

**A practice based evaluation of a community physical activity intervention, based on the 'Let Get Moving' pathway, in those with chronic disabling conditions**

Johnny Collett<sup>\*1</sup>, Hazel Walsh<sup>2</sup>, Jenny Willson<sup>3</sup>, , Toni xxxx, Hooshang??, Helen Dawes<sup>1</sup>

\*Corresponding author: Faculty of Health and Life Sciences, Oxford Brookes University

Gipsy Lane, Headington, Oxford, OX3 0BP

Tel (+44) 01865 483630

Jcollett@brookes.ac.uk

1. Centre for Movement, Occupational and Rehabilitation Sciences, Oxford Brookes University, Oxford, UK
2. Active Oxfordshire, Kidlington, Oxford, UK
- 3.

Key Words:

## **ABSTRACT**

**Background** There is limited evidence to inform extent to which physical activity interventions for the general population are appropriate for those with chronic disabling conditions.

**Aim** To evaluate the comparative effectiveness of a community physical activity intervention

**Methods** A pragmatic practice-based evaluation of a community physical activity intervention based on the Let's Get Moving pathway. The evaluation took place in Oxfordshire, UK. January 2014 and March 2016

**Results**

**Conclusion**

## **INTRODUCTION**

The benefits of physical activity (PA) for health and wellbeing to the individual are well established and result in wider economic[1] and societal gains [2, 3]. Inactivity is a major concern for public health and in the UK with a large proportion of the population inactive[4]. Lower levels of physical activity are found in those with chronic disabling condition [5], who face barriers to participation[6]. However, evidence suggests that essentially these individuals are no different from the general population in their response to exercise[3, 7] and regular physical exercise has been shown to slow disease progression and produce significant improvements in mobility, functionality, health and wellbeing [3, 8].

The UK's departments of Health's Let's Get Moving (LGM) pathway is a behaviour change intervention for physical activity to commission at a local level[9]. LGM provides a systematic way to screen and identify sedentary adults and offer a brief intervention to support behaviour change, centred on motivational interviewing [9]. Studies have indicated LGM is feasible to deliver [10, 11] and has the potential to be cost effective in the primary care setting [11, 12]. However, data demonstrating the effectiveness of the pathway remains limited[13] and there is a need for evidence to guide local commissioning and provision. It is acknowledged that significant health inequalities exist for those with disabilities in the UK in terms of participating in

physical activity [9] and, although guidelines suggest adjustments to the pathway for individuals with impairments[14], it has yet to be established the extent to which the delivery of LGM is appropriate for those with chronic disabling conditions.

This was pragmatic practice-based evaluation LGM pathway commissioned in Oxfordshire. We explored the utility of the program at recruiting and retaining individuals with chronic disabling conditions and its comparative effectiveness.

## **METHODS**

### DESIGN

A pragmatic practice-based evaluation, following recommendations of the of the 'Standard Evaluation framework for PA interventions'[15], of a community physical activity intervention.

### SETTING

Participants were identified, recruited, assessed and the intervention took place in Oxfordshire, UK. The pathway was commissioned in 2013 through Sport England's '*Get Healthy, get into sport program*' and co-ordinated by Oxfordshire Sport and Physical Activity (OXSPA), a county sports partnership

### PARTICIPANTS

#### *Recruitment:*

Multiple entry points were used to recruit people into the pathway these were broadly classified as: 1) 'Self-referral', 2) 'Health referral' and 3) 'non-health referral'.

Individuals were able to self-refer online via the OXSPA website or by returning a referral card. OXSPA used a number of marketing and promotional tools to raise public awareness of the program and to encourage people to refer themselves. Including posters distributed and displayed at 325 sites in a range of locations (colleges, coffee shops, libraries, workplaces), promotional video and case studies on OXSPA website, news articles and community events.

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#### Health professional referral

OXSPA promoted the program to potential referrers and offered half day training sessions on the Health benefits of PA, raising the issue of PA with patients and providing support to them changing their behaviour. The program focused on primary care providers (GP surgeries/health centres), but hospital based services and pharmacies were also targeted. Referrals were made to OXSPA sport development officers who assessed eligibility and enrolled participants

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#### Non-health referral

The process for non-health refers mirrored that of health referrals. Non-health referrers targeted were employers, community enterprises and service providers.

#### *Enrolment:*

People were recruited by the above means were confirmed eligible for the program at a baseline assessment performed over the phone by a sports development officer at OXSPA. The eligibility criteria were 1) adult ( $\geq 16$  years) and 2) scoring '0' (< 1 session

of 30 mins exercise/week) on the single item activity measure (ref), this was adjusted after the 8th Oct 2014 to scoring either 0 or 1. For an individual's data to be included participants also had to consent to their data being used for evaluation.

### **Intervention**

During the baseline assessment participants were verbally informed about the available activities in their area by the sports development officer and asked for their preference for motivational interview timings. An information pack, which included vouchers for subsidised activities available from their local leisure provider, was mailed to their address. Local authority contracted leisure providers were responsible for developing and delivering activities suitable subsidised for sedentary individuals and local promotion. Available activities and subsidies varied over time and according to local provision (examples available: <https://www.getoxfordshireactive.org/find-an-activity>).

Motivational interview were conducted by qualified motivational interviewers who delivered the sessions over the telephone. Participants received a maximum of 3 motivation interview sessions over a 3month period. Motivational interview schedule was determined by the participant and motivational interviewer. Participants chose how to increase physical activity, which may have included structured, including those available from the local leisure provider, and unstructured activities.

### **Assessment**

Demographic information of age, sex, ethnicity, long-term health problems and chronic disabling condition was ascertained via referral cards or on-line sign ups. Assessments were at enrolment (baseline) and followed up, 3months, 6months and 12months, a £20 gift voucher or donation to charity was offered for taking part in follow up assessments.

All assessments were carried out over the phone unless a paper version was specifically requested. Data was accepted up to one month after the secluded assessment date.

#### *Physical activity*

The primary outcome was physical activity (total MET-minutes per week) measured using the International Physical activity Questionnaire (short) telephone format (IPAQ) and was administered [16] and processed according to guidelines [17]. Metabolic equivalents were assigned to the amount of time spent in Vigorous (8.0METs x minute), Moderate (4.0 x minute) and Walking (3.3 x minute) domains in the previous 7 days. Time spent sitting and time spent doing sport (an additional question for 'Get Healthy, Get Active' projects) were also recorded but not included in the calculation of total MET-minutes per week.

#### *Perceived Health and well-being*

Health outcome was measured using the EQ-5D-5L (telephone version). The EQ-5D-5L is comprised of a descriptive system and an index score. The descriptive system comprises the following 5 dimensions: mobility, self-care, usual activities,

pain/discomfort and anxiety/depression. Each dimension has 5 levels: 1) No problems, 2) Slight problems, 3) Moderate problems, 4) Severe problems, 5) Extreme problems. The index score asks individuals to rate their health according to a 0 to 100 scale ('0 worst health you can imagine – 100 best health you can imagine') and used to indicate health related quality of life[18].

### **Process**

All participants were given an exit questionnaire upon finishing the intervention, question asked about their experience of the program and attitude to physical activity on a three point scale. The questions were administered either after their 3months assessment or if they chose to formally discontinue intervention.

### **Analysis**

Groups were formed according whether a participant had a long term illness, health problem or disability that limited their daily activities (LTC group) or not (no-LTC). All statistical analysis was analysis was performed in SPSS v 25. To compare nominal demographic data Pearson  $\chi^2$  analysis was used, post hoc differences were determined using z-tests with Bonferroni adjusted p-values, continuous data was analysed using an independent samples T-test. Outcome analysis was based on the intention-to-treat principle including all participants that enrolled, with baseline Observation Carried Forward (BOCF), used to impute missing data. The Individual PA response was calculate from IPAQ data as the proportion of people that achieved UK government guidelines for 19-64 year olds [19] and for perceived health the proportion that changed EQ5D-5L VAS by 5 points (minimal important difference) [20].

These data over assessments was analysed using the generalized estimating equations procedure, reported with between group odds ratios. To analyse within and between groups average responses a general linear model was used with Partial  $\eta^2$  reported as an estimate of effect size. Alpha was set as 0.05.

## Results

### **Recruitment and participant flow**

Participant flow can be found in figure 1, between January 2014 and March 2016, 812 people were referred, most (59.0%) by either a health professional (41.6%) or non-health referrers (17.4%). Sixty nine health organisations referred to the program. The number of referrals per referrer varied considerably (median= 2, mode= 1, range=42-1), with the top 9 referrers accounting for 50% of referrals. Seventeen non-health organisation referred and also varied in number of referrals per individual referrer (median= 3, mode= 1, range=77-1), with one referrer, accounting for over 50% of referrals (a community enterprise).

Twenty three referred people failed eligibility criteria with most of the 264 people excluded prior to the baseline assessment due to not wanting to take part or becoming uncontactable (91.3% of those excluded). 548 individuals enrolled in the program and performed the baseline assessment. Attrition of individuals assessed was relatively stable over time with over time with 71.1%, 65.5% and 67.7% of those enrolled loss to follow up at 3, 6 and 12 months respectively (Figure 1).

### Referral and enrolment demographics and baseline outcome data

Table 1 shows the demographic and group characteristics at referral and enrolment. Irrespective of group the majority of individuals referred and enrolled were women, aged over 35 years and white. A greater proportion of LTC were in the 55+ age category and less in the 35-54 years than no-LTC at both referral ( $p < 0.001$ ) and enrolment ( $p = 0.001$ ). A greater proportion of with LTC group were referred through the health referral route ( $p > 0.001$ ) and a greater proportion of those with LTC enrolled ( $p > 0.001$ ).

		Referred LTC	Referred No-LTC	Enrolled LTC	Enrolled No-LTC
<b>N</b>		264	525	214	334
<b>Sex</b>			$P = 0.898$		$P = 0.620$
	Male (%)	28.2 <sup>a</sup>	28.7 <sup>a</sup>	29.0 <sup>a</sup>	27.0 <sup>a</sup>
	Female (%)	71.8 <sup>a</sup>	71.3 <sup>a</sup>	71.0 <sup>a</sup>	73.0 <sup>a</sup>
<b>Age (years)</b>			$P > 0.001$		$P = 0.001$
	16-19 (%)	1.5 <sup>a</sup>	3.2 <sup>a</sup>	0.9 <sup>a</sup>	2.8 <sup>a</sup>
	20-34 (%)	19.5 <sup>a</sup>	25.5 <sup>a</sup>	19.3 <sup>a</sup>	23.8 <sup>a</sup>
	35-54 (%)	36.8 <sup>a</sup>	48.3 <sup>b</sup>	32.8 <sup>a</sup>	47.8 <sup>b</sup>
	55+ (%)	42.1 <sup>a</sup>	23.0 <sup>b</sup>	41.5 <sup>a</sup>	25.6 <sup>b</sup>
<b>Ethnicity</b>			$P = 0.850$		$P = 0.557$
	Asian/Asian British (%)	4.3 <sup>a</sup>	5.7 <sup>a</sup>	4.4 <sup>a</sup>	7.4 <sup>a</sup>
	Black/Black British (%)	3.1 <sup>a</sup>	3.4 <sup>a</sup>	2.4 <sup>a</sup>	3.7 <sup>a</sup>
	Mixed (%)	2.8 <sup>a</sup>	3.4 <sup>a</sup>	2.4 <sup>a</sup>	3.4 <sup>a</sup>
	White (%)	87.4 <sup>a</sup>	85 <sup>a</sup>	88.3 <sup>a</sup>	83.1 <sup>a</sup>
	Other (%)	2.4 <sup>a</sup>	2.6 <sup>a</sup>	2.4 <sup>a</sup>	2.7 <sup>a</sup>
<b>Referral route</b>			$P > 0.001$		$P > 0.001$
	Self (%)	17.0 <sup>a</sup>	52.6 <sup>b</sup>	16.2 <sup>a</sup>	41.4 <sup>b</sup>
	Health	64.4 <sup>a</sup>	17.1 <sup>b</sup>	65.2 <sup>a</sup>	37.8 <sup>b</sup>
	Non-Health (%)	18.6 <sup>a</sup>	30.3 <sup>a</sup>	18.6 <sup>a</sup>	20.8 <sup>a</sup>
<b>Enrolled in program*</b>			$P > 0.001$		
	(%)	81.1 <sup>a</sup>	64.2 <sup>b</sup>		

At referral 34.4% (n=102) of those with LTC had impairments in 2 or more categories, at enrolment this was 39.7% (n= 85). The order of impairments in terms of frequency reported were: Pain, (Referral: n=116, Enrolment: n=97), Mobility (Referral: n=126, Enrolment: n=93), Mental health (Referral: n=111, Enrolment: n=86), Fatigue

(Referral: n= 84, Enrolment: n=71), “Other” (Referral: n=76, Enrolment: n=59), Hearing (Referral: n= 20, Enrolment: n=16), Vision (Referral: n=10, Enrolment: n=9), Speaking or being understood (Referral: n=9, Enrolment: n=6), Learning (Referral: n=13, Enrolment: n=5).

Table 2 shows assessment data at enrolment, there was no difference between groups in physical activity, however, general health status (Eq5D-VAS) was significantly lower in the LTC group. EQ5DL-5L dimension scores data is provided in supplement 1 the LTC group had greater severity across all dimensions (all at  $p < 0.001$ ).

	Referred LTC	Referred No-LTC	<i>P value</i>
<b>Physical activity</b>			
Walking (MET mins/week)	441 ± 1510	398 ± 745	0.689
Moderate (MET mins /week)	104 ± 1000	81 ± 348	0.701
Vigorous (MET mins /week)	58 ± 548.	10 ± 61	0.204
<b>Total Activity (MET mins /week)</b>	<b>660 ± 1974</b>	<b>530 ± 895</b>	<b>0.367</b>
<b>General Health Status</b>			
Eq5D-VAS (0-100)	49 ± 23	57 ± 21	$p < 0.001$

### Outcome

Table 2 show outcome data, activity level increased in both groups (LTC:  $p = < 0.011$ , Partial  $\eta^2 = 0.019$ , no-LTC  $p < 0.001$ , Partial  $\eta^2 = 0.039$ ) with no difference between groups in average physical activity levels ( $p = 0.993$  ( $\eta^2 < 0.001$ )) and no difference in group time interaction ( $p = 0.118$ ). Individual response showed no difference in the proportion of people meeting PA guidelines over assessments ( $p = 0.698$ , OR=0.937: 95%CI=0.674 1.303). In addition although, most physical activity was performed in the walking domain, the proportion of physical activity performed in the vigorous domain

increased over assessments ( $p < 0.05$ ) (Table 2). Time spent doing sport also increased over assessments ( $p = 0.001$ , Partial  $\eta^2 = 0.010$ ), with no difference between groups ( $p = 0.090$ , Partial  $\eta^2 = 0.005$ ).

Whist, general health status (EQ5D-VAS) data was significantly different between groups there was no difference in the group time interaction ( $p = 0.463$ ) and group and both groups improved in perceived health over assessments (LTC:  $p = < 0.001$ , Partial  $\eta^2 = 0.044$ , no-LTC  $p = < 0.001$ , Partial  $\eta^2 = 0.045$ ). Individual response showed no difference in the proportion of individuals eliciting minimal important difference in EQ5D VAS score ( $p = 0.519$ , OR = 0.912 95%CI = 0.690-1.206).

### **Process**

Reported experience was positive and no statistical difference was found in the how groups rated their experience (table 3). However, there was a trend for those with LTC to not find the motivational interviewing as helpful, that approached significance ( $p = 0.058$ ). In both group most individuals rated physical activity as being important

for their future health and wellbeing and definitely intended to participate in physical activity in the future.

## Discussion

This evaluation found a let's get moving based physical activity care pathway effective at recruiting people with chronic disabling conditions and provides evidence that retention and effectiveness is comparable with that of the general inactive population. The data is encouraging that, irrespective of group, the brief intervention can lead to sustained participation in physical activity in those who engaged with improvements in health related quality of life observed over a year.

The importance of recruitment and referral process and the role of the health professional is confirmed by our data [9, 28]. The majority LTC were identified via health professional referrals and more likely to enrol, this is consistent with previous findings that being referred can improve uptake and length of engagement with exercise program [21, 22]. However, this evaluation also indicated that engaging primary care providers remains a challenge and a barrier to recruiting the inactive population into the physical activity care pathway [11]. Despite payment for referrals 50% of referrals were made by 9 referrers and 6 of these were primary care providers (74 GP practises under Oxfordshire CCG [23]) with the second and third most prolific referrers hospital based services. A recent study found the majority of GPs in England (80%) were unfamiliar with the UK PA guidelines and 55%, reported that they had not undertaken any training with respect to encouraging PA [22]. Never-the-less it is encouraging, in the context of this evaluation, that the majority of people referred

from health professionals had chronic disabling conditions and 34.4% of these individuals had multiple impairments, which has shown to be associated with greater levels in inactivity [5]. However, our data and that from evaluations of exercise-on-referral suggest that certain conditions and associated impairments may be underrepresented in community exercise interventions[21]. For example learning or intellectual disability made up only 4.9% of those who with disability were referred but make up 14.4% of the disabled population of England[23] and inactivity is particularly prevalent in this group even in those with mild disability [24].

We found that the program increased average PA with the effect observed comparable to the moderate treatment effect found in a meta-analysis of intervention to increase PA in healthy adults [25]. Whilst, larger effects have been found in meta-analysis of PA intervention in chronically ill adults [26] compared to healthy [25], we found no overall difference between groups in a community program for the general sedentary population. Importantly our data is encouraging that the program led to sustained behaviour change in those who engaged and provides evidence for the effectiveness of Let's Get Moving pathway [13]. Attrition remained stable after the 3month assessment and compared favourably to adherence rates reported in physical activity prescriptions programs[27]. Considering all those who enrolled 15.0% and 18.9% in the LTC and Non-LTC group respectively met PA guidelines at 12months, consistent with results from a meta-analysis that physical activity interventions can lead small to medium improvement in PA at 12 months[28]. This improved physical activity behaviour is corroborated by the observed transition towards more intense

physical activity over the 12month period and the intention to participate in physical activity in the future.

Perceived health has been shown to correlated with PA levels[29]. Baseline physical in participants was approximately 25% of the UK average of 18-64 year olds [30] and was accompany by very low perceived health. Mean index score on the EQ5D-5L of 48.9 ( $\pm$  23.0) in the LTC group was significantly lower than the no LTC group (56.8 ( $\pm$  21.1)) at baseline with both groups low compared to a UK norm for individuals with 'Insufficient' PA of 82 (95%CI: 80–83)[31]. A meta-analysis of studies in adults with chronic illness, has shown that PA interventions can improve quality of life outcomes [32]. We found a trend for a greater improvement in general health status in the LTC group. However, both group improved and remained significantly greater at baseline at 12months with an estimated 20.1% in the LTC group and 24.9% in the No LTC of those enrolled having important improvement in perceived health at 12months [20].

When evaluating the generalisability of these findings it is important to consider the program took place in Oxfordshire which is affluent area of the UK and has the greatest proportion of people meeting UK PA guidelines in England [5]. Never-the-less 17.5% (95%CI: 15.6% -19.6%) of the county remain in active and the overall referral demographic was similar to the demographic of Oxfordshire[33], with the notable exception a higher proportion of women being recruited across referral routes. A further consideration is that health referrers referred individuals that were older and although PA level reduces with age [30], better uptake and adherence to PA interventions are predicted by older age [21, 34]. The relationship between primary

care providers and community deliverers of PA intervention has been identified as a potential key factor in the success of PA promotion [35]. OXPISA's networks with local authority contracted leisure providers, healthcare, academia (including training courses for exercise professionals) and public health services and in Oxfordshire may have contributed to the number of those with chronic disabling condition referred and the appropriateness of available activities available.

Furthermore it should be considered this was a pragmatic evaluation of a community intervention and as such does not have levels the internal validity associated with more robust research designs. However, it followed recommendation of the 'Standard Evaluation framework for PA interventions'[15] and provides practice-based evidence, that has ecological validity consistent with the RE-AIM framework, and thus able to inform future interventions[36, 37]. Whilst, attrition compared favourably to PA prescriptions programs[27] it was likely to be the main source of bias in data. To negate this analysis followed the intention-to-treat principle and used Baseline Observation Carried Forward, assuming no change in baseline for those with missing data. Given the inclusion criteria for baseline PA it is unlikely that individuals PA levels would have reduced and it may well have been the case that some of those lost to follow up may have improved PA levels. Therefore estimates of effect might be view as conservative. Indeed, greatest improvement in physical activity and general health status was observed when there was least missing data.

Conclusion

In summary, the data indicates that clinicians should refer people with long term disabling conditions to community PA programs based on Let's Get Moving in order to increase physical activity and they are likely to accrue similar benefits to the general sedentary population. It supports the recommendations for the use of multiple entry routes to maximise recruitment across demographics [6] but indicates greater efforts are required to reassure individuals with disabilities about the appropriateness of the program and encourage them the self-refer. Indeed it relieved that many primary care providers remain indifferent to refereeing to community PA interventions but that hospital services and community enterprises may be a productive source of potential participants. The effectiveness of the Let's Get Moving pathway in leading to improved physical activity behaviour in sedentary individuals is supported and may also lead to improved perceived health.

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	Baseline		3months		6months		12months		P value (ES)
	<i>LTC</i>	<i>No-LTC</i>	<i>LTC</i>	<i>No-LTC</i>	<i>LTC</i>	<i>No-LTC</i>	<i>LTC</i>	<i>No-LTC</i>	
<b>Walking</b>									
MET mins/week [% of Total Activity]	441±1510 [73.2%]	398±74 [81.4%]	484±1002 [49.6%]	519±947 [58.6%]	521±1011 [48.5%]	462±772 [50.6%]	386±841 [50.4%]	495 ± 841 [52.5%]	0.878 ( $\eta^2 > 0.001$ )
<b>Moderate</b>									
MET mins/week [% of Total Activity]	104±1000 [17.2%]	81±348 [16.5%]	367±1440 [37.5%]	248±633 [28.0%]	390±1226 [36.3%]	272±900 [29.8%]	201±1026 [26.2%]	247 ± 552 [26.1%]	0.402 ( $\eta^2 = 0.001$ )
<b>Vigorous</b>									
MET mins/week [% of Total Activity]	58 ± 548 [9.6%]	10 ± 61 [2.0%]	126 ± 453 [12.9%]	119 ± 486 [13.4%]	164±642 [15.2%]	179±624 [19.6%]	179±587 [23.4%]	202 ± 839 [21.4%]	0.805 ( $\eta^2 < 0.001$ )
<b>Sport</b>									
mins/week	2.2±14.3	1.4±12.0	14.6 ± 76.7	4.1±18.3	14.2 ± 59.1	7.8 ± 39.2	8.8± 7.7	11.0 ±57.3	0.090 ( $\eta^2 = 0.005$ )
<b>Total Activity</b>									
MET mins/week [% PA guidelines]	660±1974 [0%]	530±895 [0%]	976±1571 [17.3%]	886±2686 [18.6%]	1075±1865 [19.6%]	913±2570 [17.4%]	767±1626 [15.0%]	944± 2036 [18.9%]	0.993 ( $\eta^2 < 0.001$ ) 0.698 (OR=0.937)
<b>General Health</b>									
<i>LTC</i> (VAS 0-100) [% MID]	48.9±23.0 N/A	56.8±21.1 N/A	52.3±22.1 [19.2%]	60.8±20.8 [18.2%]	54.9 ± 22.3 [24.3%]	61.2±20.3 [22.8%]	53.5± 3.1 [20.1%]	61.9 ±2 0.3 [24.9%]	<0.001 ( $\eta^2 = 0.037$ ) 0.519 (OR=0.912)

Level	1		2		3		*X <sup>2</sup> [p]
	LTC	No-LTC	LTC	No-LTC	LTC	No-LTC	
How satisfied were you with process of getting referred into the programme? ( <i>Number of responses [%]</i> )	2 [11.1%]	2 [5.4%]	8 [44.4%]	12 [32.4%]	8 [44.4%]	23 [62.2%]	1.912 [0.428]
Did you find the coaching on the telephone helpful for motivating you to take part in exercise? ( <i>Number of responses (%)</i> )	3 [20.0%]	1 [4.3%]	8 [53.3%]	8 [33.3%]	4 [26.7%]	15 [62.5%]	5.439 [0.058]
How much did you enjoy the activities you tried? ( <i>Number of responses (%)</i> )	0 [0.0%]	2 [8.3%]	7 [63.6%]	10 [41.7%]	4 [36.4%]	12 [50.0%]	1.584 [0.423]
How much do you perceive the activities you tried benefitted you in terms of your health and wellbeing? ( <i>Number of responses (%)</i> )	0 [0.0%]	1 [4.0%]	8 [72.7%]	13 [52.0%]	3 [27.3%]	11 [44.0%]	1.511 [0.625]
In general how satisfied are you with programme? ( <i>Number of responses (%)</i> )	0 [0.0%]	3 [6.3%]	5 [45.5%]	16 [50.0%]	6 [54.5%]	14 [43.8%]	0.643 [0.854]

How important do you feel physical activity is for your future and wellbeing? <i>Number of responses (%)</i>	0 [0.0%]	0 [0.0%]	7 [41.2%]	6 [17.1%]	10 [58.8%]	29 [82.9%]	3.525 [0.089]
Do you plan to participate in physical activity in the future? <i>Number of responses (%)</i>	0 [0.0%]	0 [0.0%]	3 [18.8%]	5 [15.2%]	13 [81.3%]	28 [84.8%]	0.102 [1.00]

\*Fisher Exact test (due to minimum expected count not met)



