting to the project easy. However, only two referrals were directly from a GP. The majority of participant's routes into the project was from seeing a poster or leaflet.
Cambridge	Building on existing community groups, for example a young fathers group and an Asian Women's group. Linking with existing community centres and groups enabled better design and promotion of the walking schemes.
Cambridge	Walk buggy with 'wild play' activities to observe nature and give confidence to return to greenspace.
Leeds	Piloted 3 million steps social reward within eight community organisations. 388 people walked over 15 Million steps. The project rounded off with a walk around the area led by a marching band in which over 100 people took part, followed by a community barbecue.
Manchester	GP surgeries piloting 'walk prescribing' as part of a healthier lifestyle. This uses 'Refer-all' exercise referral software under a 3 year licence. Using an online form it links up agencies, groups and organisations that would potentially be referring participants to such a programme.
Manchester	Self-guided walk / run routes creating routes that have route information boards on site and route markers around the route which were either 3, 2, or 1 kilometres in length.
Manchester	Partnerships with existing community centres has enabled the targeting of inactive individuals within Oldham's Bangladeshi and Pakistani communities and walks for specific parts of the community such as the Afro-Caribbean community and local Muslim groups who may never have gone outside of their local area. Adults with additional needs via a community interest company (Funky Fitness and Fun). The walks have given participants a better understanding of road safety, and the meaning of various road signs and marks. Afro-Caribbean self-formed group with popular i-spy walks which have increased their knowledge of local history, and given them a 'voice' so that they can add (via their own experience and knowledge of the area) to the historical content.
Norwich	Park walk: Group walks running alongside the successful Parkrun initiative on a Saturday morning. This gives a sociability to walking a lap, inspires participants and offers potential exit routes.
Norwich	Engagement using existing community based projects: For people with Learning disabilities (partnership with the Assist Trust) Teenagers (a community based youth group in a teen café) A parish nurse and community centres (hubs) established within a deprived community
Norwich	Use of social media including twitter and #walkingcitieshour