

Active Health Project Evaluation

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Acknowledgements and Declarations of Interest

The Active Health Project was funded by through the Smarter Choices, Smarter Places (SCSP) Open Fund which is funded by the Scottish Government and delivered through Paths for All.

The Active Health Project has been evaluated by the University of the Highlands and Islands (UHI) Division of Rural Health and Wellbeing, which has no affiliation with the Velocity Café & Bicycle Workshop, who manage the project, or with Paths for All.

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1. Introduction

“She just spoke to me like I was a normal human being ... She made me feel like relaxed and at ease ... like just speaking to a friend ... There was nothing like looking down at me.” (P5)¹

1.1 Background

The Active People Project aimed to increase physical activity and active travel amongst patients from four Highland GP practices. The project was funded through the Smarter Choices, Smarter Places (SCSP) Open Fund. Funded by the Scottish Government and delivered through Paths for All, the Smarter Choices, Smarter Places programme focusses on behaviour change, aiming to encourage everyday walking or cycling and sustainable travel methods for longer journeys. Velocity Café and Bicycle Workshop applied for the funding for the ‘NHS Highland Active People Project’ and managed the project. Operating from its café and workshop in Inverness, Velocity is a social enterprise which promotes cycling as a way of helping people adopt healthier lifestyles, encourage sustainable travel and improve emotional wellbeing. The Active People Project focussed on helping to motivate and engage patients who could gain individual health benefits through increasing their level of physical activity. In addition, by adopting active travel as an intervention, the project aimed to have an impact on the community’s health by increasing the use of more sustainable transport. At the end of October 2019, the project changed its title to the Active Health Project and this name is used throughout the rest of the report.

The Rural Health and Well-being team at the University of the Highland and Islands (UHI) undertook an evaluation of the Active Health Project, aiming to assess the impact of the pilot on patients’ physical activity and the effectiveness of the Link Worker role. This evaluation report gives a brief outline of the policy context, explains the methodology used by the research team, details the results of the quantitative and qualitative data analysis and, finally, presents conclusions about the project’s impact based on these findings.

1.2 Policy context

Social prescribing is attracting more interest in recognition of the potential value of non-clinical based interventions, such as exercise groups, outdoor activities, art therapies and peer support, which are all proving popular in ‘treating’ both mental health problems and addressing sedentary lifestyles. In particular, social prescribing can play a role in the self-management of health, which is an increasing priority in Scotland:

“Social prescribing is also central to the Government’s strategy on self-management of long-term conditions. Long-term conditions become more prevalent with age; with nearly two-thirds of people in Scotland developing a long-term condition by the age of 65” (Terje et al., 2019: 18).

However, the availability of such non-clinical interventions is variable across Scotland, especially in more remote and rural locations (Morton and Bradley, 2020). In *“An Integrated Health and Social*

¹ Numbers in brackets refer to the identification number of the interviewee quoted. ‘P’ indicates project participant (n=8) and ‘S’ refers to project staff interviewees (n=3).

Care Workforce Plan” the Scottish Government outlines plans to deliver 250 community link workers working in GP surgeries by 2021 (2019: 4). GPs and other health professionals could then refer patients to a community link worker who would help them to find non-clinical services and support groups which may meet their needs in terms of physical activity and mental wellbeing. The Scottish Government funded a ‘Links worker’ programme in Glasgow to tackle the effects of social disadvantage on health in communities found in the top 15% of the Scottish Index of Multiple Deprivation (SIMD). The programme involved a partnership between the Health and Social Care Alliance (Alliance) and General Practitioners at the ‘Deep End’, who work in practices in the most deprived communities in Scotland. The Programme was piloted in seven general medical practices in deprived areas of Glasgow in 2014 and compared with 8 similar practices. It employed social prescribing to enable GP general medical practices to signpost people to health and wellbeing resources in their communities. According to the Alliance, a report from the Scottish Deep End Project (Cawston, 2010) focused on the experience of GP practices in deprived areas and found:

“A high proportion of consultations with GPs being driven primarily, or largely by the experience of social adversity, especially poverty and financial problems, as well as experiences of violence, addictions, housing and many other difficulties. The GPs felt that they were often unable to respond effectively to these because of a lack of time and with difficulties in accessing community-led services which they knew would benefit their patients.”²

A research team from the University of Glasgow, Institute of Health and Wellbeing, carried out the evaluation of the Programme delivered via Community Links Practitioners (CLPs) and found some mixed results:

“Analysis of qualitative interviews with 12 patients showed that they appreciated the unconditional support offered by CLPs, feelings of being listened to and being valued by the CLP, and being able to come back to see the CLP whenever they needed. Some patients said that after seeing a CLP and visiting a community resource, they felt better able to find help themselves and self-manage problems. However, this experience was not universal and some patients did not find the CLP useful and did not engage with or did not find the CO useful.”
(Mercer et al., 2017: 3)

The evaluation did not find *“any statistically significant effects of referral to a CLP on the primary or secondary patient outcomes at 9 months compared with usual care in patients in the Comparison Practices, after adjusting for baseline differences using the best regression model. There were also no beneficial effects on self-reported healthcare utilisation”* (ibid: 5). The evaluation also found *“no differences in the primary outcome of health-related quality of life of patients who engaged with a CLP (rather than just being referred) compared with the comparison group (in the best regression model), and this was not affected by number of times seen by CLP nor whether the patient attended a community resource”* (ibid: 6).

However, the evaluation did reveal an impact on some mental wellbeing outcomes:

² Alliance website: <https://www.alliance-scotland.org.uk/in-the-community/national-link-programme/about-the-programme>, referring to ‘GPs at the Deep End: Deep End Report 8 Social prescribing (Cawston, 2010) (last accessed May 2020) https://www.gla.ac.uk/media/Media_179091_smxx.pdf

“There were some differences in the secondary outcomes of anxiety symptoms, depressive symptoms, and self-reported exercise levels. These were significantly better in those who saw a CLP twice or more compared with the comparison group. In those who attended a suggested community resource, anxiety and exercise levels also improved significantly. Effect sizes for anxiety and depression were small to moderate but of possible clinical relevance.” (ibid: 6).

In recent years a range of studies have been conducted into the effectiveness of individual social prescribing interventions, usually within urban areas, and following different models. Evidence suggests that social prescribing interventions can result in mental wellbeing benefits but outcomes for the impact on the take-up of mainstream health services is less clear:

“Common positive outcomes from social prescribing identified in the existing evidence base include increases in self-esteem and confidence; improvements in mental wellbeing; reductions in anxiety and depression; and reductions in social isolation. However, there is a lack of evidence on whether social prescribing decreases nonclinical primary care usage” (Terje et al., 2019: 7).

A systematic review was not in the scope of this evaluation, but the following examples indicate some of the factors identified in academic literature as contributing to the efficacy and value of similar link worker programmes as part of other research studies and evaluations.

- Person-centred approach and individualised recommendations/interventions - Pescheny et al. (2018), Wildman et al. (2019)
- Continuous support offered by link workers over duration of programme is important rather than simply signposting to services. Support may promote adherence to programme - Pescheny et al. (2018), Wildman et al. (2019)
- Referral by trusted health care professionals - Pescheny et al. (2018), Bertotti et al. (2018)
- Access to appropriate activities - Wildman et al. (2019)
- Emphasis on gradual behaviour change over time - Wildman et al. (2019)
- Relationship between participant and link worker is important, facilitating removal of barriers experienced accessing services - Wildman et al. (2019), Bertotti et al. (2018).
- Participant feels sense of agency - Bertotti et al. (2018: 239)

In their examination of a social prescribing pilot in London, Bertotti et al. (2018: 239) summarise the impact of link workers and suggest the underlying mechanism which may help them be effective:

“When patients are given agency and control over their time with non-imposing support from qualified SPCs [social prescribing coordinators] who are empathetic and have a good knowledge of the social support infrastructure available locally, social prescribing is likely to have a beneficial impact on service users, particularly service users with multiple and complex needs.” (p 239)

2. Active Health Project

2.1 Project stages

The Active Health project consisted of three stages, as shown in Figure 1. In the initial stage, the two Active Health Link Workers (each employed for 10.5 hours per week) received referrals from GPs or other healthcare professionals. At a later stage the project was open to self-referrals direct from the participant. The Link Workers would then arrange three face-to-face sessions with each participant, to take place over a 12-week period. Persons taking part in at least one session were described as having actively participated with the Active Health project. In the final stage, the UHI researchers received quantitative and qualitative data from consenting participants and conducted an evaluation of the Active Health project.

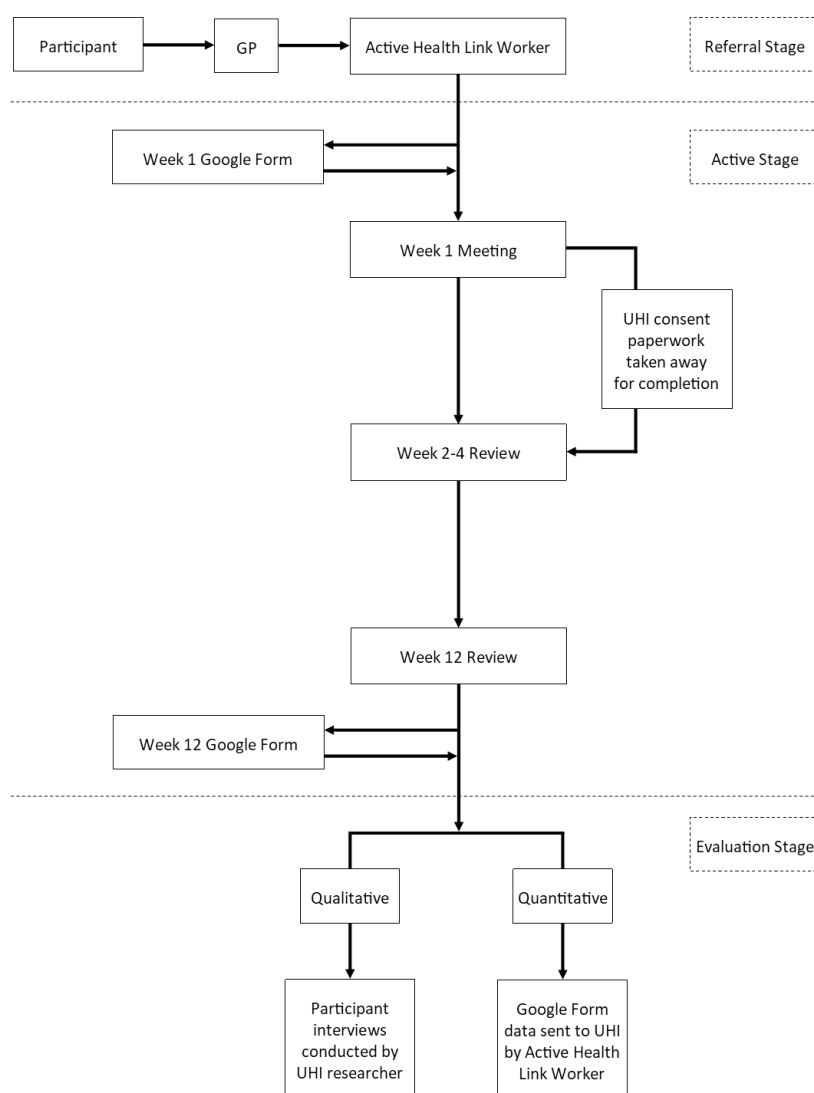


Figure 1: Active Health project process

The COVID-19 pandemic impacted on the active stage of the Active Health project. From the point that UK lockdown was imposed on 23.03.20 (Schofield, 2020), the delivery of the Active Health was affected in two ways: firstly, the standard face-to-face delivery was replaced with phone or virtual conferencing; and secondly, the standard three-session delivery was increased depending on

individual needs, because as the referrals fell from 11 per month on average in Jan to March 2020 to one referral in April 2020, the Link Workers had the extra capacity to offer more sessions.

2.2 Participants

Patients from the participating general practices were referred to the Active Health Link Workers by a GP or other healthcare professional. At a later stage the project was opened to self-referral.

The total number of referrals to the Active Health Link Workers since the beginning of the project and since the start of the evaluation in November 2019 are detailed in the table below:

Table 1: Total number of referrals by GP surgery and by number of participants

Surgery	Start date	Active People	Active Health	Total
		June – Oct 2019	Nov - end April 2020	
Cairn	June 2019	43	38	81
Southside Road	August 2019	1	7	8
Aviemore	October 2019	9	22	31
Total referrals		53	67	120
Total number of active participants		50	58	108
Total number of participants completing		33	12*	45

Notes:

*32 participants still actively engaging or on hold due to COVID-19.

An ‘active participant’ was defined as anyone attending the first consultation following referral and anyone following through from the first consultation to Week 12 was categorised as ‘completing’. Only 11 of the 58 people who actively engaged from the Active Health group of participants signed up to Florence, an automated text messaging service which sends a series of messages or ‘protocol’ to patients to facilitate the self-management of their health. The total number of participants who dropped out after week 1 and after week 2/3 were as follows:

Table 2: Total drop-out rates

Project stage	Drop-out after Week 1 (i.e. after 1 session)	Drop-out after Week 2/3 (i.e. after 2 sessions)	Total drop-out
Active People	6 (12%)	9 (18%)	15 (30%)
Active Health	11 (19%)	3 (5%)	14 (24%)
Total	17* (16%)	12** (11%)	29 (27%)

Notes:

* 2 participants still engaging, final session TBA.

** 32 participants still actively engaging or on hold due to COVID-19.

Percentages have been rounded up or down to nearest whole number.

The total number of 'active' participants up to the end of April 2020 was 108, 90% of the people originally referred. The drop-out rate across the programme until the end of April 2020 was just over a quarter at around 27%.

Table 1 shows the number of participants defined as completing the programme was low with only 41% of people seen at Week 1 completing Week 12 by the end of April 2020. However, it should be noted that this figure does not include the 34 people who were classed by the Link Workers as still actively engaging and awaiting final sessions. Of these, some participants were listed as having put the programme on hold due to the impact of COVID-19. These figures are therefore only provisional and the final completion figure cannot be given at the time of writing. Following 'lockdown', the number of referrals dropped significantly: the average number of referrals per month Jan-March 2020 was 11, whereas the number of referrals in April 2020 was one.

2.3 Google forms questionnaires

The Active Health Link Workers collected information at various stages of the Active Health project to enable them to facilitate the participants' involvement in the project. The Active Health Link Workers collected data chiefly using Google Forms questionnaires at Week 1 and Week 12, but also via other Active Health documents, e.g. 2-4 Wellbeing form, physical activity plan.

The Active Health participants completed a Week 1 questionnaire before their Week 1 Link Worker session and a Week 12 questionnaire after their Week 12 Link Worker session. The Google Forms questionnaires produced participant data relating to non-active travel (car and public transport usage), active travel/leisure (walking, cycling, and other physical activities), mental wellbeing, and demographics. The questions asked at Week 1 and Week 12 were nearly identical to enable comparisons to be drawn between the Week 1 and Week 12 responses. The Week 12 Google Forms questionnaire included a section to collect feedback on the Active Health project.

The Google Forms questionnaires were written and managed by Velocity. UHI was not responsible for editing the Active Health Google Forms, and nor was it responsible for the content of the Week 1 and Week 12 questionnaires as distributed.

Prior to the evaluation proceeding, several measures were introduced at the request of UHI. These included: the use of version control for the participant-related documents; adding labels to Likert-style questions; and replacing the use of identifiable data labels with unique ID codes.

Following the introduction of these measures, the project-related participant paperwork was set at Version 1. At the same time the Active People project was rebranded as the Active Health project allowing a clear division between the new and old versions of this health-related project.

2.4 Evaluation

The Active Health project was evaluated by the University of the Highland and Islands (UHI) Division of Rural Health and Wellbeing.

As part of the evaluation, UHI received quantitative data from the Active Health Week 1 and Week 12 Google Forms questionnaires. The transfer of quantitative data from the Active Health Link Workers to the UHI researchers closed in late-June 2020. The quantitative data was complemented by qualitative data collected by UHI in June 2020 via interviews with Active Health participants.

To permit the Link Workers to share the Active Health participants' Week 1 and Week 12 Google Forms data relating to activity levels and wellbeing with UHI, data sharing consent was obtained via the Week 1 questionnaire. To permit UHI to contact Active Health participants to invite them for interview, data sharing consent was obtained via hard copy forms given to the participants by the Link Workers at the Week 1 session, for them to bring back at the Week 2-4 session (see Figure 1).

3. Evaluation – Methodology

3.1 Introduction

The evaluation of the Active Health project is based on quantitative data collected by the Active Health Link Workers and qualitative data collected by the UHI research team.

3.2 Quantitative Methods

The UHI researchers received pseudonymised quantitative data from the Active Health Week 1 and Week 12 Google Forms questionnaires in Excel spreadsheet (programme limitations meant the Active People quantitative data was not included in the evaluation). The Active Health participants were identified only by ID number in the Excel spreadsheet. The Link Workers sent the quantitative data securely via UHI Dropbox, after which it was stored securely on the UHI SharePoint system.

The quantitative data transfer from Active Health to UHI closed in late-June 2020 to enable the evaluation to be carried out. By this point, 17 active participants had consented to take part in the Active Health evaluation; and of the consenting participants, nine had completed the project.

The UHI researchers thus received quantitative data from 17 Week 1 questionnaires and nine Week 12 questionnaires. This resulted in an evaluation dataset that contained Week 1 quantitative data for 29% of the active participants; and Week 12 quantitative data for 75% of the active participants who completed the Active Health project and for 53% of the active participants who agreed to take part in the evaluation.

The quantitative data was analysed in Excel using descriptive analysis, e.g. mean, mode, frequency. To ensure participant anonymity, the quantitative data was analysed by cohort, rather than changes attributable to individual participants, e.g. observing any shift in cohort response to a question from Week 1 (baseline) to Week 12.

With regards to data handling, it should be noted that Google Forms automatically inserts questionnaire data into Excel spreadsheet. For the most part, this automatic data insertion resulted in several satisfactorily formatted columns of data for analysis; however, the evaluation had to overcome the following data preparation difficulties, which should be noted for future analysis:

- The frequency and intensity responses were inserted together in a single cell per participant per destination for the walking, cycling, and *Other activities* questions.
- The reasons preventing walking were inserted together in a single cell per participant, with free-text associated with the *Other* response included in those same cells.
- The reasons preventing cycling were inserted together in a single cell per participant, including the free-text associated with the *Other* response option.
- The *Other activities'* activity type responses were inserted together in a single cell per participant.
- The numbering system advised for the *Other activities'* activity type question appeared to cause confusion during questionnaire completion (see Section 4.7 for full details).

3.3 Qualitative Methods

The evaluation employed qualitative research methods involving semi-structured interviews with project staff and participants. The Link Workers agreed to act as ‘gatekeepers’ and approach Active Health participants to establish whether they were interested in taking part and, if so, whether they agreed to their contact details being passed to a researcher so that they could be contacted by telephone or email. The researcher could thereby give details on the project, offer the opportunity to ask questions and, if appropriate, arrange an interview. Due to the ‘lockdown’ measures imposed, the interviews were all conducted by telephone. This research did not necessitate collecting detailed information on a participant’s health background, although the interviewee could disclose more about their condition and/or history if they wished. Interview questions elicited participants’ positive and negative experiences of the programme in order to determine the impact of the intervention, reasons for success, barriers, and suggestions for improvement. Project information and consent forms were sent to interviewees electronically or by post. Interviews were audio recorded for the purposes of thematic data analysis.

The aim had been to interview participants who had taken part in the stage of the programme from which the questionnaire data was collected and analysed. However, due to reasons explained in the limitations section (see Section 3.4), interviews had to be offered to any previous participants in the programme. Altogether eight participants were interviewed about their experiences together with three members of Active Health project staff.

The qualitative data collection focused on answering the following research questions:

- What are the impacts of the intervention on the physical activity levels of participants?
- What are the impacts on the mental health and well-being of participants?
- What is the impact on active travel?
- What works well about the intervention?
- What are the factors that make the intervention successful?
- What requires improvement?
- Are there barriers to implementation and take-up of the intervention? If so, what are they and how can they be overcome?

3.4 Limitations

The evaluation was not designed at the same time as the project proposal and funding application. The UHI Rural Health and Wellbeing research team was commissioned to carry out an evaluation after the commencement of the project. Therefore, this had an impact on the research design which had to be compatible with the project, already underway from the beginning of April 2019. The project evolved differently to the original plan and had to respond to ‘teething problems’ when setting up in the GP surgeries, including resolving difficulties over not being able to access NHS systems. It took longer than anticipated to work through this stage in the first surgery which acted as a ‘pilot’ before opening out to other surgeries as planned. It was agreed that the evaluation should start when the project had overcome these preliminary difficulties and was rolled out to other surgeries in its agreed format following on-going revisions to the project. However, this led to a further delay in starting the evaluation. In addition, the evaluation had to use questionnaires already

devised and used by the Active Health project. Some revisions were agreed between UHI and Active Health in order to facilitate the evaluation, but limitations remained as detailed in the section on quantitative data analysis. The ownership of the questionnaire remained with the project rather than the evaluation as it was being used as a tool in the intervention. Around the weeks of Christmas and New Year there was a drop off in referrals and therefore the pool of potential participants in the evaluation was reduced. Towards the end of March 2020 there was another fall in the number of referrals due to 'lockdown' measures implemented as a result of COVID-19, which meant fewer people visiting the GP surgeries and therefore another reduction in the number of potential participants. Amongst existing participants there was a perceptible decline in attendance via video link consultations which had to be introduced as face-to-face sessions were no longer possible. According to Link Workers more people missed these 'virtual' meetings. In addition, there was a tendency for participants not to complete the final week 12 questionnaire and, therefore, not respond to the request to take part in an evaluation interview. Link Workers also perceived there was an over burden of paperwork linked to both the project and the evaluation. In the second year of funding (from May 2020), it was agreed that the evaluation would not continue into year 2. Given the delayed start and drop in referrals, it was therefore difficult for the evaluation to recruit people who had experienced the whole 12-week cycle within the first year of the project, particularly without a further evaluation extension.

The early project delays and the withdrawal from external evaluation, combined with the drop-off in referrals and missed 'virtual' consultations, curtailed the length of the evaluation and therefore limited the number of potential participants. It was not possible to ascertain why some people did not attend video consultations or failed to complete Week 12 questionnaires. Although it would be reasonable to assume that the 'lockdown' had an impact on participation, the range of ways this impacted participants and their attitudes to the programme cannot be known. The impact of COVID-19 is likely to be extremely complex given the closure of leisure facilities, home-working, shielding, and caring responsibilities, as well as the effect on mental health and wellbeing on top of any consequences from catching the virus. The impact on physical activity levels, which may have increased or decreased, is very complex and will depend on how individuals were personally affected by 'lockdown' measures. No data was collected on those who dropped out at any stage of the programme. The evidence cannot be used to make general claims about experiences of the other participants or speculate about the motivations and views of those who did not engage with the programme or who dropped out of it. Neither was any data gathered from GPs or other healthcare professionals referring patients. There is therefore no evidence about attitudes to or practice of referral and how that might differ between individuals, professional role or location. Furthermore, the relatively short period of time allocated for the evaluation did not allow for gauging the sustainability of lifestyle changes beyond the programme.

Although these limitations were evident, the evaluation was able to carry out quantitative and qualitative data collection and analysis for the number of participants available to the evaluation. These findings are presented in the following sections.

4. Evaluation – Quantitative Findings

4.1 Introduction

Of the 67 people who were referred to the Active Health Link Workers, 58 gave informed consent for the purpose of taking part in the Active Health project. Of these 58 active participants, 17 gave further informed consent for their questionnaire data to be shared with the UHI researchers as part of the Active Health project evaluation. For the purposes of the Active Health quantitative data analysis, these 17 participants will hereafter be referred to as the 'evaluation participants', when presenting and discussing their responses at Week 1 (n=17) and at Week 12 (n=9).

The findings are laid out as per the order in which the Google Forms questionnaires were completed by the Active Health project participants. The questions from the Active Health questionnaires are included in bold italics, with other description as necessary in the grey boxes in Sections 4.3-4.9. Unless specified, the same questions were asked in both the Week 1 and Week 12 questionnaires.

4.2 Demographic data

Analysis of the evaluation participants' data has revealed the following characteristics in terms of gender, age, referral route, participation duration (completed and ongoing), and delivery method.

Gender: The evaluation participants' male/female split at Week 1 and Week 12 is near identical (see Figure 2), with 35% and 33% males, and 65% and 67% females at Weeks 1 and 12 respectively.

Age: The evaluation participants ranged from 20-29 years to 70-79 years of age at Week 1 (see Figure 3). The average age of the evaluation participants at Week 1 (n=17) was 58 and at Week 12 (n=9) it was 55. Note: The Active Health project was open to all ages.

Referral route: Thirteen (76%) of the evaluation participants were referred by a doctor and four (24%) were referred by a nurse. None of the evaluation participants were self-referred.

Participation duration (completed): Nine evaluation participants took an average of 102-days to complete the 12-week (approximate equivalent 84-day) Active Health project. The evaluation participants' completion duration ranged from 86-days to 133-days, with a mode of 86-days, which was the completion duration for three of the nine evaluation participants. Note: The completion duration is measured between the dates that the Week 1 and 12 Google Forms questionnaires were completed. The Week 1 Google Forms was completed prior to the Week 1 Link Worker session and the Week 12 Google Forms was completed after the Week 12 Link Worker session (see Figure 1).

Participation duration (ongoing): As of 19/06/2020, seven of the evaluation participants were still participating in the Active Health project, with an average duration of 146-days. Note: The duration start point is taken from the date on which the Week 1 Google Forms questionnaire was completed.

Delivery method: The Active Health project was designed to be delivered face-to-face; however, due to the COVID-19 pandemic, the project delivery method needed to be changed, as shown in Figure 4). At Week 1, the delivery method used with the evaluation participants was 100% face-to-face. At Week 12, the delivery method used with the evaluation participants consisted of one face-to-face delivery, while the other Week 12 sessions were delivered via video conference (VC) (n=5), phone (n=2), and email (n=1).

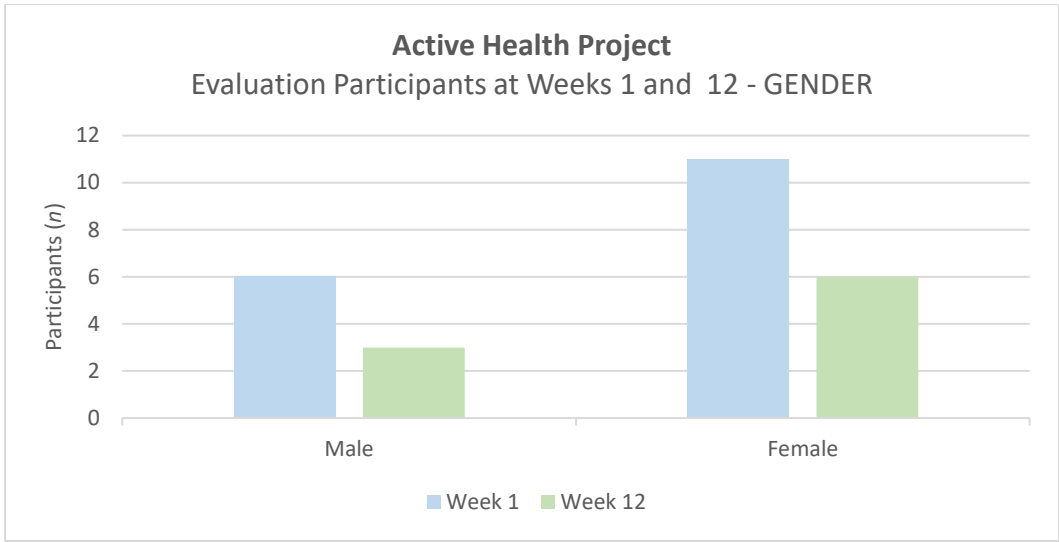


Figure 2: Evaluation participants - gender

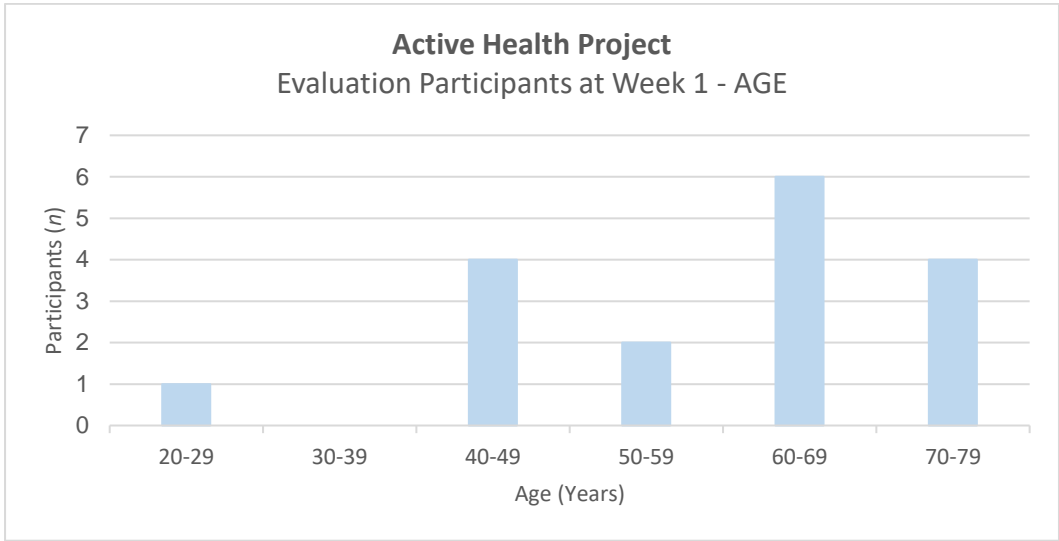


Figure 3: Evaluation participants - age

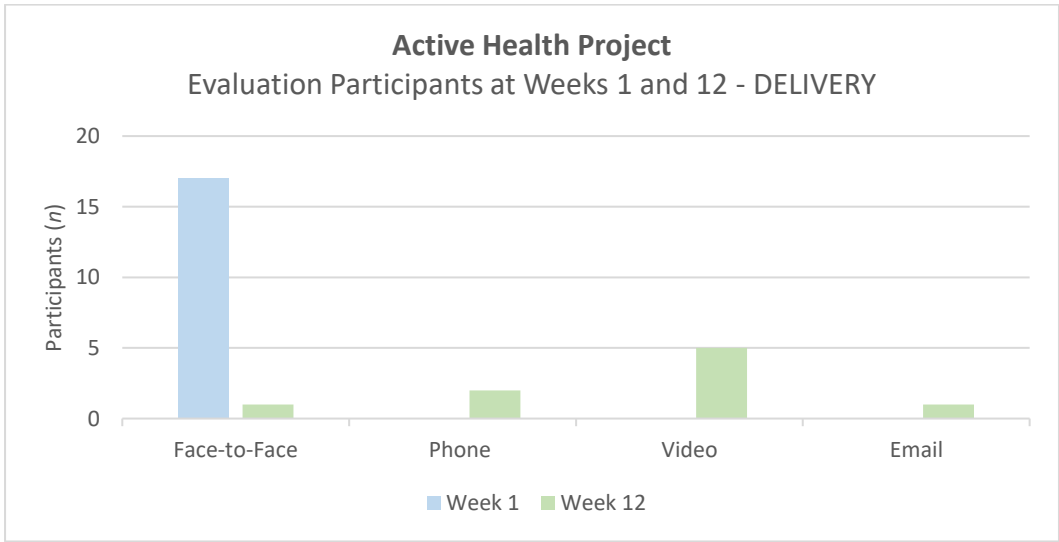


Figure 4: Evaluation participants - delivery method

4.3 Car usage

To investigate car usage (non-active travel), the participants were asked: ***Do you own or use a car?*** and ***What do you use the car for?***

With regards to *What do you use the car for?* the participants were asked to select any relevant purposes from: Visiting family or friends; Commuting to work; As part of my job; Taking others to/from destinations; Travelling to education/meetings/appointments; Going to the shops; Other journeys. Participants were asked to select their frequency of car use from: 5 or more times/week; 3-4 times/week; 1-2 times/week; 2-3 times/month; once a month or less.

The car ownership/usage is near identical, with 88% (n=15) and 100% (n=9) of the evaluation participants owning/using a car at Weeks 1 and 12 respectively (see Figure 5).

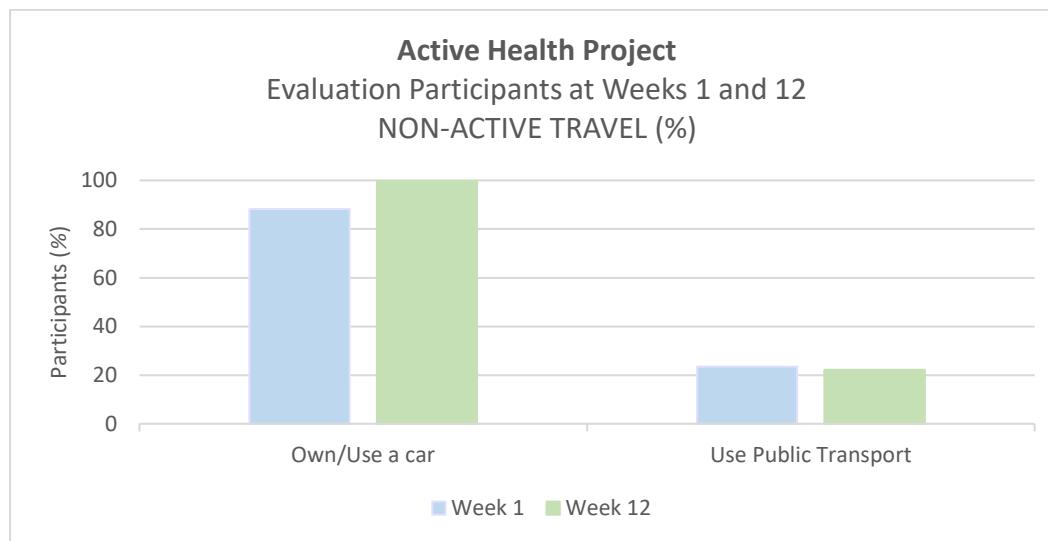


Figure 5: Evaluation participants - non-active travel - car/public transport (%)

The car use by frequency at Weeks 1 and 12 is shown in Figures 6 and 7 respectively.

Car usage by frequency (total responses per frequency option)

Week 1: 5 or more times/week (n=13); 3-4 times/week (n=6); 1-2 times/week (n=17); 2-3 times/month (n=9); and once a month or less (n=14).

Week 12: 5 or more times/week (n=1); 3-4 times/week (n=5); 1-2 times/week (n=13); 2-3 times/month (n=3); and once a month or less (n=22). Note: There was no 'Never' option for car use frequency nor for public transport, though there was for the walking and cycling questions.

The findings suggest that the evaluation participants have reduced their daily car trips, with 13 responses for '5 or more times/week' at Week 1 and only one such response at Week 12. This change might be connected to the increase in single monthly trips, with 14 responses at Week 1 and 22 responses at Week 12. However, it should be noted that differences in car usage by frequency may be related to the fact that the Week 12 cohort represents only 53% of the Week 1 (baseline) evaluation participant cohort. This evaluation is conducting comparisons on a cohort-basis only and as such, cannot compare individual behavioural change relating to car usage.

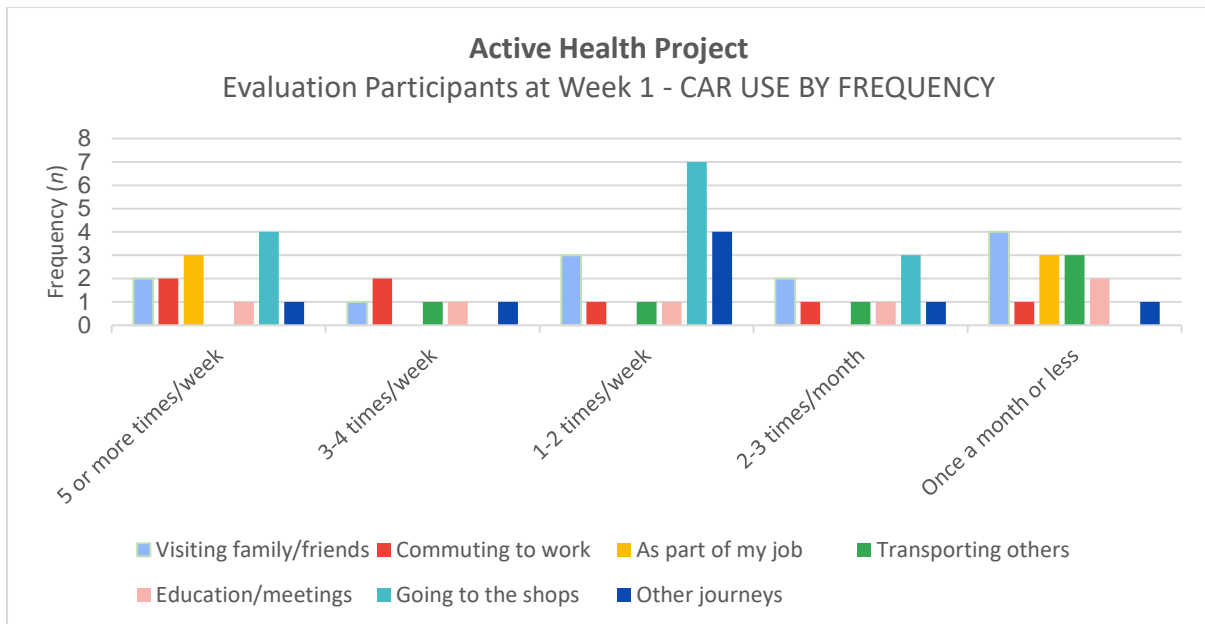


Figure 6: Evaluation participants - car usage by frequency (week 1)

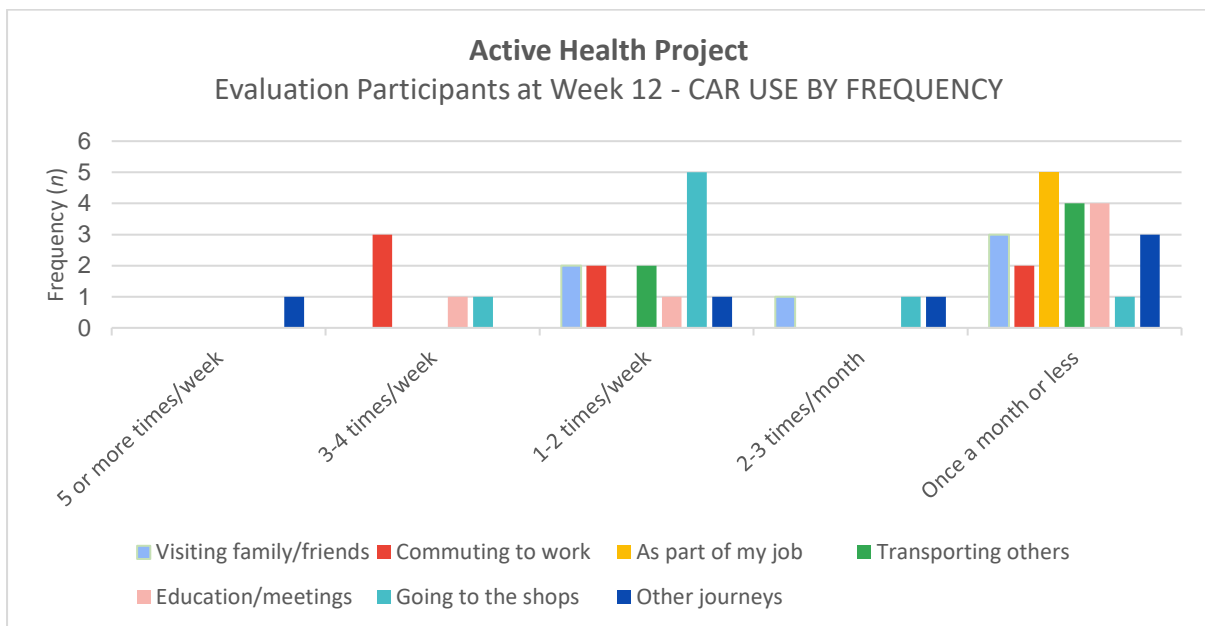


Figure 7: Evaluation participants - car usage by frequency (week 12)

The car usage by destination at Weeks 1 and 12 is shown in Figures 8 and 9 respectively.

Car usage by destination (total responses per destination option)

Week 1: Visiting family or friends (n=12); Commuting to work (n=7); As part of my job (n=6); Taking others to/from destinations (n=6); Travelling to education/meetings/ appointments (n=6); Going to the shops (n=14); and Other journeys (n=8).

Week 12: Visiting family or friends (n=6); Commuting to work (n=7); As part of my job (n=5); Taking others to/from destinations (n=6); Travelling to education/meetings/ appointments (n=6); Going to the shops (n=8); and Other journeys (n=6).

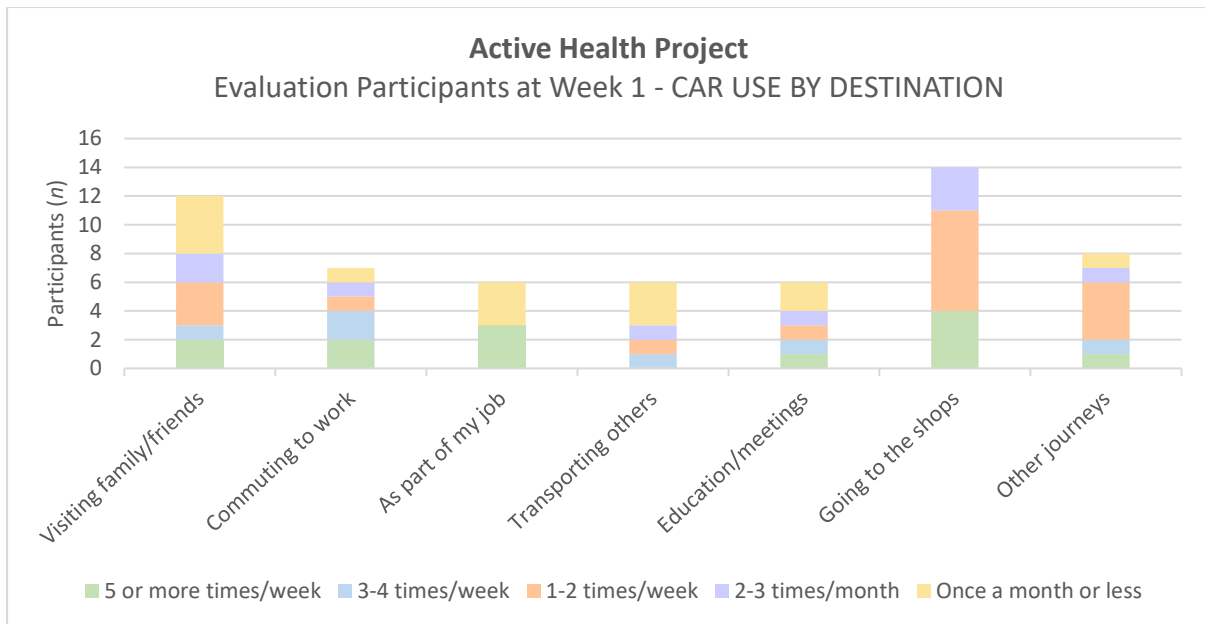


Figure 8: Evaluation participants - car usage by destination (week 1)

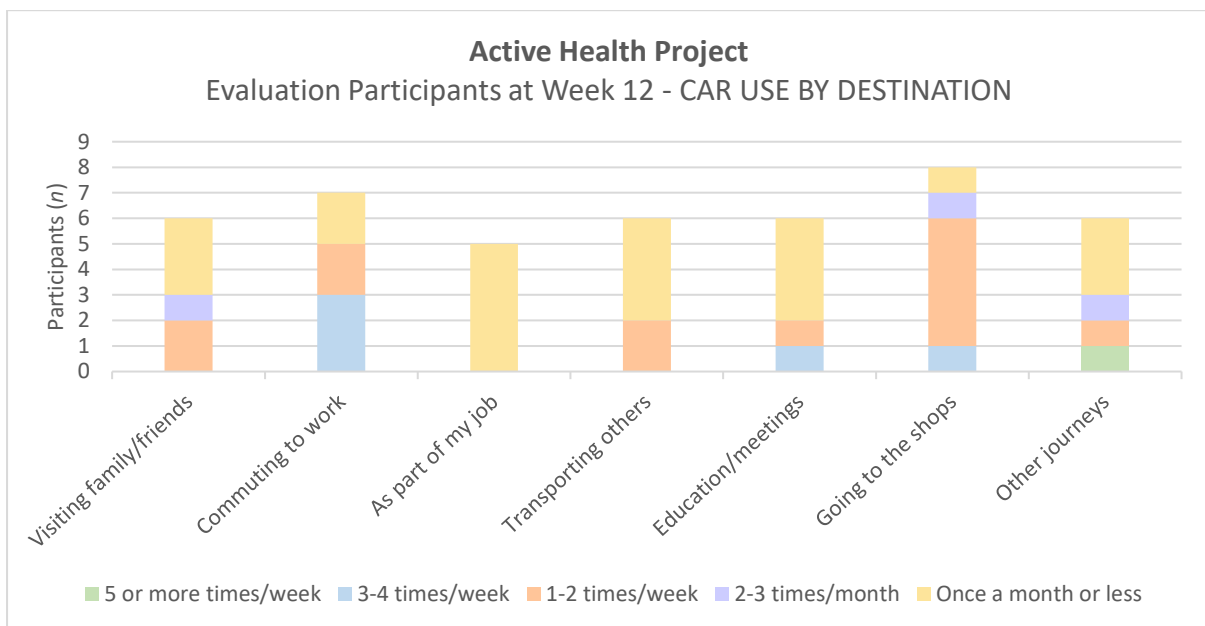


Figure 9: Evaluation participants - car usage by destination (week 12)

The findings suggest that *Going to the shops* is the evaluation participants' main reason for using their car. *Going to the shops* receives the highest number of responses at Week 1 and at Week 12, though the frequency composition differs considerably at Week 12. The frequency of visiting the destinations reduces from Week 1 to Week 12, but all of the destinations are still visited to some extent. The *Other journeys* option is the only destination at Week 12 to continue having a frequency response of '5 or more times/week' (albeit just one). However, as the questionnaire did not include a free-text cell to capture evaluation participants' comments in relation to the *Other journeys* option, the responses related to this destination option could not be explored further.

4.4 Public transport usage

To investigate public transport usage (non-active travel), the participants were asked: ***Do you use public transport?*** and ***If you replied yes, what journeys do you usually use public transport for?***

With regards to *What journeys do you usually use public transport for?* the participants were asked to select any relevant purposes from: Visiting family and friends; Commuting to work; As part of my job; Taking others to/from destinations; Travelling to education/meetings/ appointments; Going to the shops. Participants were asked to select their frequency of public transport use from: 5 or more times/week; 3-4 times/week; 1-2 times/week; 2-3 times/month; once a month or less.

The public transport usage is near identical, with 24% (n=4) and 22% (n=2) of the evaluation participants using public transport at Weeks 1 and 12 respectively (see Figure 5). The frequency and destination of public transport usage at Weeks 1 and 12 are shown in Figures 10 and 11.

Public transport usage by frequency (total responses per frequency option)

Week 1: 5 or more times/week (n=0); 3-4 times/week (n=0); 1-2 times/week (n=0); 2-3 times/month (n=3); and once a month or less (n=8).

Week 12: 5 or more times/week (n=0); 3-4 times/week (n=0); 1-2 times/week (n=0); 2-3 times/month (n=0); and once a month or less (n=3). Note: There was no 'Never' option for public transport use frequency nor for car, though there was for the walking and cycling questions.

Public transport usage by destination (total responses per destination option)

Week 1: Visiting family or friends (n=3); Commuting to work (n=1); As part of my job (n=1); Taking others to/from destinations (n=2); Travelling to education/meetings/appointments (n=1); Going to the shops (n=3).

Week 12: Visiting family or friends (n=1); Commuting to work (n=0); As part of my job (n=0); Taking others to/from destinations (n=1); Travelling to education/meetings/ appointments (n=0); Going to the shops (n=1). Note: There was no 'Other journeys' option for public transport use destination, though there was in the car questions.

The Week 1 findings suggest that the evaluation participants are infrequent users of public transport. The public transport frequencies and destinations are both further reduced at Week 12; however, it should not be presumed that this change has occurred as a result of the Active Health project. Any differences in the use of public transport may be related to the fact that the Week 12 cohort represents only 53% of the Week 1 (baseline) evaluation participant cohort.

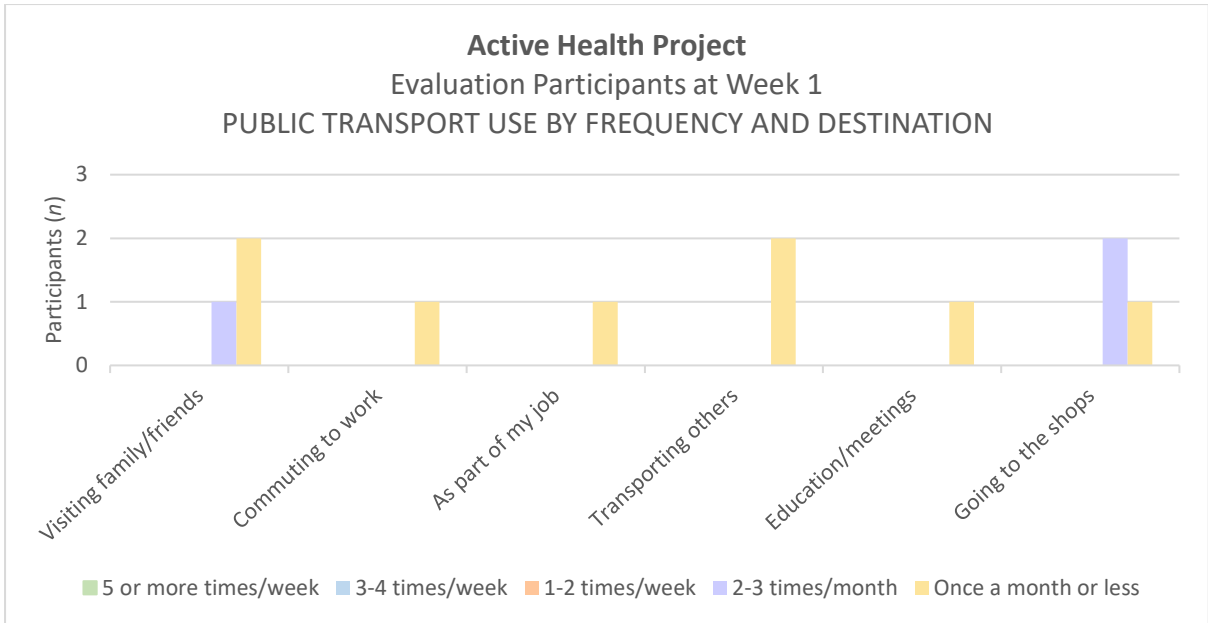


Figure 10: Evaluation participants - public transport usage by frequency and destination (week 1)

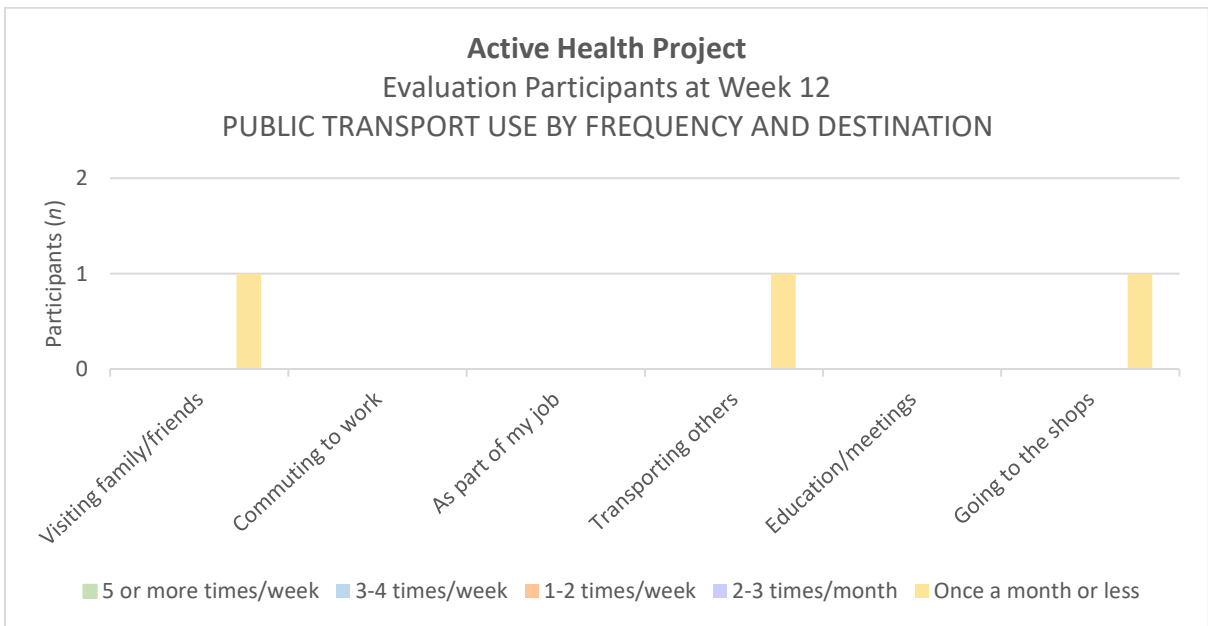


Figure 11: Evaluation participants - public transport usage by frequency and destination (week 12)

4.5 Walking

To investigate walking level (active travel/leisure), the participants were asked: ***How often do you go for a walk?*** and ***How much effort do you put in?*** during the last two months.

With regards to *How often do you go for a walk?* the participants were asked to select any relevant purposes from: Visiting family and friends; Commuting to work; As part of my work; Travelling to education/meetings/appointments; Going to the shops; For fun, leisure or to walk your dog; For health/fitness. And to select one frequency per selected walking purpose, from: 5 or more times/week; 3-4 times/week; 1-2 times/week; 2-3 times/month; once a month or less; Never.

With regards to *How much effort do you put in?* the participants were asked to select the effort they put into each walking purpose from one of two options: Taking it easy; Putting in effort.

The participants were then asked: **On average how many minutes do you spend walking each week to get somewhere (e.g. shops/work/meetings)** and **On average how many minutes do you spend walking each week for leisure/pleasure?**

The participants were also asked: **Would you like to walk more?** and **Tell us about what prevents you from walking?**

With regards to *Tell us about what prevents you from walking?* the participants were asked to select any relevant reasons from: Mobility issues; Pain; Not knowing where to walk; No-one to walk with; Traffic; Weather; Feeling unsafe; Lack of time; Other.

The evaluation participants' walking level at Weeks 1 and 12, is shown by frequency in Figures 12 and 13, by destination in Figures 14 and 15, and by intensity in Figures 16 and 17.

Walking by frequency (total responses per frequency option)

Week 1: 5 or more times/week (n=6); 3-4 times/week (n=3); 1-2 times/week (n=8); 2-3 times/month (n=9); once a month or less (n=7); Never (n=32).

Week 12: 5 or more times/week (n=6); 3-4 times/week (n=9); 1-2 times/week (n=4); 2-3 times/month (n=2); once a month or less (n=5); Never (n=25).

Walking by destination (total responses per destination option, including 'Never')

Week 1: Visiting family and friends (n=9); Commuting to work (n=8); As part of my work (n=8); Travelling to education/meetings/ appointments (n=8); Going to the shops (n=13); For fun, leisure or to walk your dog (n=11); For health/fitness (n=8).

Week 12: Visiting family and friends (n=7); Commuting to work (n=6); As part of my work (n=7); Travelling to education/meetings/appointments (n=7); Going to the shops (n=8); For fun, leisure or to walk your dog (n=8); For health/fitness (n=8).

Walking by intensity (total responses per intensity option)

Week 1: Taking it easy (n=12); Putting in effort (n=6).

Week 12: Taking it easy (n=5); Putting in effort (n=7).

Note: The intensity options for the walking questions were worded differently to the cycling and *Other activities*, with the term 'Putting in effort' used rather than 'Trying hard'.

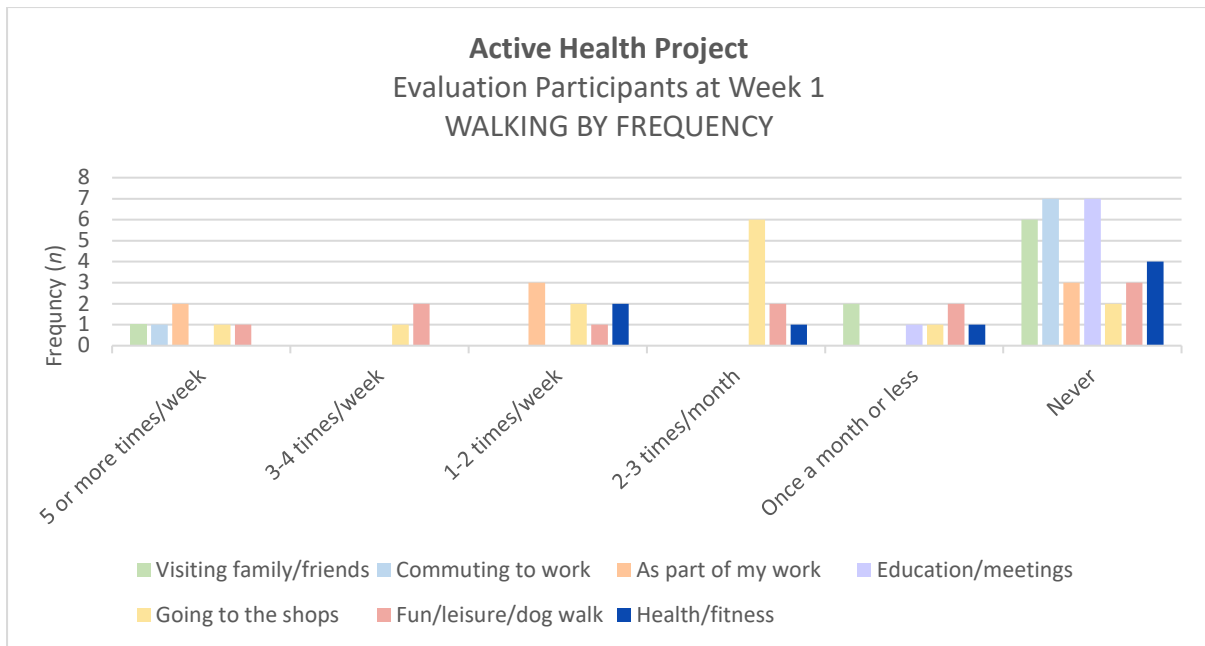


Figure 12: Evaluation participants - walking by frequency (week 1)

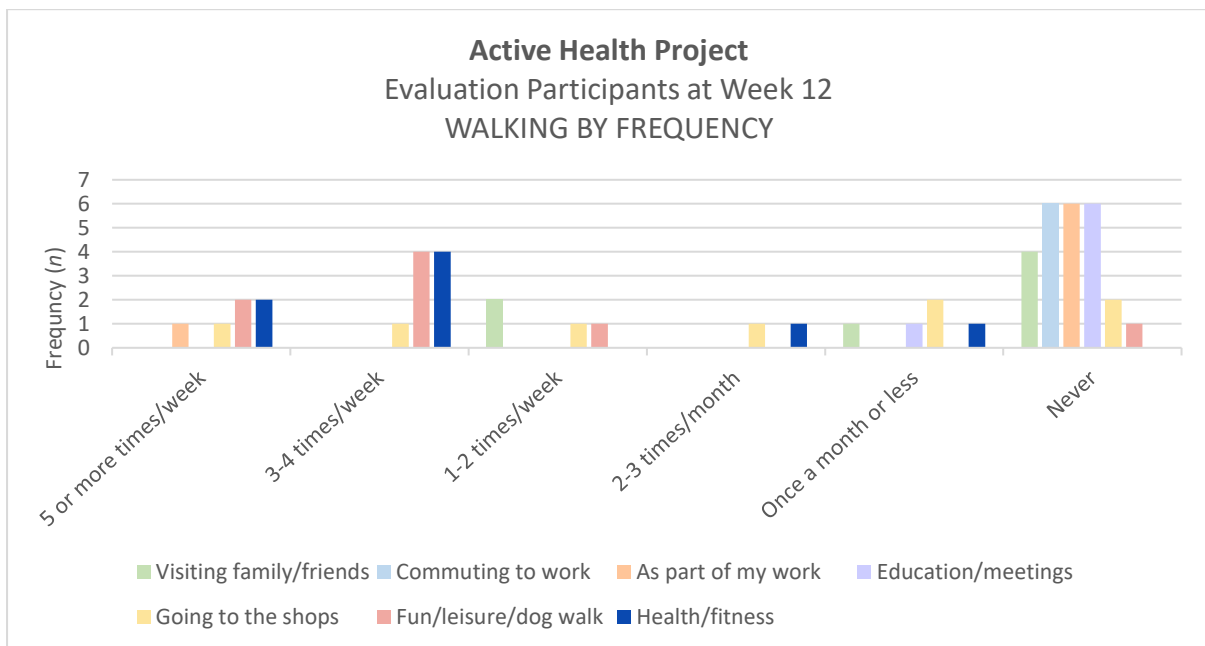


Figure 13: Evaluation participants - walking by frequency (week 12)

The findings suggest an increase in the frequency of walking for the fitness and leisure categories. At Week 12, there were responses relating to ‘Health/fitness’ in the ‘5 or more times/week’ and ‘3-4 times/week’ categories, when these two categories contained no such responses at Week 1. The findings appear to indicate an increase in walking for leisure in many of the frequency categories. There is also an increase in the walking intensity of ‘Putting in effort’, albeit by just one response, and the total number of ‘Never’ responses for walking by frequency fell from 32 at Week 1 to 25 at Week 12. These findings suggest that the Active Health project is positively impacting the evaluation participants’ physical activity levels; however, it must be noted that the Week 12 walking responses have been skewed by COVID-19 (see section 4.9).

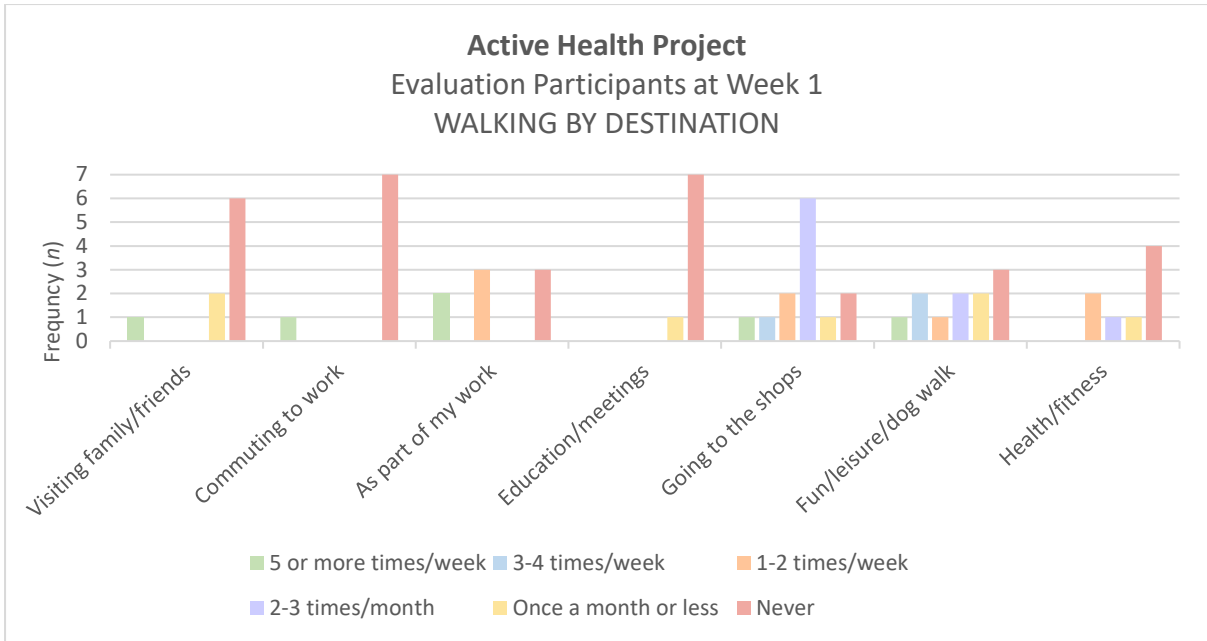


Figure 14: Evaluation participants - walking by destination (week 1)

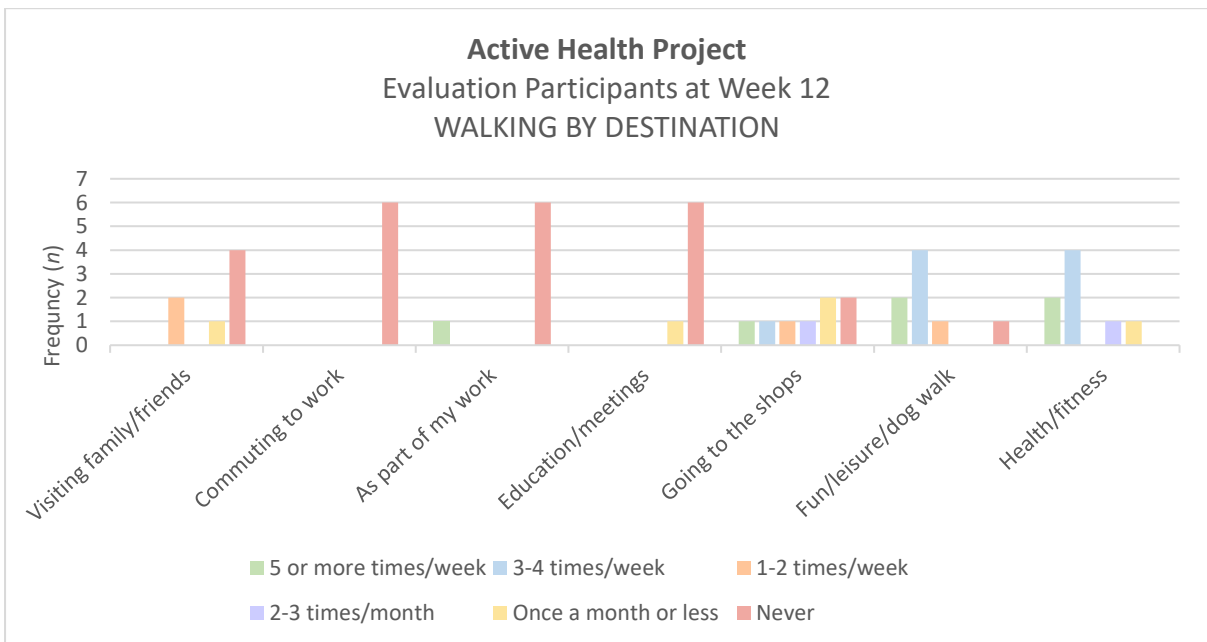


Figure 15: Evaluation participants - walking by destination (week 12)

The Week 1 and Week 12 findings for walking by destination are fairly similar, with the majority of the evaluation participants’ walking seemingly being done for shopping, leisure, and fitness reasons.

The Active Health project aimed to increase physical activity, with a focus on active travel, yet the walking by destination results for Week 12 are actually lower than Week 1 for all of the destination categories, except walking ‘For health/fitness’. It should be noted, however, that the Week 12 walking results have been skewed by COVID-19 (see Section 4.9 for more details) and that the Week 12 cohort represents only 53% of the Week 1 (baseline) cohort.

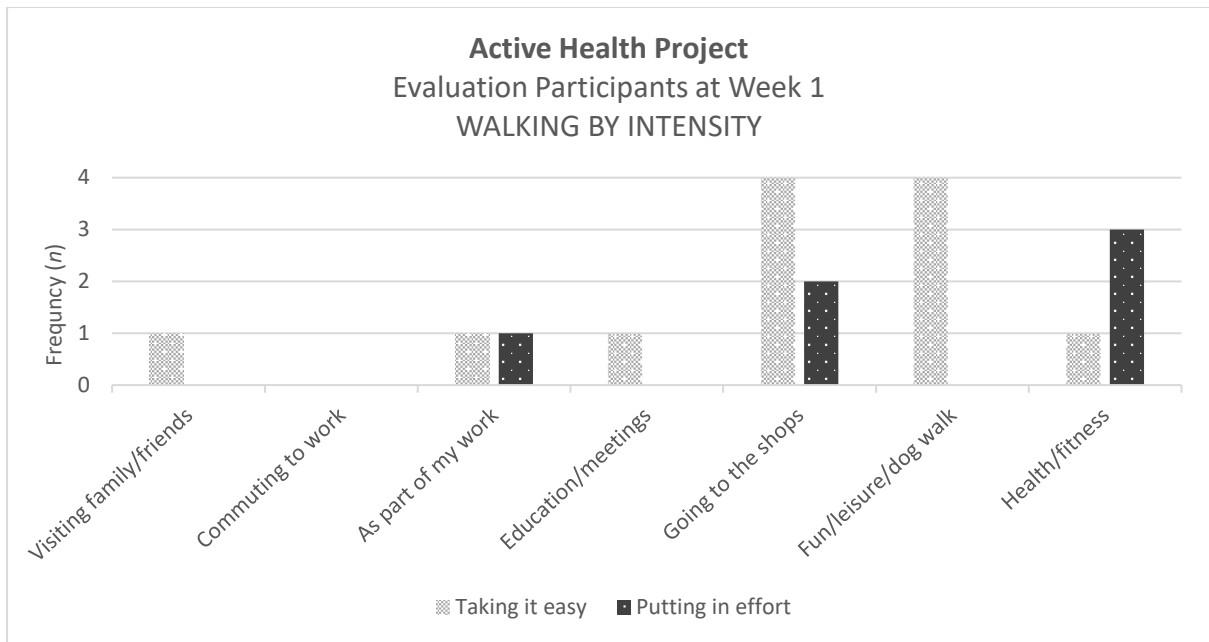


Figure 16: Evaluation participants - walking by intensity (week 1)

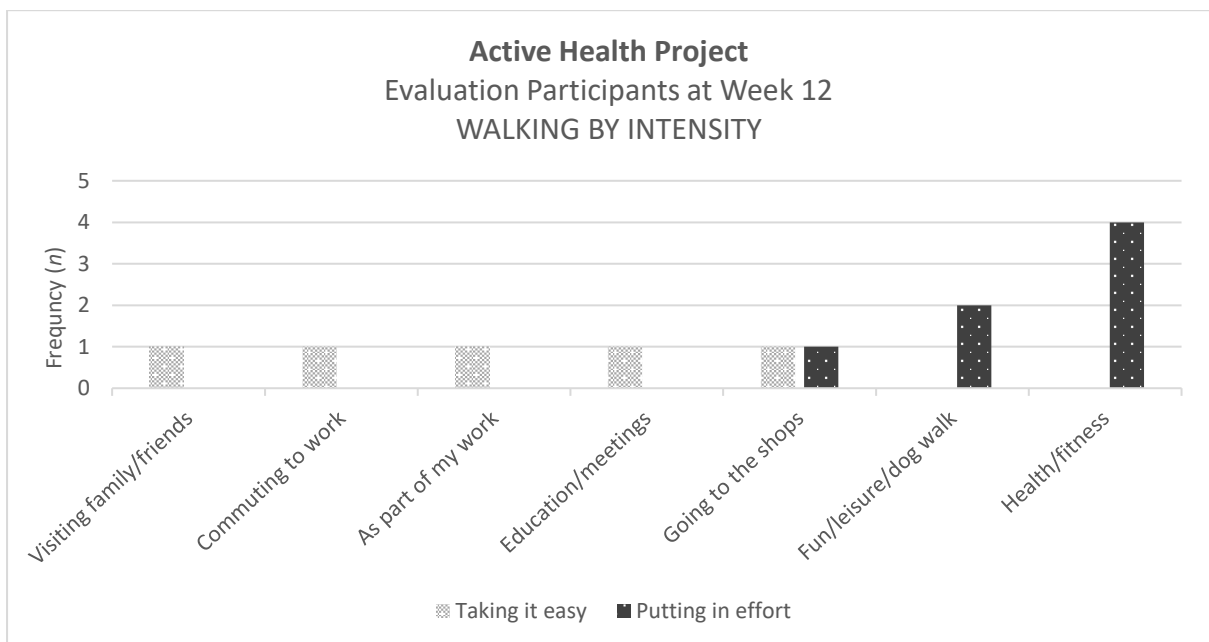


Figure 17: Evaluation participants - walking by intensity (week 12)

There were relatively few walking by intensity responses recorded by the Week 1 and Week 12 cohorts. It is interesting to see that the 'Putting in effort' responses increased at Week 12, albeit by just one response, despite Week 12 representing just 53% of the Week 1 (baseline) cohort.

The walking by intensity findings suggest a decrease in walking intensity for work and shopping reasons at Week 12 (potentially as a result of COVID-19), while at the same time showing an increase in the categories relating to leisure and fitness (again, potentially influenced by COVID-19).

The average minutes spent walking each week to get somewhere (active travel) or for leisure/pleasure at Weeks 1 and 12 is shown in Figure 18. This figure is based on valid responses ranging from zero upwards; blank responses to the associated question at Weeks 1 and 12 were not assumed to indicate zero minutes and were thus excluded from this calculation.

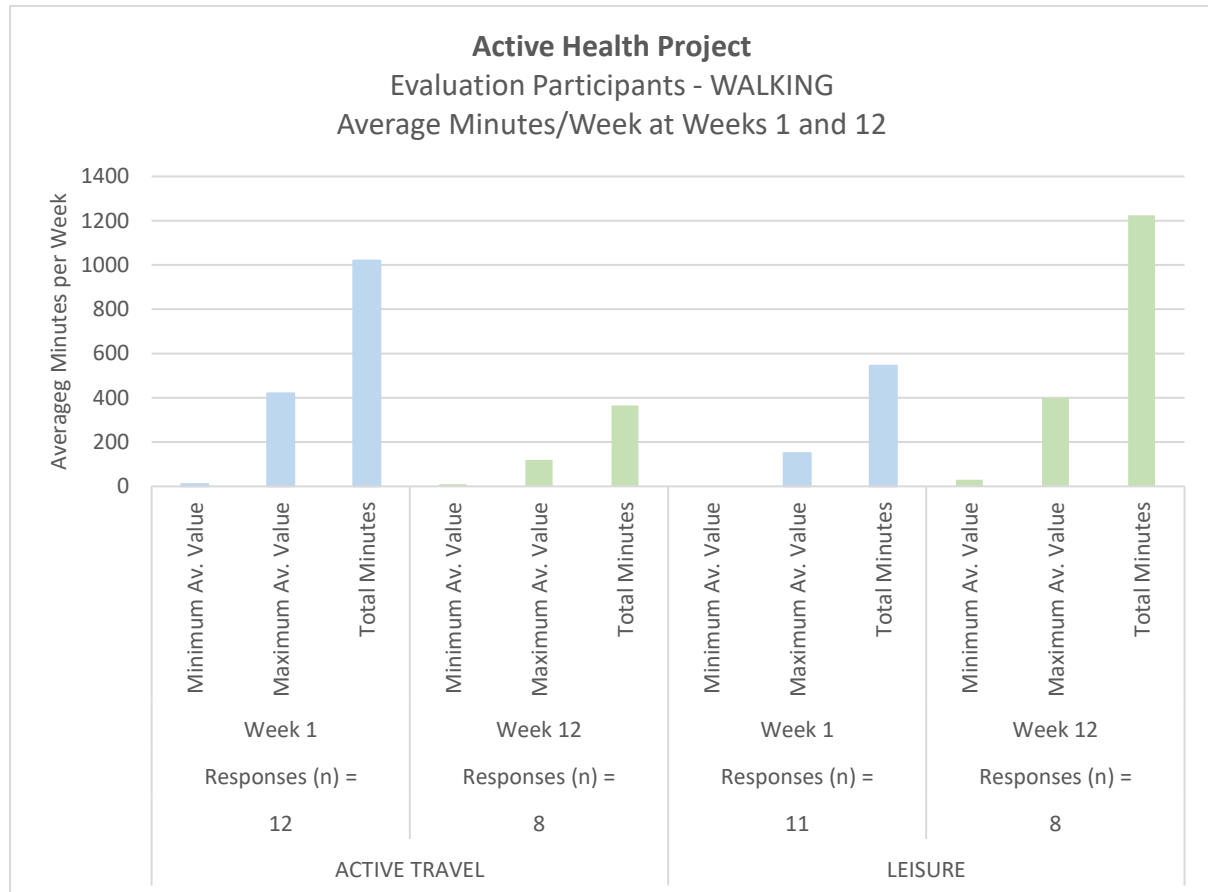


Figure 18: Evaluation participants - walking - average minutes/week (weeks 1 and 12)

Figure 18 received a similar number of valid responses (i.e. a number ranging from zero upwards) per cohort to the questions relating to the average number of minutes walked per week. The question asking about the average minutes walked for active travel was answered by 71% of the Week 1 cohort and 89% of the Week 12 cohort. The question asking the average minutes walked for Leisure was answered by 65% of the Week 1 cohort and 89% of the Week 12 cohort. The findings show that the total number of minutes walked for active travel decreased from 1020 minutes at Week 1 to 365 minutes at Week 12. The total number of minutes walked for Leisure increased from 545 minutes at Week 1 to 1225 minutes at Week 12. It should be noted that the Week 12 physical activity results were skewed by COVID-19 (see participant feedback in Section 4.9).

At Week 1, 88% (n=15) of the evaluation participants said they would like to walk more. At Week 12, 89% (n=8) of the evaluation participants still said they would like to walk more. As the findings show the evaluation participants are walking more for leisure at Week 12, but less for active travel, means the responses to this question may have been skewed by COVID-19 (see section 4.9).

The reasons preventing walking amongst the evaluation participants at Weeks 1 and 12 are shown in Figure 19. One (or more) reason preventing walking was provided by every participant in the Week 1 cohort (n=17/100%) and Week 12 cohort (n=9/100%).

The findings suggest that the reasons preventing walking either remained static or reduced in frequency from Week 1 to Week 12. The total number of reasons preventing walking reduced from 32 at Week 1 to 18 at Week 12; however, it should be noted that the Week 12 cohort represents just 53% of the Week 1 (baseline) cohort.

The biggest change related to the evaluation participants having ‘No-one to walk with’, which fell from five responses at Week 1 to zero responses at Week 12. It should be noted, however, that in the early stage of the COVID-19 pandemic, the UK Government prohibited unnecessary contact with people from other households. Therefore, COVID-19 may have influenced the results for ‘No-one to walk with’, as this potential barrier to walking may no longer have been a choice for some evaluation participants (note: to enable further exploration, it would have been useful if the demographic data had captured if the evaluation participants lived alone).

There are six *Other* responses in Figure 19, with four at Week 1: Prefer to cycle (n=1), Not sure (n=1), Nothing (n=1), and Caring responsibilities (n=1); and two at Week 12: Post-thrombotic syndrome (n=1) and Coronavirus ‘lockdown’ (n=1).

It is positive to see that ‘Traffic’ was not stated by any participants at Weeks 1 or 12 as being a barrier to walking.

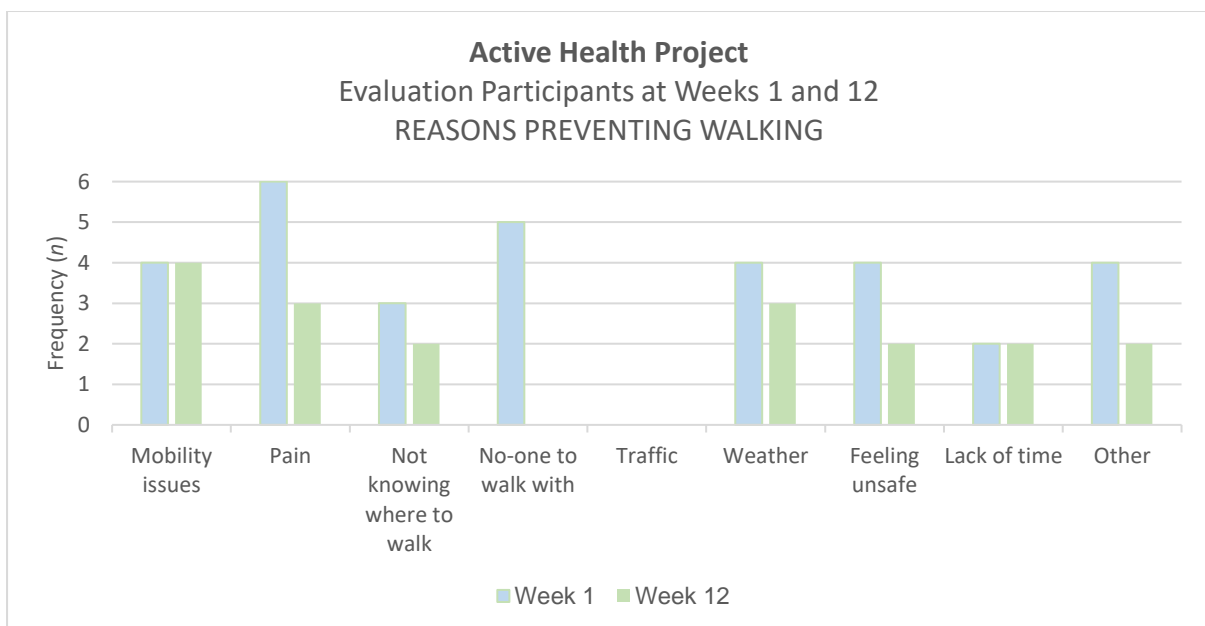


Figure 19: Evaluation participants - reasons preventing walking (weeks 1 and 12)

4.6 Cycling

To investigate cycling level (active travel/leisure), the participants were first asked: ***Are you interested in cycling?***

The participants were then asked: ***How often do you ride a bicycle?*** and ***How much effort do you put in on average?*** during the last two months.

With regards to ***How often do you ride a bicycle?*** the participants were asked to select any relevant purposes from: Visiting family and friends; Commuting to work; As part of my work; Travelling to education/meetings/appointments; Going to the shops; For fun, leisure or to walk your dog; For health/fitness. And to select one frequency per selected cycling purpose, from: 5 or more times/week; 3-4 times/week; 1-2 times/week; 2-3 times/month; once a month or less; Never.

With regards to ***How much effort do you put in on average?*** the participants were asked to select the effort they put into each cycling purpose from one of two options: Taking it easy; Trying hard.

The participants were asked: ***On average how many minutes do you spend cycling each week to get somewhere (e.g. shops/work/meetings)?*** and ***On average how many minutes do you spend cycling each week for pleasure or leisure?***

The participants were then asked: ***Tell us about what prevents you from cycling?***

With regards to ***Tell us about what prevents you from cycling?*** the participants were asked to select any relevant reasons from: Mobility issues; Pain; Not knowing where to cycle; No-one to cycle with; Traffic; Weather; Lack of time; I don't feel safe when cycling; I don't feel confident when cycling; I don't have a bike; My bike is broken; I can't ride/haven't ridden for ages; Other.

The initial cycling question asked if participants were interested in cycling, to which 47% (n=8) and 67% (n=6) of the evaluation participants answered 'Yes' at Weeks 1 and 12 respectively (note: the Week 1 and Week 12 questionnaires did not ask a similarly-worded question for walking).

The evaluation participants' cycling level at Weeks 1 and 12, is shown by frequency in Figures 20 and 21, by destination in Figures 22 and 23, and by intensity in Figures 24 and 25.

Cycling by frequency (total responses per frequency option)

Week 1: 5 or more times/week (n=0); 3-4 times/week (n=0); 1-2 times/week (n=3); 2-3 times/month (n=1); once a month or less (n=2); Never (n=73).

Week 12: 5 or more times/week (n=0); 3-4 times/week (n=3); 1-2 times/week (n=3); 2-3 times/month (n=4); once a month or less (n=0); Never (n=41).

Cycling by destination (total responses per destination option, including 'Never')

Week 1: Visiting family and friends (n=13); Commuting to work (n=11); As part of my work (n=11); Travelling to education/meetings/ appointments (n=11); Going to the shops (n=11); For fun, leisure or to walk your dog (n=11); For health/fitness (n=11).

Week 12: Visiting family and friends (n=7); Commuting to work (n=7); As part of my work (n=7); Travelling to education/meetings/appointments (n=7); Going to the shops (n=7); For fun, leisure or to walk your dog (n=8); For health/fitness (n=8).

Cycling by intensity (total responses per intensity option) - Week 1: Taking it easy (n=1); Trying hard (n=3). Week 12: Taking it easy (n=1); Trying hard (n=5). Note: The intensity options for the cycling and *Other activities* questions were different to those used in the walking questions.

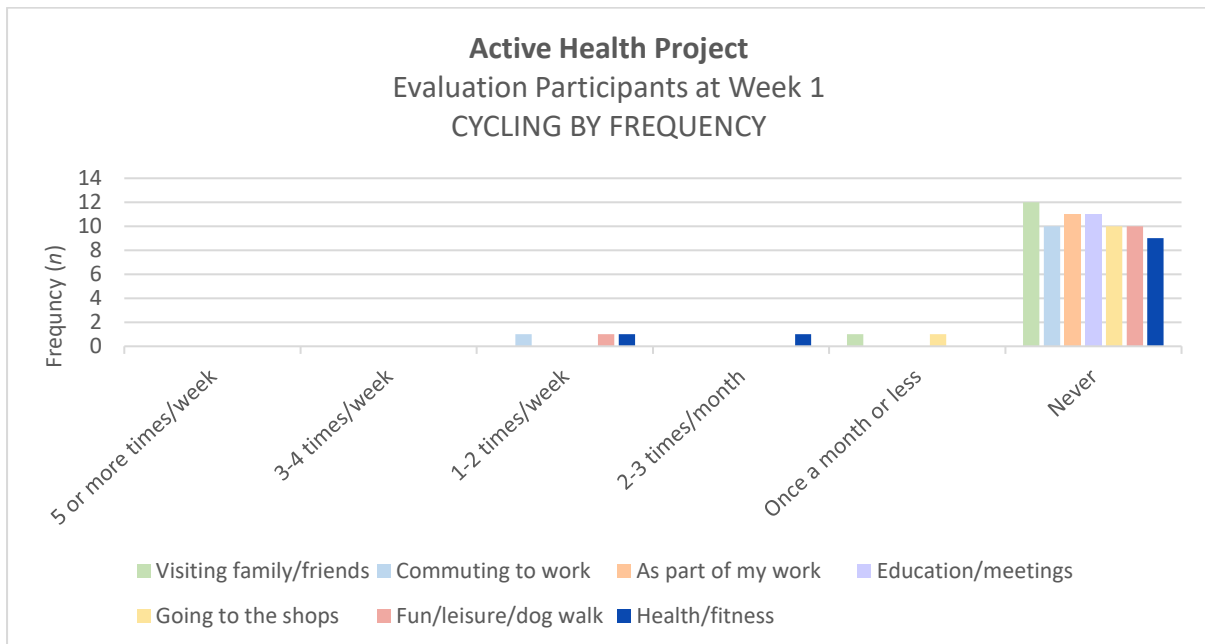


Figure 20: Evaluation participants - cycling by frequency (week 1)

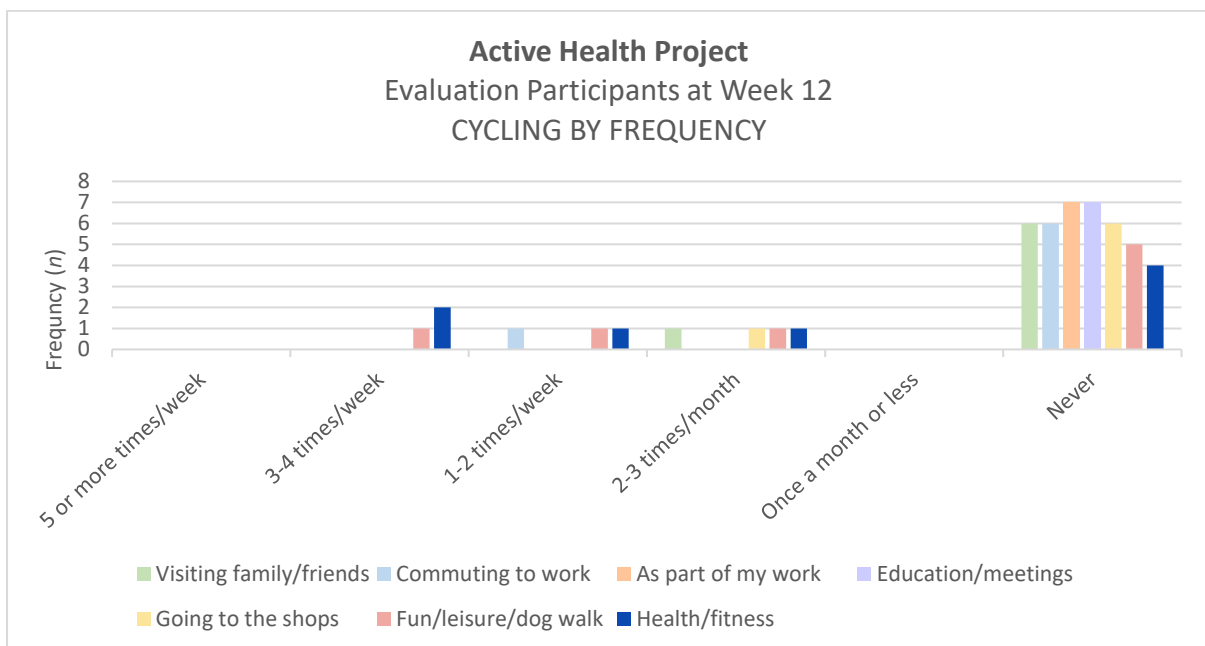


Figure 21: Evaluation participants - cycling by frequency (week 12)

The findings appear to suggest an increase in the evaluation participants' cycling frequency. The responses for cycling by frequency (excluding 'Never') increased from six at Week 1 to ten at Week 12. Plus, there were three fitness and leisure related responses in the '3-4 times/week' category at Week 12, when no such responses existed at Week 1. This suggested increase is however, based on a small amount of data, when compared to the similarly-worded question in the walking section, which received 33 and 26 responses (excluding 'Never') at Weeks 1 and 12 respectively.

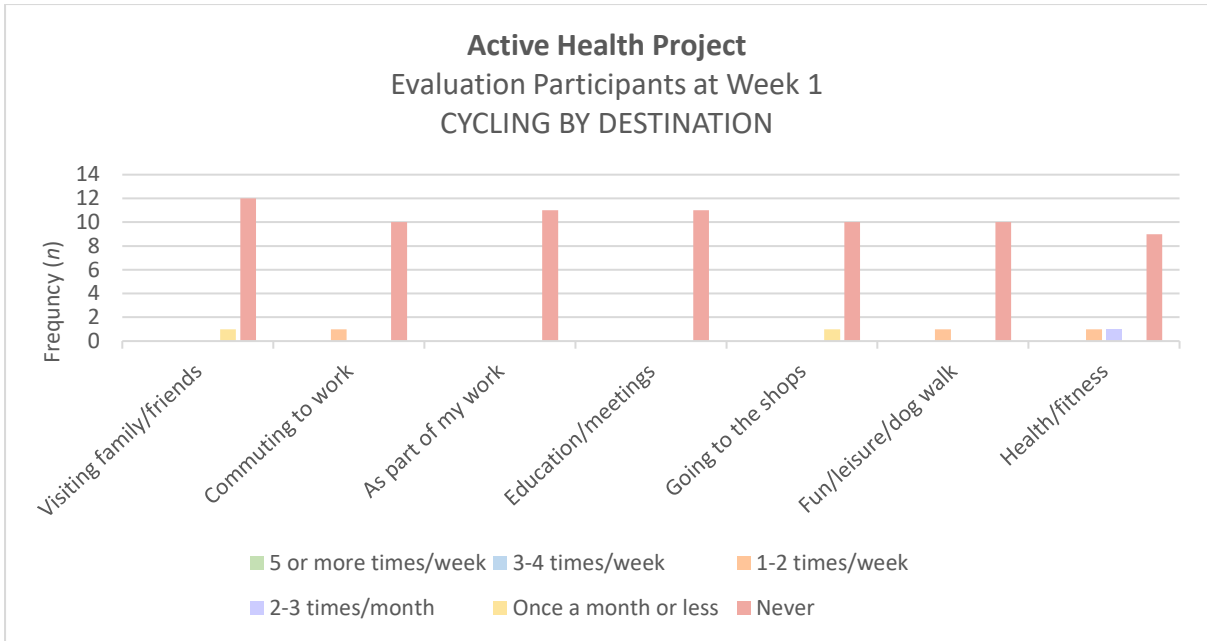


Figure 22: Evaluation participants - cycling by destination (week 1)

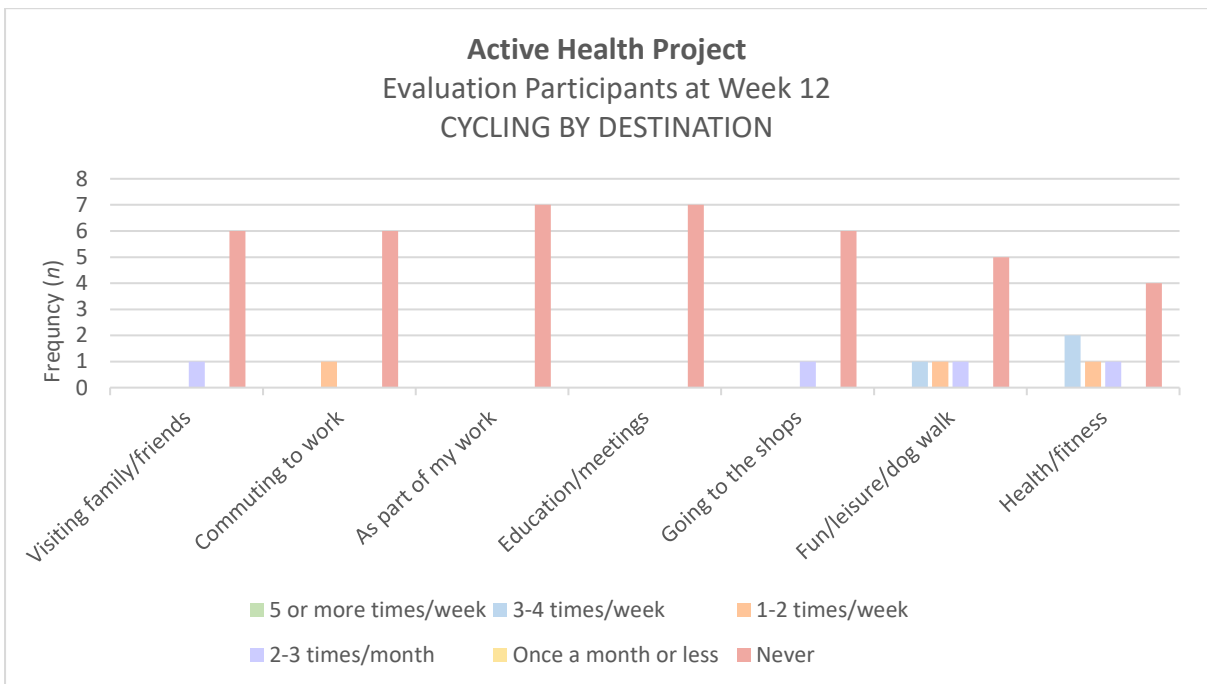


Figure 23: Evaluation participants - cycling by destination (week 12)

The findings indicate that the majority of the evaluation participant' cycling is being done for leisure and fitness purposes, while a small element is being done for active travel, involving shopping, commuting, and visiting family. The overall number of responses for cycling by destination (excluding 'Never') has increased from Week 1 to Week 12; however, it must be noted that the findings relating to cycling by destination are based on a small amount of data, when compared the similarly-worded question in the walking section.

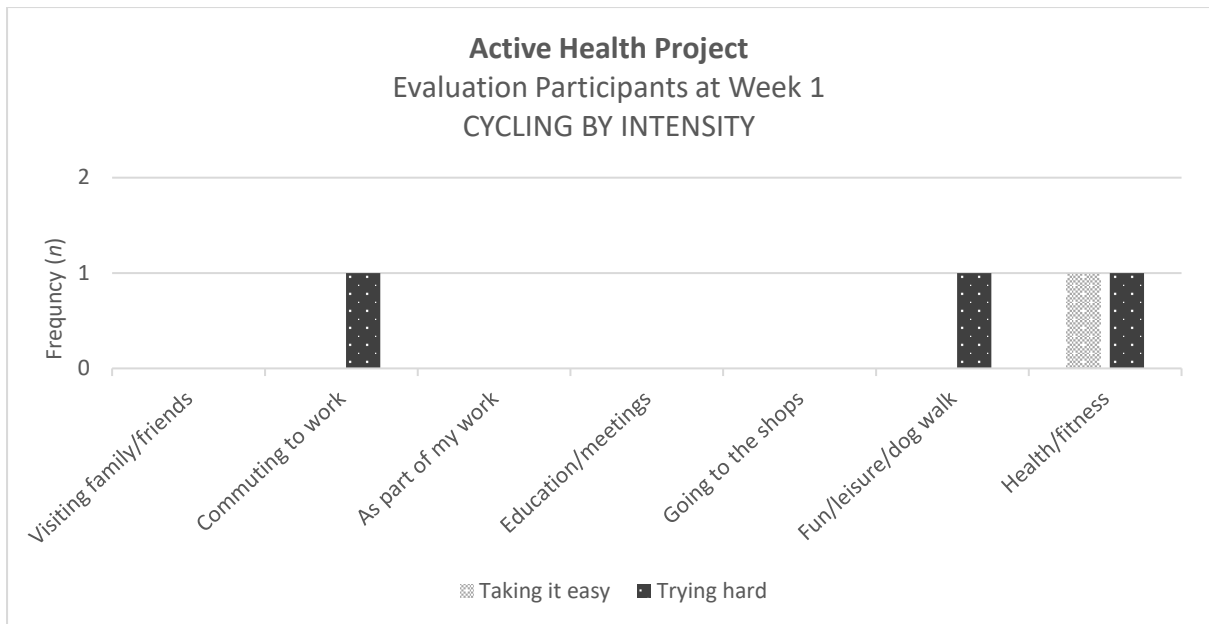


Figure 24: Evaluation participants - cycling by intensity (week 1)

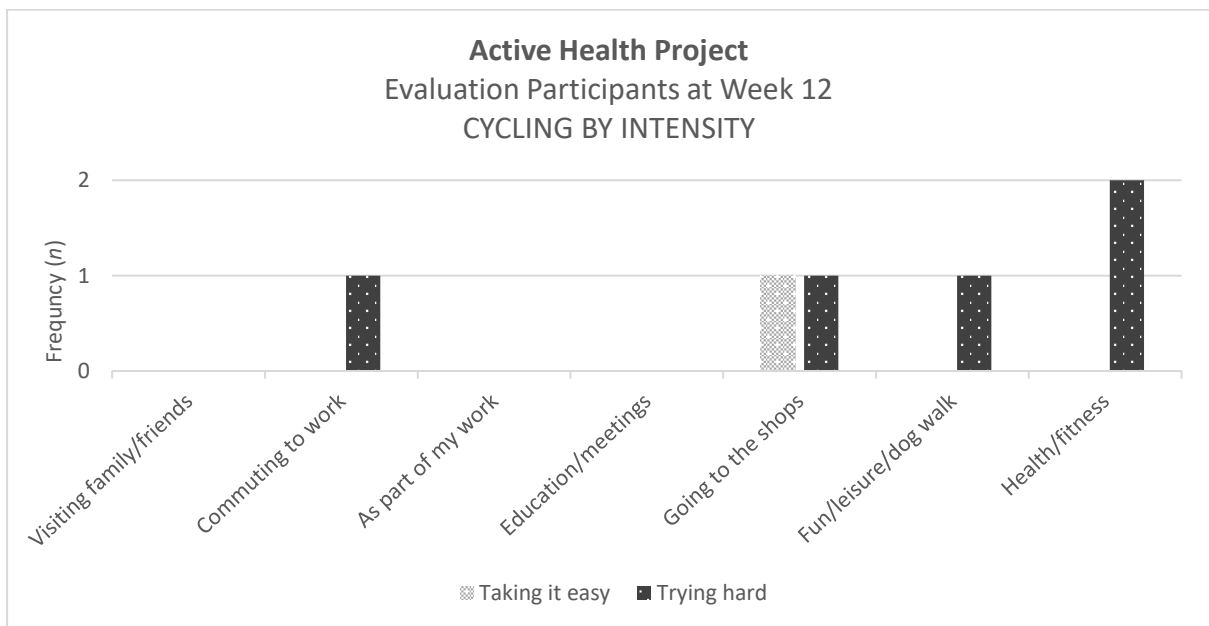


Figure 25: Evaluation participants - cycling by intensity (week 12)

The Week 1 and Week 12 findings for cycling by intensity are fairly similar, with each cohort featuring a low number of responses confined to three destination categories at Week 1 and four destination categories at Week 12. The majority of the evaluation participants who responded to this question at Weeks 1 and 12, stated they were 'Trying hard' when cycling.

The average minutes spent cycling each week to get somewhere (active travel) or for leisure/pleasure at Weeks 1 and 12 is shown in Figure 26. This figure is based on valid responses ranging from zero upwards; blank responses to the associated question at Weeks 1 and 12 were not assumed to indicate zero minutes and were thus excluded from this calculation.

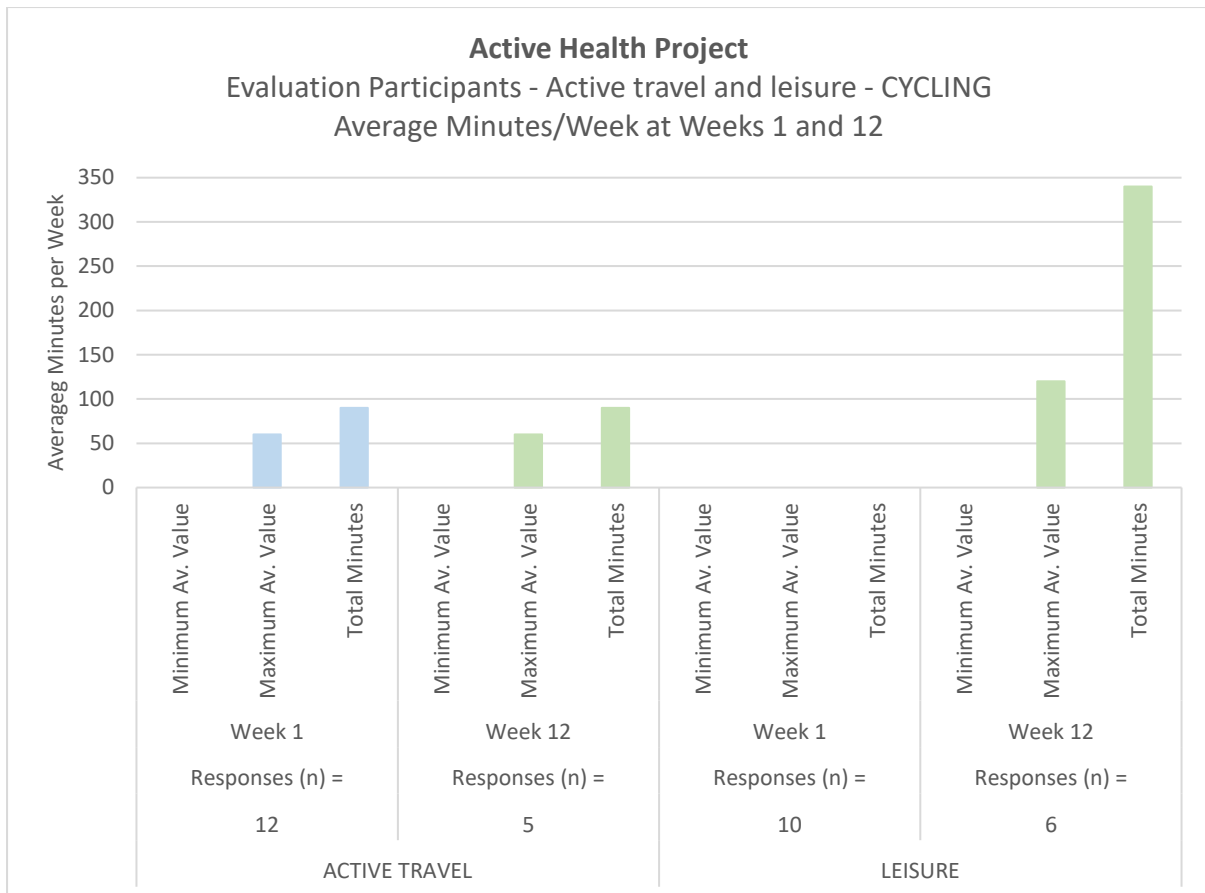


Figure 26: Evaluation participants - cycling - average minutes/week (weeks 1 and 12)

Figure 26 received a reasonably wide-ranging number of valid responses (i.e. a number ranging from zero upwards) to the questions relating to the average number of minutes cycling per week. The question asking about minutes cycled for active travel was answered by 71% of the Week 1 cohort and 56% of the Week 12 cohort. The question asking minutes cycled for Leisure was answered by 59% of the Week 1 cohort and 67% of the Week 12 cohort.

The findings show that the average number of minutes cycled for active travel at Weeks 1 and 12 were identical at a total of 90-minutes. The average number of minutes cycled for Leisure at Weeks 1 and 12, was zero and 340 minutes respectively. It should be noted that the Week 12 physical activity results were skewed by COVID-19 (see participant feedback in Section 4.9).

The evaluation participants were asked at Weeks 1 and 12 if they would like to walk more. It is noted that a similarly-worded question was not asked at either Weeks 1 or 12 in relation to cycling.

The reasons preventing the evaluation participants from cycling are shown for Weeks 1 and 12 in Figure 27. One (or more) reason preventing cycling was provided by almost every participant in the Week 1 cohort (n=16/94%) and Week 12 cohort (n=9/100%).

The findings suggest that many of the reasons preventing cycling reduced from Week 1 to Week 12, for example, lack of confidence, not knowing how to ride, pain, and not knowing where to cycle. The total number of reasons preventing cycling reduced from 39 at Week 1 to 27 at Week 12.

The biggest change related to 'Can't ride/haven't ridden for ages', which reduced from six to one response at Week 12. Other fairly big changes were 'Not knowing where to cycle' and 'Don't feel confident cycling', which both fell by three responses at Week 12. Two reasons for preventing cycling remained static, that of 'Traffic' and 'Bike broken'. Interestingly, 'Lack of time' had zero responses at Week 1, but three responses at Week 12. There are two *Other* responses In Figure 27, which were both at Week 1: May have to carry laptop and files (n=1), and Nothing (n=1).

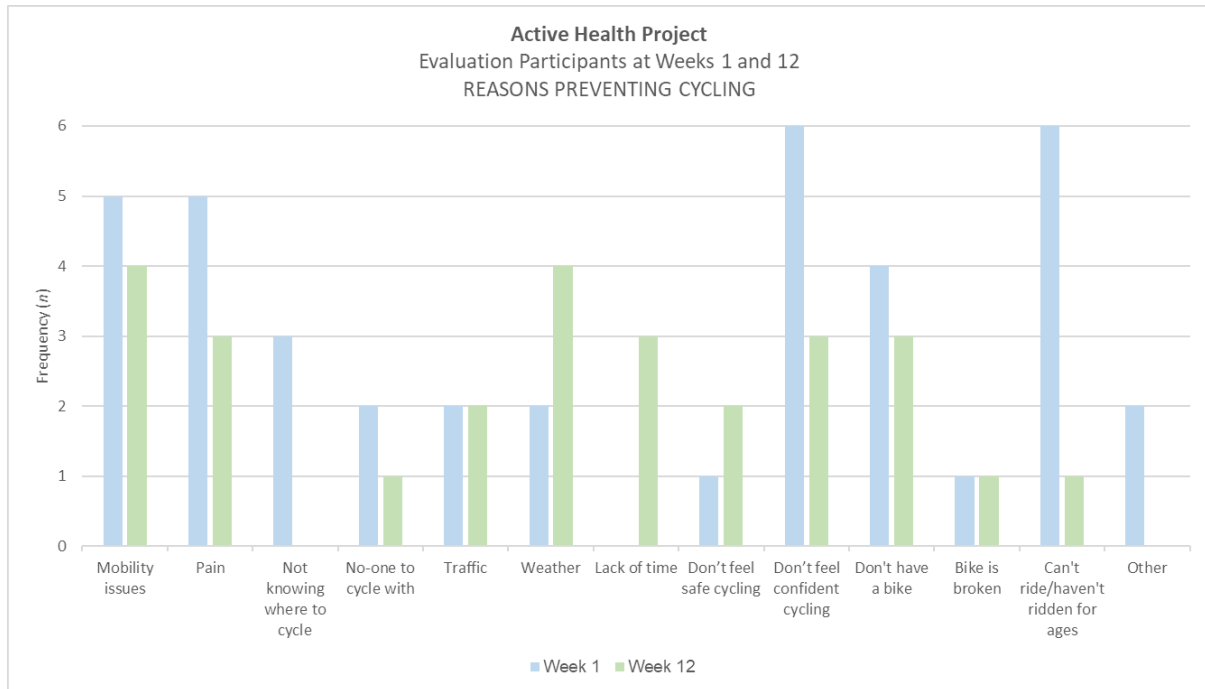


Figure 27: Evaluation participants - reasons preventing cycling (weeks 1 and 12)

4.7 Other activities

To investigate what any other physical activities were being undertaken (active travel/leisure), the participants were asked: ***Do you do any other physical activities?***

With regards to *Do you do any other physical activities?* the participants were asked state what other activities they did using numbering and text, e.g. 1. Swimming, and then to select the frequency for the other physical activities (to a maximum of three) from: 5 or more times/week; 3-4/week; 1-2/week; 2-3/month; once a month or less. And to select the effort they put into the other physical activities (to a maximum of three) from one of two options: Taking it easy; Trying hard.

The participants were also asked **How many minutes on average do you spend each week on other activities?**

It would appear that the *Other Activities* questions were not formatted in an optimum manner, as the two questions (see grey box directly above) resulted in a number of partial or invalid responses.

The responses that this evaluation consider to be of a partial nature, include for example: three participants listed no activities, yet each gave an average number of minutes that they did other activities per week; one participant responded at Week 1 with activity type and frequency, plus average minutes spent on other activities per week, while at Week 12, they gave the activity type and frequency, but no details of average minutes on other activities per week.

The responses that this evaluation consider to be invalid, include for example: one participant gave a frequency, but no activity; one participant responded with a number but no accompanying text to indicate what activity had been carried out.

Responses considered invalid were removed from UHI's dataset, while responses of a partial nature were retained. The results from the *Other activities* questions (presented below) are provided with the caveat that they probably do not give an accurate picture of the cohort and should not be used to draw conclusions about the other activities undertaken by the evaluation participants.

At Week 1: Four evaluation participants said they were doing other activities: swimming, Otago, and aquarobics - all at 1-2 times/week; and housekeeping - no frequency given. The swimming intensity was given as trying hard (note: the intensity options for the *Other activities* and cycling questions were different to those used in the walking questions). The minutes per week for *other activities* at Week 1 for five evaluation participants ranged from 45-120 minutes, with an average of 93 minutes.

At Week 12: Five evaluation participants said they were doing other activities, with two participants doing two other activities each, which were: Mr Motivator – for seniors and chair yoga (5 or more times/week); swimming, Otago, and gardening (all at 1-2 times/week); gardening (2-3 times/month); and hiking (once a month or less). The intensity given for all of the activities, except gardening, was trying hard; no intensity was given for the gardening being done 1-2 times/week, while the gardening being done 2-3 times/month was carried out taking it easy. The minutes per week for other activities at Week 12 for five evaluation participants (note: this is not the same five people who listed activities) ranged from 20-90 minutes, with an average of 52 minutes.

This evaluation recommends that the *Other activities* questions are redesigned prior to future use by the Active Health project.

4.8 Wellbeing

To investigate wellbeing, the participants were asked to select a response (None of the time; Rarely; Some of the time; Often; All of the time) to seven statements in the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS): *I've been feeling optimistic about the future; I've been feeling useful; I've been feeling relaxed; I've been dealing with problems well; I've been thinking clearly; I've been feeling close to other people; I've been able to make up my own mind about things.*

The evaluation participants' SWEMWBS scores at Weeks 1 and 12 are shown in Figures 28 and 29 respectively. At Week 12, there is an increased proportion of 'All of the time' and 'Often' responses, and a reduction in 'Some of the time' and 'Rarely' responses. The statement *I've been able to make up my own mind about things* receives only 'All of the time' or 'Often' responses at Week 12. The 'None of the time' response is not selected at Week 1 or 12. Note: SWEMWBS is validated for use with persons aged 13 to 74 (Warwick Medical School, no date). The Week 1 evaluation participants include one person aged over 74, while the Week 12 evaluation participants are aged 74 or under.

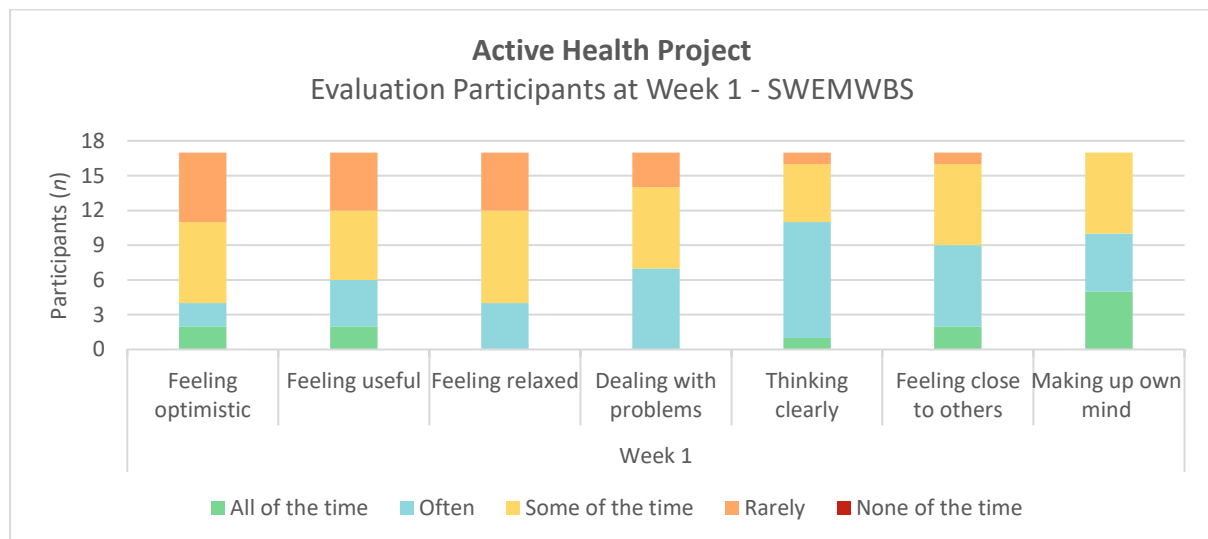


Figure 28: Evaluation participants - SWEMWBS (week 1)

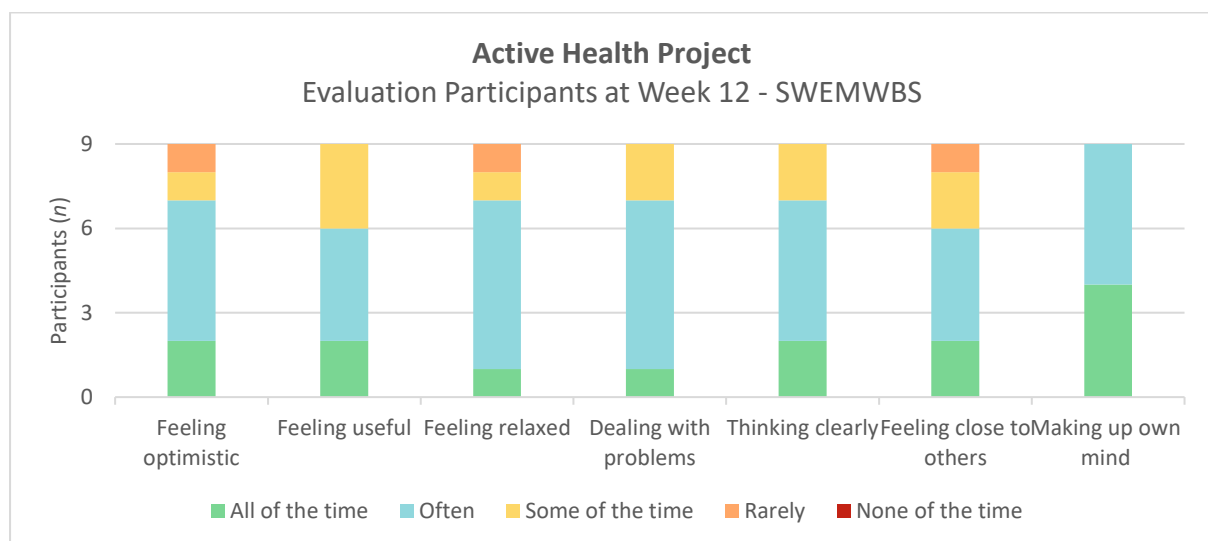


Figure 29: Evaluation participants - SWEMWBS (week 12)

4.9 Feedback

To gather feedback on the Active Health project, with the aim of improving the project for future participants, the completing participants were asked as part of the Week 12 questionnaire to provide feedback (positive or negative) in response to the following questions:

Have you been more active over the last 12 weeks than you were before starting the project?

Has it helped in any other, maybe unexpected ways (regardless of whether you have increased your activity levels or not)?

Would you recommend Active Health sessions to others?

Is there anything we can do to improve the service or that you would like to comment on?

UHI received Week 12 Google Forms questionnaire data and, thus also feedback, from nine (53%) of the 17 evaluation participants. Of these completing evaluation participants, eight (89%) said they had been more active over the last 12 weeks than they had been prior to starting the Active Health project, i.e. putting more effort into their exercise (n=1); improved stability when exercising (n=1); walking more (n=3); and cycling more (n=1). It should be noted though, that the project duration was often longer than the set 12-week duration (see *Participation duration (completed)* in Section 4.2) and the completing evaluation participants were actually answering this question after an average of 14.5-weeks.

Other ways in which the completing evaluation participants felt that they were helped by the Active Health project are as follows: increased flexibility (n=2); weight loss (n=1); feeling happier (n=1); reduced breathlessness when climbing stairs (n=1); introduction to online activities (n=1); improved positive mental outlook (n=1); improved confidence in relation to talking to others about fitness (n=1); changed attitude to exercise (n=2), and having more energy (n=1).

COVID-19 was cited by four of the completing evaluation participants as influencing their project outcome. Three participants appear to attribute their increased physical activity to COVID-19, while one participant appears to blame their lack of increase in physical activity on COVID-19.

Nine (100%) of the completing evaluation participants said they would recommend Active Health sessions to others. Three of the completing evaluation participants said the Link Worker meetings were helpful; one Link Worker in particular was complimented on being inspiring, supportive, encouraging, and understanding. The Florence text messaging service was mentioned by one completing evaluation participant as helping with motivation. Only one suggestion was given in response to improving the Active Health project, which was to have a 6-month follow up post-completion to see if the Active Health project was still benefiting former participants.

5. Evaluation – Qualitative Findings

5.1 Participants

5.1.1 Introduction

The majority of interviewees were referred to the Link Workers by a healthcare professional, mostly their GP, while only two had self-referred. The reason for referral was to increase their physical activity levels but it was their choice whether to follow through with the programme. The need for support to help keep themselves motivated was identified by interviewees as a factor in signing up to the programme. It was described by one interviewee as a “*boot up the backside to get me started*” and “*a bit of a reality check about the impact of not addressing the elephant in the room*” (P10)³. Although participants did not generally know what to expect from the programme, other than hoping they would become more active as a result of participation, most had no worries about taking part. Concern had been felt by one interviewee because of his perceived track record, his “*frustrating habit*” of not engaging and committing properly and the perception that he was “*notoriously bad for making excuses for not making commitments*” (P10).

On the whole, interviewees attended all the sessions required and were satisfied that the number of sessions had been sufficient. However, they were offered further contact in the form of a check-in after completing the 12-week programme and this support was appreciated where taken up. Descriptions of the first consultation with a Link Worker were very positive and the meetings were characterised by their informality and relaxed conversational style. It took the form of an “*easy flowing*” conversation (P8). The Link Workers were described variously as ‘open’, ‘approachable’ and ‘friendly’. Recalling that he had felt nervous, a participant described how the Link Worker talked him through the process and put his mind at rest, making it clear there was “*no right or wrong*”:

“I can do what I want to do exercise-wise and build myself up ... [she] talked me through some of the exercises that I could do and set out some goals of things that I wanted to do and just set some targets” (P9).

‘Feeling at ease’ and being able to talk ‘openly’ were commonly reported:

“She just spoke to me like I was a normal human being ... She made me feel like relaxed and at ease ... like just speaking to a friend ... There was nothing like looking down at me, as if to say ‘look at the size of you, you should be fitter’ ... she made me feel at ease and just spoke to me about what would I like, what would I interested in, what would I like to do ...” (P5).

Most of the interviewees said they had been more physically active in the past but were now dealing with weight gain, injuries and/or long-term health conditions like diabetes. During the first consultation the Link Worker and participants discussed what kind of activities they wanted to do. All interviewees raised increasing the amount of walking they were already doing. Walking targets were set during these conversations with the participants, if helpful, and included walking to the local shop, walking laps ‘round the block’, step counting, or taking grandchildren to school. Other activities covered were cycling, joining an exercise class, yoga, meditation/mindfulness, and dancing.

³ Numbers in brackets refer to the identification number of the interviewee quoted. ‘P’ indicates project participant (n=8) and ‘S’ refers to project staff interviewees (n=3).

The Link Worker had a list of mobilisation exercises to give out as appropriate that could be done at home. One interviewee (P5) starting walking up and down the stairs, instead of sitting down watching TV, or if she could not get out for a walk in the evening. She said she had gym equipment at home that she hung clothes on and said the idea of going to the gym with all the “*slim people*” scared her.

Only three interviewees used Florence, an automated text messaging service that sends reminders and support to patients. This series of messages or ‘protocol’ is designed to support individuals in the self-management of their health. Florence was introduced for Active Health participants at a later stage in the project so not all of the interviewees had access to it and one interviewee did not have a smart phone so could not make use of it. For one interviewee it was very helpful as it ‘spurred her on’, telling her not to let it get her down, that she had done well so far, and did not make her feel like a failure. One night she had not gone out walking because it was raining and she could not be bothered. Receiving the Florence text the following day, she thought she should have done it and went out for longer walk that evening, feeling “*somebody’s trying to help me here and you’re not helping yourself. If you can’t help yourself, why should anybody else sort of help you?*” (P5).

However, the other two interviewees did not find Florence as constructive. According to one, he had not fully engaged with because it was an “*automated, inhuman type entity*” (P10). Although he thought it was a useful tool to tap into, he did not feel so committed because it was not a person. The text messages sent by the Link Worker after he had taken part in a sporting event, was more effective. For him it was about accountability and making the commitment to a professional, which meant it was “*more difficult to hide*” (P10). Similarly, another liked being reminded of what he had and had not done, but did not find the automated “*stock answers*” helpful (P8).

5.1.2 Impact on physical activity

All but one interviewee reported that their physical activity level had increased. This particular participant had not been able to benefit from the programme at all due to a change in personal circumstances, which had meant an increase in caring responsibilities preventing her taking up the opportunities. She remained hopeful of being able to join in the planned activities at a later date. Generally, interviewees reported the positive impact variously as follows:

- Increased physical activity – e.g. more walking, cycling, mobilisation exercises, gardening, going to gym (prior to ‘lockdown’)
- Feeling more comfortable at their activity level
- Finding daily activity was normalised
- Going for longer or harder walks
- Feeling a sense of achievement
- Improved self-confidence when being active outside
- Increased knowledge about activity and nutrition
- Acquiring a “*road map*” (P10) for the way ahead to increase activity

Not having a rigid timescale for achieving targets was appreciated. Participants could build up their activity level gradually as it suited them and this helped them feel their goals were within reach.

5.1.3 Impact on mental health and wellbeing

Although most people thought the programme had had a positive effect on their mental wellbeing, views were more mixed on this aspect than on physical activity. After undertaking exercise interviewees experienced a range of positive effects, which they linked to a greater sense of mental wellbeing:

- Feeling more relaxed
- Enjoying being in nature
- Being more mindful
- Feeling a sense of achievement
- Being able to process things
- Feeling more positive

Finding the effect difficult to describe, an interviewee said she felt “*not so slobbish*” (P5) as a result. So far she has managed to keep up some form of exercise and feels if she stops, then she could get back in touch with the Link Worker to tell them she is struggling (P5). The Link Worker had made it clear that she could get back in touch if she needed someone to talk to. At first, she had been going up and down the stairs three times, and at the bottom of the stairs she was like a “*burst balloon*”, but now she is able to manage ten times. As a result of this increase, she feels “*chuffed to bits*” and describes the effect of her achievement:

“Wow, I’ve gone from three to ten. When I walk the dogs, when we go up into the woods there’s a wee hill and by the time I get up to it, I’m normally on my knees. Of lately I’ve been able to get to the top of them, like yeah, look at me, look at me go ... Once I’ve done it, I’m like wow, I do feel like I can achieve this and ... I’ve gone from ‘Och, I’ll never get this done, I’ll never be able to do that’, to like ‘yeah you can. If you can try, you can do it’.” (P5)

Another found the exercise from his gardening and cycling had “*eased the sitting in a room at home with only skype contact with colleagues*” (P8). He was convinced that cycling is excellent for his mental health, enabling him to feel he has achieved something and felt “*almost at one with nature*” (8). Two interviewees found it had no perceptible effect on their mental wellbeing because either they felt positive already (P4) or because there was still “*a long way to go*” (P10):

“It’s a start but I don’t think it addresses it all like a magic wand.” (P10)

5.1.4 Impact on active travel

The programme had relatively little impact on active travel which was generally not a priority or a particular motivation for these interviewees. Two interviewees reported either walking to work (P10) or to the shop (P6) rather than driving, while another said he had been cycling to work but did not distinguish between the goals for health and active travel (P8).

5.1.5 What is different about this intervention?

Interviewees thought it was a good and appropriate scheme to increase physical activity, although individual motivation and effort were also key to success, so it would not work for everyone and “*you’ve got to put in to get out*” (P4). In comparison to seeing a GP, the length of time spent with a Link Worker was identified as an important difference. GP appointments tend to be much shorter at

10-15 minutes but the first consultation with the Link Worker was up to 60 minutes and allowed time for discussion about aims and barriers, as well as options for increasing physical activity. According to the interview data, it enabled people to understand the reasons for their attitudes to activity and barriers to achieving goals. One person (P10) found it more empathetic, not that he thought healthcare professionals were not empathetic, but the extra time encouraged this feeling which is difficult to generate in a 10-minute consultation. Similarly, another (P11) characterised it as more personal because the Link Worker had the chance to get to know you quite well.

Accountability was another key element with contact with the Link Worker over 12 weeks helping to keep participants focussed and feeling they had to report back on progress. However, this was generally seen as being encouraged rather than pushed. There was also a perception that the plan for activities and targets was tailor-made according to individual abilities and aspirations rather than handing out the generic health advice often given out by healthcare professionals. Being treated as an individual was an extremely important element. Seeing the GP could be an intimidating, stressful and scary experience whereas the Link Workers engendered an atmosphere perceived as more relaxed, caring and non-judgemental. According to one person going to the GP is more stressful as she is *"not a big fan of doctors"* (P3). Another felt that with the specific role of the Link Worker gives the consultation a dedicated purpose, thereby legitimising their conversation, whereas you might feel *"silly"* talking to the GP about physical activity or think you are wasting their time (P6). If it is the GP, then you are more likely to think it is written in *"black and white"* and more regimental (P9), even if they are saying the same thing as the Link Worker:

"The Link Worker is more approachable ... compared to a doctor. The doctor's got more stature around him. You are more scared of a doctor than you are of a Link Worker" (P9).

He adds:

"If it comes from a doctor then you think well there's underlying reasons why he's wanting you to go and do this, that or the other ... if it comes from a Link Worker, you are a bit more relaxed and probably at ease" (P9).

Several interviewees thought seeing the Link Worker had helped them with self-motivation:

"It was good to have someone to kind of motivate me. And like she was so positive about what I was doing that it made me feel like I could do more" (P3).

Having this support was an important factor:

"I've tried it before but like when it's just me trying then I feel like I kinda give up. It doesn't feel like I am being accountable for it" (P3).

Previously a participant had felt pushed by a healthcare professional into something he did not want to do (P4). Not feeling as if she were being judged or singled out because of her weight or condition was important for another interviewee, who came to realise that she could still exercise even if she was overweight (P5).

5.1.6 Factors for success

All the interviewees were very positive about the programme and said they would recommend it to others. However, one interviewee (P10) did qualify this by adding that it was *"horses for courses"*

and it would not suit everyone, but he would recommend it to those in similar circumstances. Generally, interviewees had confidence in the Link Workers, finding them knowledgeable and reliable when getting back to them about activities. They gave one person what he described as an “*unbelievable level of support*” (P10). Specific factors cited for the perceived success of the project were as follows:

- Discussion – the opportunity to talk through what you want out of an activity and the range of options available, having someone to speak to and bounce ideas off.
- Reflection – opportunity to reflect on possible barriers to achieving their goals, to remove and/or manage them and to think about a strategy to help them meet goals.
- Conversational style that was informal and relaxed, enabling people to feel at ease and comfortable allowing them to talk freely.
- Approach of Link Workers – described as approachable, friendly, encouraging and not condescending.
- Link Workers were supportive and contactable, “*at the end of an email*” if needed (P6).
- Non-judgemental.
- Link Workers’ good communication skills – open, friendly and good at listening.
- Type of activities – picking an activity they would enjoy and would work for them.
- Accountability – challenged and made accountable for activity levels.
- No pressure – the targets were not “*regimental*” (P9) and people could choose to do as much or as little as they wanted.
- Realistic goals – the Link Workers understood individual capabilities and goals were realistic.
- Motivation – helped participants to feel and keep motivated.
- Facebook page – three interviewees liked and followed it.
- Flexibility – could change appointment times.

The lack of pressure and the fact recommendations were tailor-made were particularly appreciated:

“I knew that there was nobody going to be pushing me into anything or doing anything ... at my own pace if I was wanting to do it, it was at my own pace ... She didn’t put any pressure on me, saying ‘Right you’re here today, you have to do this’. There was no pressure. It was just simple. Look ____, if you’re interested ... you could try this or you could try this ... There was no pressure at all ... it was somebody just interested in wanting to help me out a bit and do something” (P5).

A previous GP had made her feel under pressure and she had not liked him in the end. Although goals were set together through discussion and without pressure, there was still a sense of ‘accountability’, which was also an extremely important factor. This sense of having to account for what they had done in combination with the perception of realistic goals, was an important element in maintaining motivation and making a commitment. It is “*easy to be passive*” (P8) in the view of one interviewee.

5.1.7 Barriers

Few major barriers to participation in the programme were reported. One interviewee encountered significant problems accessing particular activities/classes because of incompatibility with working

hours (P6) and another was unable to participate at all due to caring responsibilities (P11). Generally, problems due to lack of self-motivation, lack of energy and/or poor mental health were identified. Views diverged on the sustainability of chosen activities with a degree of uncertainty evident about the future. For example, one interviewee thought it would be useful to have more sessions over a longer term and that 12 weeks was not enough to set up a routine (P3). Another thought there would be a benefit to continuing sessions in order to hold him to account (P10), which he had found helpful. Having lost and regained weight in the past, an interviewee expressed concerned about sustaining the progress she had made (P5). The implementation of 'lockdown' measures had disrupted some targets like walking or cycling to workplaces or attending classes at leisure centres. For one interviewee, 'lockdown' had meant that the activity goals had not been his primary focus, which was necessary to be effective, and he would need to address this after 'lockdown' (P10).

5.1.8 Improvements

Few improvements were suggested. The location was mentioned with one person (P10) who described not having a dedicated consultation space and moving around the surgery *"like encroaching on facilities"*. He thought having a base or a *"hybrid"* wellbeing facility would be an improvement and a *"good investment for the health service"* (P10) which would produce tangible results. Possibly located within the UHI campus, it would provide a space where the programme could be a full-time activity and offer people a consistent time and place. A different person also identified the location as potentially problematic because the setting could be off putting for some people (P11).

Developing the scheme by enabling groups of similar individuals similar in activity levels to get together was suggested (P10) as a way of supporting people to go forward. A similar suggestion was made for *"a club for fat people to do an exercise class"*:

"You know everyone is in the same boat and you're all sort of together ... You know no one's going to be looking at you because they're in the same boat as you" (P5).

An extra text message mid-week was suggested for Florence (P5). Improving the marketing, e.g. through a campaign via the radio or specialist clubs to increase awareness of the scheme, was also put forward (P8). Making the programme longer than 12 weeks was also proposed to help embed a new active routine (P3).

5.2 Staff

5.2.1 Introduction

For the Link Workers, the project aim was to support people to become more active in recognition that a lack of self-motivation and lack of knowledge of local resources are barriers to increasing exercise levels. There is a perception that activity is hard work and that you need to be *"lycra-clad"* according to one interviewee (S7). The project was designed to be more 'person centred' in order to successfully engage people in increasing their activity levels in everyday life in a way acknowledged as realistic. Some people feel *"excluded"* from being active and think there is nothing out for them (S2). Their role was to help people identify and overcome their barriers, examine their motivations and look at their expectations. Following discussion, they could then suggest opportunities in their local area or discuss things they could do themselves near or at home. They found activities that would work for each individual, linked them up with appropriate resources and helped to keep

people motivated and on track. Through the use of motivational interviewing, the Link Worker could build up a relationship with the participant, enabling them to discuss their thinking on exercise, challenges and how activity fits into their lives. The Link Worker aimed to identify a strategy which would be feasible and sustainable for that individual. They had relevant backgrounds in personal training, exercise, wellbeing interventions, advice work or life coaching. All the Link Workers were satisfied with the level and range of training they had received in preparation for the work, namely, motivational interviewing, Decider Skills, Distress Brief intervention (Support in Mind) and Well Now (NHS). In addition, they felt well-supported in their role. However, the availability of key project leaders due to time constraints had been an issue, particularly in the early stage of setting up the programme in the first surgery.

5.2.2 Referral process

Initially the healthcare professional would email the Link Worker with basic information, such as the patient's name and contact details, but the project introduced a referral form involving signed patient consent to improve data protection processes. A reason for referral would not always be given. But, on the whole, this was not always deemed necessary by the Link Workers because of the initial one-hour consultation which allowed them to get background information from the patient. According to one, they could then stay open-minded. Patients could also have their own reasons for signing up which might differ from that of the healthcare professional. It was accepted that GPs did not have much time during a consultation to introduce the project or to process referral forms. Although they do not get much information from the form, they are reliant on the GP or other healthcare professional referral as the safeguard to ensure the patient is capable of increasing physical activity. The Link Workers do not have access to patient records and they are not medically trained. Their advice is reliant on what the patient says they are capable of doing. They are guided by what the person wants to do and knowing their own limits.

5.2.3 Programme stages

During the initial stage of the programme, the duration of the first consultation was increased from half-an-hour to one-hour and the Week 4 review from 15-minutes to 30-minutes. This had an impact on the number of patients they could meet but allowed participants more time to tell their story and give background information. The original design had envisaged half-an-hour for the first consultation and 15-minutes for the review in six-hour blocks. It aimed to reach 500 people. The timing of the review was changed from Week 4 to Week 2/3 in order to ensure that the participants were clear about what they were trying to achieve and to support them at an earlier stage. According to one interviewee the big gap in contact from week 3 to week 12 sometimes lost participants although Florence, introduced at a later stage, helped support certain individuals. Some wanted another opportunity to check in after completing the 12 weeks, which was recognised as a relatively short time to establish a regular routine of activities. If the participant believed the gap was too long, the Link Worker agreed to check in with them, but this was not formalised. If not requested, then they would "*leave the ball in their court*" (S7).

5.2.4 Type of activities

Although the type of activities discussed varied (e.g. dancing, basketball, golf, martial arts, exercise classes, cycling, running) according to people's interest, most people were interested in walking, often on their own rather than in an organised group, which was easy and open to most people.

Common goals included step counting, counting climbing up and down the stairs, parking the car further from the shop. For some the mobilisation exercises were enough to do at home. The Link Workers and participants did not necessarily set distance or duration targets for activities but aimed to engage in activities in the way they wanted. They did not act as personal trainers setting a detailed routine and monitoring progress. As one said, the aim was to get participants to do something they enjoyed and to know they were engaging with it, in the hope that this would be a catalyst for further activity.

5.2.5 Impact

On the whole the Link Workers thought participants had increased their level of physical activity as a result of the programme. Even if progress appeared to be relatively modest, this could still have a positive effect. For example, being able to join in with things like playing with grandchildren or noticing that their breathing had improved were valued improvements. The Link Workers also thought that the programme had a positive impact on people's mental health and wellbeing. According to one Link Worker (S2), people enjoy having time to speak to them and chat through their issues. It can be both important, helpful and support mental wellbeing, even if not a lot has obviously changed. Changing an individual's state of mind was identified as a key element (S1). As found with participant interviewees, the Link Workers themselves did not think active travel had been a main motivation for participants. In terms of longer-term sustainability, the Link Workers believed some had built this change their lives, whereas others would have fallen by the wayside and "drift into not doing things" (S2). With the award of a second year of funding, they are able to leave an "open door" (S2) so people can get back in touch.

5.2.6 Factors for success

Factors explaining the perceived success of the project were identified by the Link Workers as follows:

- Person-centred – the Link Worker starts at whatever stage the participant is when they start the programme. The Link Worker does not tell people what they have to do or what they think is best for them but focuses on what the participant themselves feels is the best way forward. In the past they have been given advice and they know what to do, but they do not do it. Usually they are not asked why they do not engage or why it is difficult (S7). The Link Workers believe it is important people understand their own challenges and motivations. They are able to link each person with activities so that it is "uniquely individual" (S2).
- Team-working – the project team works well together (S2).
- Partnership with NHS – gives credibility (S2).
- Good relationship between the project team and the surgery – very important and a real strength.
- Referrals by healthcare professionals – this identifies people who could benefit therefore it is not random, already "a seed within there" (S2).
- Local knowledge – they know what is available and how to find out relevant information.
- Participant engagement – when someone engaged fully, it was successful (S1).
- One-hour consultation – the increase to one hour was successful because time was required to talk about barriers and to allow people to explore the reasons and verbalise them (S1).

- Leadership – the programme benefited from the “*passion and drive*” (S1) of the people leading the project and their belief in it.
- Discussion – having the opportunity to think and discuss why they are committing facilitates a change of mind set (S7).
- Review – an important stage to discuss what has been positive and difficult. After changing from 4 to 2/3 weeks, they did not lose as many people. Participants have the opportunity to really think about it and reflect on why they have not changed, what gets in the way and what underlies it all. It is holistic and touches on things that have been a feature in their lives (S7).
- Based in GP surgery – being in the surgery and being able to drop into staff coffee breaks “*felt like a meeting*” (S7) and provided valuable contact with GPs, keeping the Link Workers visible.
- Introduction of Florence (S7) – generally seen as positive.
- Relationships with other organisations – need to keep up valuable relationships.

5.2.7 Barriers

Barriers identified included pain, mobility problems e.g. walking with aids, fear of not being able to get home or managing a walk/other activity. Since ‘lockdown’, referrals had dropped as people were not going to the surgery for normal routine issues. There had been a mixed response to the adoption of ‘Near Me’ video consultations. The technology had been relatively easy to use but existing participants were unable to use it or did not want to use it. However, they found new people were happier to use it, as this was ‘normalised’ under these circumstances. Some dropped away with ‘lockdown’ and did not respond. However, the Link Workers are able to respond to challenges of ‘lockdown’ and still able to offer a service (S2).

5.2.8 Improvements

Several changes had been made to the programme, but further problems were identified, and adaptations were suggested by the Link Workers as follows:

- Introducing a 6-month follow up.
- Increasing working hours – although the original design had taken into account the session time and some administration, promoting the project with medical staff had not been included (S1). More time was needed to increase the number of people seen and allow more time to complete administrative tasks.
- Improving data protection processes – there was uncertainty over data protection and GDPR. The Link Workers cannot access NHS systems because they are not NHS staff. They could not use the booking system, which meant more time spent on administration (S1).
- Introducing a feedback mechanism – currently no formal system for feeding back to GPs after referral. They had to get verbal consent from the patients to feedback. It had been decided that GPs would be invited to the project steering group meetings so quarterly findings could be presented, but no GPs came to the last meeting and then ‘lockdown’ was implemented. It would be good to have a more formal feedback mechanism to show the impacts and help increase referrals (S7).

- Changing or varying location – with more funding, they could see if changing the location makes a difference. A non-surgery location would be easier to organise, but the link workers thought this would not necessarily have the same influence with participants. However, changing the location was suggested by some participants.
- Regular space in surgery - getting rooms had been difficult and had slowed the project down. Although they managed eventually to get a regular space in the first surgery, expanding to other surgeries was still a problem (S2).
- Increasing VC meetings – having had to move to VC meetings under new restrictions, they could try offering this in future to reach more areas e.g. remote and rural. It is likely they would offer a “*blended version*” of in-person and video calls in the future.
- Adapting Florence – there were mixed views from participants and more messages could have been helpful.
- Creating a database – having a database with information on potential activities and providers that could be kept up to date would be useful (S1).
- Increasing project promotion - reliance on key GPs ‘spreading the word’ about the programme. It is difficult to find time to promote the scheme among GPs and GPs do not have much time with patients to raise the programme (S7). The link workers did not know why some GPs took longer to refer people while some used the Link workers straight away. They went to meetings to be introduced to staff and promote the project but there was no regular formal contact.
- Reducing paperwork - the Link Workers experienced difficulties in getting all the forms completed by participants. There were many different forms associated with the project, including initial referral form, Week 1 Questionnaires, consent forms (project participation, evaluation, and Florence), the activity plan and diary, as well as patient feedback forms.
- Improving data collection – participants do not always fill out the forms and complete the final week 12 questionnaires. The Link Workers find feedback is given to them in person and this is a problem for reporting (S7).
- Improving sustainability – if funding had been awarded for longer than one year, then GPs might have engaged more readily in it (S1).

6. Conclusion

“Once I’ve done it, I’m like ‘Wow, I do feel like I can achieve this’ and ... I’ve gone from ‘Och, I’ll never get this done, I’ll never be able to do that’, to like ‘Yeah you can. If you can try, you can do it’.” (P5)

Quantitative data analysis suggests that the Active Health programme helped increase the physical activity level of its participants; however, it is not possible to draw clear conclusions about the Active Health programme for the following reasons: firstly, the Week 12 evaluation cohort represents only 53% of the Week 1 (baseline) evaluation cohort; secondly, comparisons were conducted on a cohort-basis only and thus could not identify individual behavioural change; and thirdly, the Week 12 responses included in the evaluation were affected by the COVID-19 pandemic, both seemingly in terms of participant behaviour in relation to physical activity and active travel, and explicitly in terms of participant feedback. Bearing these reasons in mind, the quantitative data appears to suggest a decrease in car usage, an increase in walking for health/fitness, a slight increase in cycling for health/fitness, and a reduction in the reasons preventing walking and cycling; while also suggesting a decrease in walking for active travel and no increase in cycling for active travel. The participants were asked about *Other activities*; however, these questions proved problematic and it was not possible to draw findings from the incomplete quantitative data.

The participant feedback from the Week 12 questionnaire was positive, with participants expressing several benefits of the Active Health programme. Becoming more active resulted in participants putting in more effort, having improved stability, and cycling and walking more. While the increased activity brought other benefits: increased flexibility, weight loss, feeling happier, reduced breathlessness, introduction to online activities, improved mental outlook, increased energy, increased confidence, and a changed attitude to exercise. These benefits were not mentioned by all participants. The Week 12 feedback section permitted free-text responses and the frequency in which the benefits were mentioned by each of the nine responders varied from zero to four. In addition, three participants attributed their increased physical activity to COVID-19.

Qualitative data analysis clearly indicates that the impact of the Active Health Link Worker was, on the whole, positive for those participants interviewed. Although some found their mental wellbeing had improved, the greatest impact was seen in an increase in self-reported physical activity, the main aim of the project. Interviewees reported an increase in activities like walking, cycling, mobilisation exercises, gardening, and going to the gym (prior to ‘lockdown’). The programme also helped some interviewees feel more comfortable at their activity level and to normalise daily activity. Not having a rigid timescale for achieving targets was appreciated. Participants could build up their activity level gradually, helping them feel their goals were realistic and within reach. Few of the interviewees reported either walking or cycling to work or to the local shop rather than driving. The programme did not, therefore have a big impact on active travel amongst these interviewees, for whom it did not appear to be a priority or main motivation to increase activity. After taking exercise, interviewees experienced a range of positive effects which they linked to a greater sense of mental wellbeing including feeling more relaxed, positive and mindful. Experiencing a sense of achievement was a key element. The programme helped interviewees feel motivated and keep on track with their goals, acting as a *“boot up the backside”* and *“a bit of a reality check”* (P10). Meetings with Link Workers were characterised by their informality and relaxed conversational style.

The Link Workers were described as 'open', 'approachable' and 'friendly', making it clear there was "no right or wrong" (P9). 'Feeling at ease' and being able to talk 'openly' were commonly reported.

One of the key factors for success cited amongst interviewees was the opportunity to reflect on possible barriers to achieving their goals, to remove and/or manage them and to think about a strategy to help meet goals. The opportunity to talk one-to-one combined with the relaxed, conversational approach enabled them to feel at ease and speak freely. Through the use of motivational interviewing, the Link Worker could build up a relationship with the participant, enabling them to discuss their thinking on exercise, challenges and how activity fits into their lives. This person-centred approach was very important. Instead of being given generic exercise advice, participants were asked what they wanted to do and what they were interested in. Having the time to discuss what you want out of an activity as well as the range of options available was appreciated by interviewees. The Link Worker aimed to identify a feasible and sustainable strategy for each participant. They found activities they hoped would work for every individual, linking them up with appropriate resources and helping to keep people motivated and on track. Recommendations were tailor-made to individual preferences and capabilities. Participants could pick something they would enjoy and were not pushed into activities. Being treated as an individual was an extremely important element and helped people to keep motivated and engaged. Although they were choosing activities and setting their own realistic targets with the Link Workers, accountability was still viewed as a fundamental factor in making it successful.

Having contact with the Link Worker over 12 weeks helped to keep participants focussed and feeling they had to report back on progress even though there was no pressure to set and meet targets. This sense of accountability was generally characterised as a positive incentive and interviewees felt they were being encouraged rather than pushed. In addition, the Link Workers thought the following features of the programme were important in making it successful:

- Team-working
- Credibility from the partnership with NHS
- Good relationship between the project team and the surgeries
- Referrals were made by healthcare professionals who identified people who could benefit
- Strong leadership

In comparison to seeing a GP, the length of time spent with a Link Worker was identified as an important difference. The first consultation with the Link Worker was up to 60 minutes and allowed time for discussion about aims and barriers as well as options for increasing physical activity. According to the interview data, it enabled people to understand the reasons for their attitudes to activity and barriers to achieving goals. Seeing the GP can be an intimidating, stressful and scary experience whereas the Link Workers engendered an atmosphere experienced as more relaxed, personal, caring and non-judgemental.

Few major barriers to participation in the programme were reported. Specific problems due to incompatibility of activities with working hours and caring responsibilities were cited by two individuals. General issues resulting from lack of self-motivation, lack of energy and/or poor mental health were reported. Link Workers found common barriers amongst participants included chronic

pain, mobility problems (e.g. walking with aids), fear of not being able to get home or managing a walk/other activity. Views amongst participants diverged on the sustainability of their chosen activities with a degree of uncertainty expressed about the future. The implementation of 'lockdown' measures had disrupted some targets like walking or cycling to workplaces or attending classes at leisure centres. Since the start of 'lockdown', referrals to the Link Workers had dropped as people were not going to the surgery for normal routine issues.

On the whole, the participant interviewees were satisfied with the programme and did not think major improvements were required. There were a few suggestions such as improving marketing to reach more people and changing the surgery location to a non-clinical setting. Increasing the programme duration was also proposed in order to help embed a new active routine over the longer term. Since the start in April 2019, the project has undergone several changes to improve its ways of working such as adapting the referral system, lengthening the consultation times, and bringing forward the review meeting from Week 4 to Week 2/3. Potential issues remain such as the Link Workers not having access to patient records. As the Link Workers are not medically trained, their advice is reliant on the participants' self-assessment of their capabilities, although the referral from a healthcare professional was seen as a safeguard. However, the programme also opened to self-referral without the necessity of consulting a health professional. Generally, the interviewees had confidence in the Link Worker's knowledge and the Link Workers did not express any concerns about their role in this regard.

The participant and staff interview data suggests the following changes would help to improve the programme:

- Increasing the duration of the programme to incorporate at least one additional follow up appointment at 6 months.
- Increasing the working hours of Link Workers – to increase the number of people seen, to allow time for administration and sustaining relationships with partner organisations, to enable more follow-up appointments to support people over the longer term.
- Greater clarity over data protection procedures.
- A formal feedback mechanism – to present results to GPs and thereby increase awareness of the programme amongst GPs.
- Exploration of different locations outside the primary care setting.
- Increase VC appointments to enhance flexibility and access and also to extend the service to remote and rural areas.
- Improve the promotion of the scheme amongst GPs to boost referrals.
- Collect data on referral from GPs – attitudes to the service and reasons for referring or not referring.
- Participant data – examine ways of improving data collection procedures and questionnaire design and encouraging the completion of Week 12 questionnaires.

The limitations of the evaluation have been explained in full in the Methodology section. The number of participants in the programme was lower than originally estimated. The pool of available evaluation participants was reduced by delays in setting up the programme through the pilot stage

and a drop in referrals at both Christmas time and due to the COVID-19 'lockdown'. The interview data cannot be used to make general claims about experiences of the other active participants. The evaluation cannot speculate about the motivations and views of those who either did not engage with the programme at all or who dropped out of it. Neither was any data gathered from GPs or other healthcare professionals referring patients. There is therefore no evidence about their attitudes to or experience of referral and how that might differ between individuals, professional role or location.

The total number of 'active' participants up to the end of April 2020 was 108, 90% of the people originally referred. The number of participants defined as completing the programme was low with only 41% of those people who were seen at Week 1 completing Week 12 by the end of April 2020. However, it should be noted that this figure does not include the 34 people who were classed by the Link Workers as still actively engaging and awaiting final sessions. Of these, some were listed as having put the programme on hold due to the impact of COVID-19. These figures are therefore provisional and the final completion figure cannot be given at the time of writing.

Following 'lockdown' referrals dropped significantly: the average number of referrals per month during Jan-March 2020 was 11, whereas the number of referrals in April was one. No data was collected on those who dropped out at any stage of the programme. The impact of COVID-19 is likely to be complex given the closure of leisure facilities, home-working, shielding, and caring responsibilities, as well as the effect on mental health and wellbeing on top of any consequences arising from catching the virus. It is impossible from this data to understand the complexities and the impact on physical activity levels that may have either increased or decreased for individuals depending on how they were affected by 'lockdown' measures. The period of the evaluation was relatively short and did not allow time for gauging the sustainability of lifestyle changes beyond the 12-week programme.

The quantitative and qualitative data analysis suggests that the Active People/Health programme has the potential to increase physical activity levels at least in some individuals who actively engage with the Link Workers and complete the programme. The data sheds light on the mechanism that has made the programme successful for these individuals. The Link Worker offers something very different to the generic health advice often given out routinely by health professionals and presented in the media. The Link Worker has both the time and the skills to: firstly, engender a relaxed, informal atmosphere where people feel at ease and able to talk openly; secondly, to enable the participants to reflect on their motivations, barriers and past experiences; thirdly, to suggest tailor-made options based on individual preferences, self-perceived capabilities and acceptable, realistic, personalised goals; fourthly, to provide support and encouragement balanced with a sense of accountability over the duration of the programme; and lastly, to build on small achievements to help change the participant's mindset towards their physical activity and their future capabilities.

The data therefore suggests the element of reflection has the potential to be transformative in terms of motivation and readiness to change. The balance between accountability and not being pushed is carefully judged, enabling people to feel motivated by having to report back to someone on their progress but not overburdened or challenged beyond their limits. Even small progress may yield significant results in terms of self-motivation and confidence. Achieving a relatively modest target may give people confidence that they can achieve more and may strengthen self-motivation.

Going forward this could potentially have an impact on the sustainability of any lifestyle change, but this cannot be gauged within the remit of this study.

Although there was only a small number taking part in the evaluation, the findings indicate it was a positive experience for participant interviewees and helped them make some changes to their lifestyle and increase their physical activity levels. The data highlights a difference between the Link Worker programme and the type of advice they may have received in the past from healthcare professionals. There is sufficient evidence to suggest a more in-depth longitudinal study into participation in the Link Worker programme would be extremely worthwhile, particularly in a rural context. Longer term research could investigate the full potential of this scheme, help identify and embed good practice to roll out to other GP practices and explore ways to improve the efficacy and sustainability of the Link Worker programme going forward.

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8. Appendix

8.1 Participant Information Sheet - Questionnaires

Participant Information Sheet - Questionnaires

Project title: NHS Highland Active People Evaluation

Research department/team: Division of Rural Health and Wellbeing, University of the Highlands and Islands (UHI).

Invitation

Thank you for taking time to read this form. We would like to invite you to take part in a research study, which will involve completing a series of three questionnaires. A few participants will also be asked if they would like to be interviewed after the questionnaires have been completed. Before making any decision, it is important that you understand why the research is being done and what your role will be. Please read the following information and feel free to contact us if anything is unclear or if you require further information.

What is the purpose of this research?

The aim of this study is to collect and understand participants' experiences of the NHS Highland Active People project and to assess the impact of taking part on individuals' health and well-being. NHS Highland is testing a new 'Link Worker' role as a way of increasing physical activity and sustainable travel among patients in four NHS Highland GP surgeries. This UHI evaluation will help to assess whether the pilot is effective and to gauge the impacts.

Why have I been asked to take part?

You have been asked to take part because you are registered with one of the practices taking part and your healthcare professional has recommended that you should increase your level of physical activity. You may have been referred to the Link Worker or you may have received a leaflet on the options for increasing physical activity locally.

Do I have to take part?

No. It is up to you whether to take part. If you do decide to take part, you will be given this information sheet to keep and asked to sign a consent form. You are free to withdraw at any time and without giving a reason. You can refuse to answer the questions we ask.

If I agree to take part, what will I have to do?

Following your consultation with the healthcare professional you will either be referred to a Link Worker or given a leaflet about options for increasing physical activity. You will receive a questionnaire to fill out after your consultation and then subsequent questionnaires at one month and three months from that date. The questionnaire may be given to you in person or sent to you by post to complete in your own time. A few of the participants given the questionnaires will be asked if they would like to be interviewed for the project. In this event, a researcher would contact you and arrange a convenient time to meet you at an agreed location. You will be asked to sign the written consent form (attached). You will be asked a series of questions designed to gather your experiences as a participant. The aim is to identify what works well and what does not work well and to assess any impact on your physical activity and use of sustainable transport. This will last between 30 and 60 minutes. Even if you agree to complete the questionnaires, you do not have to agree to be interviewed if you do not wish to.

How will my contributions be used?

The questionnaire data will be analysed by researchers from the team and used to produce a report on the results of the project. If you are interviewed, the researcher will take notes and with your permission, your interview will be audio-recorded to keep an accurate record of what has been said. Only members of the research team will have access to the recordings. Your name will not appear on the transcripts. You may request a copy of the interview transcript. The researchers will examine the notes and recordings from all of these interviews. They will pick out themes to be used in the writing up of the project findings. All quotations will be anonymised. The information will be used to produce the project report. The report and research findings may be used to produce articles for publication in peer-reviewed journals, conference posters and presentations. All questionnaire data, recordings, transcripts, and consent forms will be kept on SharePoint, UHI's electronic filing system. Only the project research team will have access to them.

What will happen to my personal information?

All the personal information we collect will be kept confidential. The University has strict rules to make sure that all information arising from research is safely stored and does not reveal personal information about you. The information is held on SharePoint, UHI's electronic filing system. Personal information is held for five years after the publication of the research results and is then destroyed. You will not be identified in any associated reports, publications and conference presentations. Any quotations would be anonymous.

What are the possible disadvantages and risks in taking part?

There are no foreseeable risks associated with the research. The questionnaires and interviews are for research purposes only and will have no bearing on your individual health or wellbeing. If you do feel uncomfortable, upset or threatened in any way during an interview, please let the researcher know and we will stop the interview and/or get help if required.

What are the possible benefits of taking part?

You will not obtain any immediate direct benefit from participation in the research.

Who is carrying out this research?

The evaluation is being led by Dr Sara Bradley, Research Fellow from the University of the Highlands and Islands. A Research Assistant, employed by the University, will also be working on the project. The project is funded by the Smarter Choices, Smarter Places Open Fund.

What do I need to do if I want to withdraw from the research project?

If you wish to withdraw from the research project, you can tell the Link Worker, your GP surgery or the research team. You can tell the researcher during an interview and/or contact Dr Sara Bradley, Research Fellow from the University of the Highlands and Islands (contact details below).

What if I have questions or want further information about the project?

If you have any questions or require further information, please contact:

Dr Sara Bradley, UHI Rural Health and Wellbeing, Centre for Health Science, Old Perth Road, Inverness, IV2 3JH. E-Mail: sara.bradley@uhi.ac.uk. Tel: [REDACTED].

If you have a query that you feel cannot be addressed by the research team, please contact the UHI Research Office Administrator: Tel 01463 279000, email: ro@uhi.ac.uk

Thank you for taking the time to consider participating in this study. Your contribution to the project is greatly appreciated. Please keep this information sheet.

8.2 Participant Information Sheet - Interviews

Participant Information Sheet - Interviews

Project title: UHI Evaluation of NHS Highland Active People (Active Health)⁴ Project

Research department/team: Division of Rural Health and Wellbeing, University of the Highlands and Islands (UHI).

Invitation

Thank you for taking time to read this form. We would like to invite you to take part in an evaluation of the NHS Active People Link Worker project, which will involve being interviewed by a researcher from the University of the Highlands and Islands (UHI). Before making any decision it is important that you understand why the evaluation is being done and what your role will be. Please read the following information and feel free to contact us if anything is unclear or if you require further information.

What is the purpose of this research?

NHS Highland is testing a new Active People 'Link Worker' role as a way of increasing physical activity and sustainable travel among patients in four NHS Highland GP surgeries. The aim of the UHI evaluation is to collect and understand participants' experiences of the NHS Highland Active People project and to assess the impact of taking part. This UHI evaluation will help to assess whether the pilot is effective and whether participants think it could be improved in any way.

Why have I been asked to take part?

You have been asked to take part because you have had a consultation with an Active People Link Worker at your surgery. The evaluation is looking at how the Link Worker project is working and you will be asked questions about your experience.

Do I have to take part?

No. It is up to you whether to take part in the evaluation and whether to be interviewed. You are free to withdraw at any time and without giving a reason. You can refuse to answer the questions we ask. If you decide not to take part, it will have no effect on your meetings with the Link Worker.

If I agree to take part, what will I have to do?

During your consultation with the Active People Link Worker at your surgery, you will be asked if you are interested in being interviewed for the evaluation. If you are interested, you will be asked if the Link Worker can pass your name and contact details onto a UHI researcher. The researcher will then contact you to give you information about the evaluation and answer any questions. If you wish to go ahead, the researcher will arrange a convenient date and time to interview you at an agreed location (e.g. your home). If you do decide to take part, you will be given this information sheet to keep and asked to sign a consent form. You will be asked a series of questions designed to gather your experiences as a participant of the Active People Link Worker Project. The aim is to identify what works well and what does not work well about the project and to ask about the project's impact on you. This will last between 30 and 60 minutes. You do not have to continue with the interview if you do not wish to. You can have someone with you during the interview if you wish.

⁴ The Active People link workers changed the project name from Active People to Active Health, November 2019.

How will my contributions be used?

During the interview, the researcher will take notes and with your permission, your interview will be audio-recorded to keep an accurate record of what has been said. Only members of the research team will have access to the recordings. Your name will not appear on the transcripts. You may request a copy of the interview transcript. The interview data will be analysed by researchers from the team and used to produce a report on the results of the project. The researchers will examine the notes and recordings from all these interviews. They will pick out themes to be used in the writing up of the project findings. All quotations will be anonymised. The report and research findings may be used to produce articles for publication in peer-reviewed journals, conference posters and presentations. All data, recordings, transcripts and consent forms will be kept on SharePoint, UHI's electronic filing system. Only the project research team will have access to them.

What will happen to my personal information?

All the personal information we collect will be kept confidential. The University has strict rules to make sure that all information arising from research is safely stored and does not reveal personal information about you. The information is held on SharePoint, UHI's electronic filing system. Personal information such as your name and contact details, taken for the purpose of the evaluation, will be destroyed after the evaluation has been completed. Interview data is held for five years after the publication of the research results and is then destroyed. You will not be identified in any associated reports, publications and conference presentations. Any quotations would be anonymous.

What are the possible disadvantages and risks in taking part?

There are no foreseeable risks associated with the research. The interviews are for research purposes only and will have no bearing on your individual health or wellbeing. If you do feel uncomfortable, upset or threatened in any way during an interview, please let the researcher know and we will stop the interview and/or get help if required.

What are the possible benefits of taking part?

You will not obtain any immediate direct benefit from participation in the research.

Who is carrying out this research?

The evaluation is being led by Dr Sara Bradley, Research Fellow from the University of the Highlands and Islands. A Research Assistant, employed by the University, will also be working on the project. The project is funded by the Smarter Choices, Smarter Places Open Fund.

What do I need to do if I want to withdraw from the evaluation?

If you wish to withdraw from the research project, you can tell the Link Worker, your GP surgery or the research team. You can tell the researcher during an interview and/or contact Dr Sara Bradley, Research Fellow from the University of the Highlands and Islands (contact details below).

What if I have questions or want further information about the evaluation?

If you have any questions or require further information, please contact:

Dr Sara Bradley, UHI Rural Health and Wellbeing, Centre for Health Science, Old Perth Road, Inverness, IV2 3JH. E-Mail: sara.bradley@uhi.ac.uk. Tel: [REDACTED].

If you have a query that you feel cannot be addressed by the research team, please contact the UHI Research Office Administrator: Tel 01463 279000. Email: ro@uhi.ac.uk

Thank you for taking the time to consider participating in this study. Your contribution to the project is greatly appreciated. Please keep this information sheet.

8.3 Privacy Notice

Privacy Notice

University of the Highlands and Islands: Evaluation of the NHS Highland Active People Project.

It is important to us at the University of Highlands and Islands that we protect your privacy. This statement explains the information we collect during the research, why we collect it and where we disclose it.

This privacy statement relates to the following process:

University of the Highlands and Islands research for the Evaluation of the NHS Highland Active People Project.

Your information will be used for the following purposes:

The University of the Highlands and Islands is participating in the NHS Highland Active People Evaluation. The University of the Highlands and Islands is carrying out the research and evaluation. This project will pilot the use of a Link Worker to increase physical activity and active travel. The information received will be used to produce a report which will evaluate the pilot project and make recommendations on how it might be developed. The report may be used to produce articles for publication in peer-reviewed journals, conference posters and presentations.

Our legal reasons for using the data are:

Use of the data is necessary for the purposes of legitimate interests pursued by us or by a third party (in respect of us interviewing you as part of this research, analysing the results and writing the report).

The processing is undertaken under the legitimate interest of the University of the Highlands and Islands. The legitimate interest(s) of the controller or third party is:

To evaluate the Active People Link Worker pilot and make recommendations on developing the intervention to improve the health and well-being of participants.

Sharing of data:

Only the research team will have access to personal data (e.g. name, contact details) relating to any individual. Personal data will be destroyed after the completion of the project.

Your data will be retained for the following length of time:

The evaluation data (from interviews and questionnaires) will be retained for up to five years and then destroyed, but there is no set retention period.

The following rights are rights of data subjects:

- The right to access your personal data
- The right to rectification if the personal data we hold about you is incorrect
- The right to restrict processing of your personal data

The following rights apply only in certain circumstances:

- The right to withdraw consent at any time if consent is our lawful basis for processing your data
- The right to object to our processing of your personal data
- The right to request erasure (deletion) of your personal data

- The right to data portability

You also have the right to lodge a complaint with the Information Commissioner's Office about our handling of your data.

The Data Controller of the information being collected is:

University of the Highlands and Islands (UHI)
Executive Office, 12B Ness Walk
Inverness, IV3 5SQ
Telephone: 01463 279000

For any queries or concerns about how your personal data is being processed you can contact:

- Data Protection Officer at UHI: dataprotectionofficer@uhi.ac.uk
- Dr. Sara Bradley UHI: sara.bradley@uhi.ac.uk

8.4 Consent Form for Research Participants

Consent Form for Research Participants

Project title: NHS Highland Active People Evaluation

Research department/team: Division of Rural Health and Wellbeing, University of the Highlands and Islands (UHI).

Please read our project information sheet before completing this form. Please initial the boxes below:

1. I confirm that I have read and understood the Participant Information Sheet dated 26th June 2019 (V1.0) for the above study.

2. I confirm that I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

3. I agree to receive and complete the evaluation questionnaires.

4. I agree that a researcher may contact me at a later date to ask me if I would like to be interviewed.

5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without any consequences.

6. I understand that any identifiable information about me, which is gathered in the course of and as the result of my participating in this project will be: (i) collected and retained for the purpose of this project and (ii) accessed and analysed by the researcher(s) for the purpose of conducting this project.

7. I understand information that identifies me will not be made public and I will not be identified in publications, project reports and conference presentations.

8. I agree to be contacted for further information if required.

I agree to take part in the project named above.

Name of Participant Date Signature

Name of Researcher Date Signature

8.5 Consent Form for Evaluation Participants

Consent Form for Evaluation Participants

Project title: UHI Evaluation of NHS Highland Active People (Active Health)* Project

Research department/team: Division of Rural Health and Wellbeing, University of the Highlands and Islands (UHI).

Please read our project information sheet before completing this form. Please initial the boxes below:

1. I confirm that I have read and understood the Participant Information Sheet dated 4th December 2019 (V2.0) for the above study.
2. I confirm that I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
3. I agree to be interviewed for the evaluation.
4. I agree that the interview can be recorded using an audio device
5. I agree that the research team can have access to my questionnaire data.
6. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without any consequences.
7. I understand that any identifiable information about me, which is gathered in the course of and as the result of my participating in this project will be: (i) collected and retained for the purpose of this project and (ii) accessed and analysed by the researcher(s) for the purpose of conducting this project.
8. I understand information that identifies me will not be made public and I will not be identified in publications, project reports and conference presentations.
9. I agree to be contacted for further information if required.

I agree to take part in the project named above.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

*The Active People link workers changed the project name from Active People to Active Health in November 2019.