National Centre for Sport & Exercise Medicine
Working for Health & Wellbeing

Sheffield Hallam University | Advanced Wellbeing Research Centre

#EasierToBeActive

Making it easier to be active with a health condition

Report of findings from Phase two

May 2021

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Background and rationale to the research project

The #EasierToBeActive project is being delivered over three phases of data collection from March 2020 through to June 2021.

- Phase one – online conversation (March – May 2020)
- Phase two – qualitative interviews (November 2020 – March 2021)
- Phase three – online conversation (planned May – June 2021)

This report presents data from phase two – in depth qualitative interviews and focus groups. An in depth report from the findings from phase one of the project can be accessed at https://www.shu.ac.uk/advanced-wellbeing-research-centre/projects/ETBA

One in three adults in England live with a long-term health condition and those of us that have them are twice as likely to be amongst the least physically active[1]. We need 'a 'friction-less' experience for people with long term health conditions to engage with and participate in physical activity opportunities. The #EasierToBeActive project aims to explore how this frictionless experience can be created to address some of the challenges facing people with a health condition have to being active.

This phase of the project aimed to address some of the recommendations highlight from phase one:

- Test and validate the themes that emerged from the first online workshop;
- Engage those with lived experience of health conditions and their carers, people from ethnically diverse backgrounds and seldom heard communities, economically deprived communities, older people, and those who are digitally excluded;
- Explore additional areas including gaps in the themes from the first online workshop - the importance of an inclusive workforce that represents those that it serves, the need for more education and support for carers, the impact of socio-economic status and health inequalities.

Overview of participants

In phase two interviews and focus groups (n=16) were conducted with 26 stakeholders form 23 organisations based across the UK. Interviews were conducted online November 2020 – March 2021. Analysis and findings will be used to inform phase three of the project – the final online conversation due to take place in May 2021.

Summary of findings

In phase one, five cross-cutting themes were identified which were reflected across the whole conversation. These themes included the need for an individualised focus and the areas in which the wider systems around the individual could influence a frictionless journey to moving more. Termed the 5 I's framework, this framework has been refined following analysis of the qualitative interview conducted in phase two. These themes. The five themes identified in phase two include:

Individualised - Putting the *individual* at the heart of everything we do.

[1] Public Health England Guidance, Health matters: physical activity - prevention and management of long-term conditions, published 23 January 2020

Inclusive - Ensuring that opportunities for physical activity are *inclusive* for people with long-term conditions.

Inclusive - Ensuring that opportunities for physical activity are *inclusive* for people with long-term conditions.

Influencers - Recognise there are a range of people *influencing* how active a person with a long-term condition maybe.

Informed - Everyone is *informed* of the benefits and opportunities of being more active with a long-term condition.

Integrated - Strive to have a seamless *integrated* offer for people with long-term conditions to be more active.

Summary of recommendations

Phase two has allowed the opportunity to check, challenge and refine the key themes that were developed in phase one and two. During both of these phases, *what* needed to be done was shared, however there was less information provided on *how* the system could turn these into a reality. Phase three will specifically focus on this how through questioning and final refinement of the potential of the five I's to be developed as guiding principles in creating a frictionless experience for people with long term health conditions to be more active.

A key recommendation from phase one was the need to host a conversation that was as large and diverse as possible. This was also highlighted in discussions with the steering group and from feedback from our wider project partners. In phase one, the voice of people with lived experience of long term conditions was relatively small (7.9% of participants identifying as having a long term condition). In phase three there will be a focus on engaging with people with experience of or those caring for people with a long term condition.

Introduction

One in three adults in England live with a long-term health condition and those of us that have them are twice as likely to be amongst the least physically active[2].

Supporting people with long-term health conditions into activity is critical in increasing population physical activity levels and reducing inequalities for people with long-term health conditions.

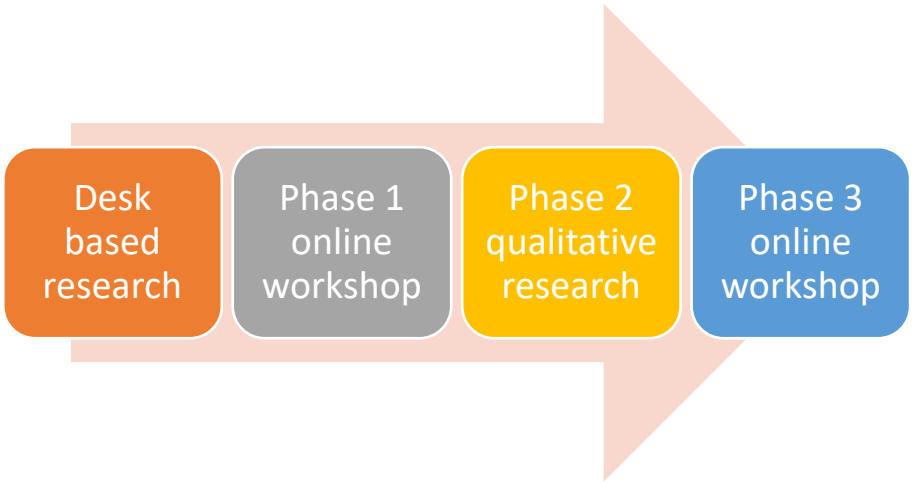
We know that being active can make a significant positive impact on our health and wellbeing, and help to manage conditions, reduce the impact and severity of symptoms and increase our quality and length of life. However, there are a range of barriers preventing people with conditions from getting active, including personal barriers like confidence and the unpredictability of conditions. But there are also external barriers, that are often practical or logistical challenges, within the sport and physical activity system itself.

We need 'a 'friction-less' experience for people with long term health conditions to engage with and participate in physical activity opportunities. The #EasierToBeActive project aims to explore how this frictionless experience can be created to address some of the challenges facing people with a health condition have to being active. The project has been conducted over three phases to address the following aims:

- To make it easier for people with health conditions to get involved in sport and physical activity, to help them manage their conditions, reduce their symptoms and live longer, better quality lives.
- To build up a picture of how we can work together to shape the design, provision and promotion of services so that the system makes it #EasierToBeActive.
- To raise awareness, bring the sector together, and spread best practice and new ideas.

To address these aims we have used the following approach throughout the project:

Figure 1 - stages of data collection



[2] Public Health England Guidance, Health matters: physical activity - prevention and management of long-term conditions, published 23 January 2020

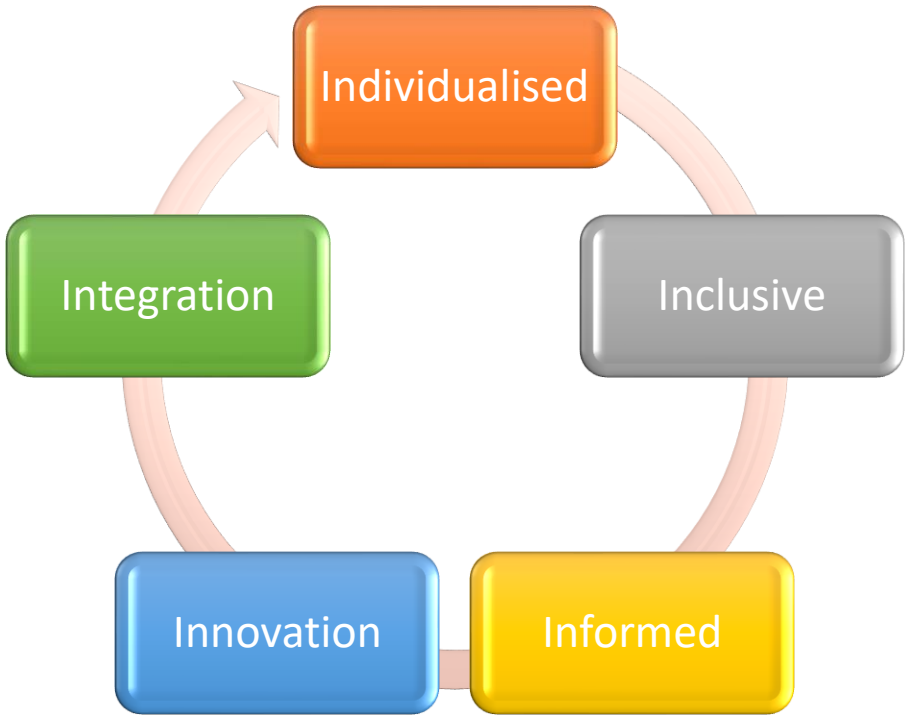
This report is the second of three reports to present the findings from each phase of the #EasierToBeActive project. The report (prepared September 2020) from phase one which was undertaken in March – June 2020 sets out more details of the rationale and context to the project https://www.shu.ac.uk/advanced-wellbeing-research-centre/projects/ETBA. Phase two was conducted between November - March 2021. This report highlights the findings from phase two and sets out the approach to be taken in phase three to be held May – June 2021.

Summary of methods and learning from phase one

Phase one was conducted using a national online conversation. 637 people registered their interest. 351 people completed the gateway survey and logged onto the platform to share their ideas and to read and vote on what others have shared. Participants were invited to contribute ideas about what could be done differently to make it easier to be active with a health condition, how they or their organisation have succeeded in making an impact, how they were adapting their physical activity or physical activity offers during the Covid-19 lockdown period, and any other ideas to improve the experience of being active for people with health conditions. Together they shared over 1,100 contributions – a combination of ideas, comments, and votes.

Analysis of the contributions identified five cross-cutting themes that were reflected throughout the whole conversation. They cover the intrinsic factors linked to motivation and the various user touchpoints within the system, right through to the wider system and cultural environment. These are set out below in figure 2.

Figure 2 – the Phase one - 5i's framework



Individualised - Participants in the online workshop were very clear about their desire for an individualised, person-centred approach when it comes to helping people with long-term conditions to be more active. They want to see individualised pathways that map their own personal journeys and goals, they want services that respond to their specific needs and the ability to choose amongst them based on their interests and preferences. They want individual support that can tap into their personal motivations, help them through difficult times and celebrate successes.

Inclusive - The need for inclusivity kept emerging throughout the conversation. Participants want to see an inclusive workforce that represents those that it serves. They would like to see inclusive marketing that uses language and images that diverse populations can relate to. They would like services that remove barriers to inclusion whether they are related to socio-economic factors, language, digital literacy, accessible facilities or anything else. The system also needs to be inclusive in the process of designing new services, processes and systems, involving a wide array of stakeholders and particularly people with long-term conditions.

Informed - The need for information and education was also evident in the conversation. It is needed at schools when initial attitudes towards physical activity are shaped; it is needed at the doctor's office where healthcare professionals need to give advice or recommend a service; it is needed by people with conditions who want to understand the benefits of physical activity or make a choice about specific offerings, judge the qualifications of an instructor or learn about the experience of a peer.

Innovative - The recent global health crisis demonstrated that in order to be sustainable and effective, the system and the actors within it should engage in continuous improvement and innovation, adapting to changing external circumstances and the evolving needs of the people it serves. More creative ways should be employed in designing services that appeal to and meet the needs of wider audiences, reaching and informing diverse populations, as well as transforming cultures and cities to support physical activity.

Integrated - Integration and coordination of efforts and information throughout the system is necessary to achieve our shared goals. At the local level, integration may mean healthcare professionals connecting and exchanging knowledge with local instructors. At the national level, it may mean the creation of information systems and platforms that aid collaboration and knowledge exchange or help measure impact and promote good practices.

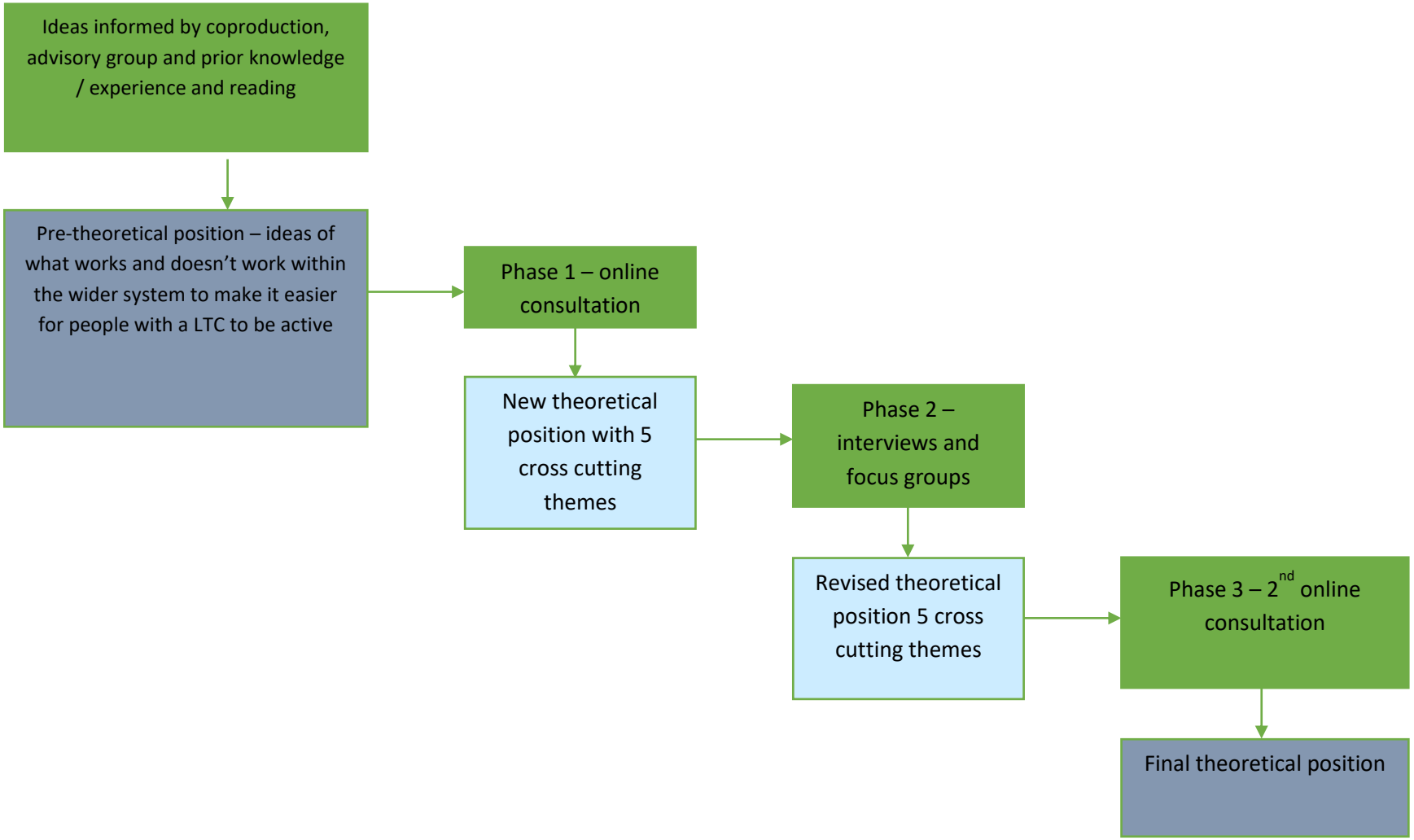
At the end of phase one, several recommendations were identified that aimed to be addressed in phases two and three:

- Test and validate the themes that emerged from the first online workshop;
- Engage those with lived experience of health conditions and their carers, people from ethnically diverse backgrounds and seldom heard communities, economically deprived communities, older people, and those who are digitally excluded;
- Explore additional areas including gaps in the themes from the first online workshop - the importance of an inclusive workforce that represents those that it serves, the need for more education and support for carers, the impact of socio-economic status and health inequalities.

Phase Two - Methodology and methods

Methodology

The project uses a realist informed methodology. Relist methodology aims to explore what works for who and in what circumstances and can be thought of as consisting of a spiral of theory development and testing. In this study, the method consisted of spirals, each one building, and refining theories of would support the health and physical activity sector to create a frictionless experience for people with health conditions to be more active. Figure ## explains these spirals of data collection and theory development and highlights how the findings from each phase are tested and refined as we go into the next phase.


Ideas informed by coproduction, advisory group and prior knowledge / experience and reading
Pre-theoretical position – ideas of what works and doesn't work within the wider system to make it easier for people with a LTC to be active
Phase 1 – online consultation
New theoretical position with 5 cross cutting themes
Phase 2 – interviews and focus groups
Revised theoretical position 5 cross cutting themes
Phase 3 – 2nd online consultation
Final theoretical position

Methods

To test and validate the themes from phase one, phase two was conducted using qualitative semi-structured interviews and focus groups. This approach was chosen to allow for an environment to facilitate open communication between the interview participant and the researcher (Holstein & Gubrium, 2012). Semi-structured interviews strike a balance between a structured interview and unstructured interview. In semi-structured interviews, questions are open ended, thus not limiting the choice of answers (Holstein & Gubrium, 2012; McCracken, 1988). Focus groups bring together people as a group to discuss a particular topic. They allow members to hear the views of others and as such more can provide an opportunity of more reflection and refinement of thoughts and discussion points (Ritchie and Lewis 2003). The interviews and focus group schedules were conducted using topic guides (appendix 1). These were developed in consultation with the project steering group which includes representation from Sport England, Public Health England, the Richmond Group of Charities, the National Centre for Sport and Exercise Medicine, Advanced Wellbeing Research Centre and Clever Together. Using topic guides ensured consistency across the interviews whilst allowing the researchers the opportunity to follow up on emerging themes raised by the participants (Ritchie, Lewis, McNaughton Nicholls, & Ormston, 2014). Topic guides also provide prompts for the interviewer to ensure the interview and focus group stays on track with the topic area whilst generating depth and detail in the participants' responses (Creswell, 2003; Patton, 2002

The phase two interviews and focus groups were structured using the initial framework from phase one. We used this as an opportunity to sense check the findings from phase one and build on some areas that the steering group and research team identified as potential gaps in the data. The overarching themes we explored were: intrinsic factors, key actors, pathways and referrals, service design, marketing and communications and integration and collaboration within the system. We explored how participants considered health inequalities could impact a person with a long term condition and their ability to be active and asked participants what resources and outputs they would like to see at the end of the #EasierToBeActive project to help them in their daily roles. Finally, we asked participants if there was anything missing in what was discussed that they thought would be pivotal in making it easier to be active for people with health condition.

Interviews and focus groups were undertaken between November 2020 and March 2021. They were conducted online using MS Teams at a time convenient for the participant(s). They were digitally recorded and transcribed verbatim by a professional transcribing company. Two researchers undertook the interviews, both employees of Sheffield Hallam University in the Advanced Wellbeing Research Centre and Centre for Behavioural and Applied Psychology.

Recruitment and participants

Participants in phase two included stakeholders from across the health and physical activity system from a range of organisations including trusts, governing bodies, local government, health, voluntary and charities. The list of organisations was co-developed with the #EasierToBeActive project steering group. Potential participants were approached by a member of the steering group with information about the project and an invitation to be involved in an interview. In total 15 interviews and focus groups were held with representation from the following organisations:

- Chartered Institute for the Management of Sort and Physical Activity (CIMSPA)

- Royal College of General Practice
- UK Active
- Public Health England
- Local Government Public Health
- Local Government
- UK Coaching
- Physical Activity Clinical Champions Programme
- Richmond Group of Charities
- Local Delivery Pilots
- Active Partnership Network
- Activity Alliance
- Carers UK
- Sport England

Approach to coding and analysis

Data from the semi-structured interviews and photovoice were analysed using framework analysis techniques (Ritchie & Lewis, 2003; Ritchie & Spencer, 1994). Framework analysis was developed at the National Centre for Social Research (Ritchie & Spencer, 1994) but is often used in heath research (Gale, Heath, Cameron, Rashid, & Redwood, 2013). Framework analysis is a pragmatic approach to qualitative data analysis which allows the researcher to be immersed in the data and understand the experiences of the participants (Hackett & Strickland, 2019). Framework analysis is like other thematic and content analysis approaches, all of which aim to develop themes from relationships in the similarities and differences in data (Gale et al, 2013).

Framework analysis allows the integration of pre-existing themes (those from phase one) into the emerging data analysis and provides a clearly defined analytical structure that contributes to the transparency and validity of the results (Ritchie & Lewis, 2003).

Following the development of the framework, anonymised data was entered and coded using the NiVivo software. Analysis was conducted by the two researchers who undertook the interviews and focus groups. Emerging findings were shared and refined following discussions with the project steering group.

Findings

Overall, 15 interviews and focus groups were conducted with a total of 26 participants from 23 different organisations. The 5 I's framework that was developed from Phase 1 was initially used to analyse the data. After the first round of analysis, it was felt by the research team that the 'Innovative' theme was not applicable to this dataset. Therefore 'Innovative' was replaced by 'Influence' as this better represented the current data. Table 1 below sets out the thematic framework developed from phase two. The table highlights the five high level themes using the 5 I's and the linked subthemes. Explanations are provided for each theme and sub-theme. The chapter continues to provide a summary of the findings and relevant quotes form the interviews.

Theme	Explanation	Sub-theme	Explanation
Individualised	Putting the **individual** at the heart of everything we do.	Autonomy and empowerment	Promote autonomy and empowerment to encourage people with a long-term condition to be more active.
		Acknowledge and understand circumstances	Acknowledge and understand the circumstances in which people live.
		Suitable opportunities	Providing suitable opportunities that meet the needs and wants of the individual with a long-term condition to be more active.
Inclusive	Ensuring that opportunities for physical activity are **inclusive** for people with long-term conditions.	Co-design	Giving a voice to people with long-term conditions to decide, design and deliver physical activity opportunities to be active.
		Accessible language	Communications and marketing appropriate to the audience.
		Removing barriers of accessibility	We need to understand the perceived and actual (physical, digital, communication) barriers for a person accessing a physical activity opportunity.
Influencers	Recognise there are a range of people **influencing** how active a person with a long-term condition maybe.	Professional workforce	The workforce has a diverse set of skills to include accredited qualifications, people skills (empathy, behaviour change), lived experience.
		Individual networks	Recognising the networks around the individual (e.g. friends, partners, carers) have a distinct role in supporting a person with a long-term condition to be more active.
Informed	Everyone is **informed** of the benefits and opportunities of being more active with a long-term condition.	System	Ensuring the network around a person with a long-term condition is informed about how to support them to be more active (e.g. opportunities, knowledge of long-term conditions, people skills and empathy).

		Individuals	Individuals are informed about their long-term condition and how, why and where they can be more active.
Integrated	Strive to have a seamless **integrated** offer for people with long-term conditions to be more active.	Barriers to integration	System level challenges such as data sharing, short term funding, shared appreciation of the physical activity agenda
		Enablers to integration	Shared pathways between organisations, relationships between people and organisations

Individualised

There was an overarching agreement from participants that physical activity pathways needed to be Individualised to help make it easier for people with long-term health conditions to lead an active lifestyle. This means ensuring that services put the person with a long-term condition at the heart of any physical activity pathway, to ensure it was personalised to their needs. Within this theme, lower-order themes were created including, acknowledging and understanding circumstances, suitable opportunities, and autonomy and empowerment. The following section will provide more detail and quotes related to these themes.

Autonomy & Empowerment

The need to empower a person with a long-term condition and promote autonomy to make their own decisions about how and what physical activity they want to participate in was discussed. It was felt that individuals should make their own decisions about what activities they want to participate in, with enjoyment and feeling comfortable being a priority. The role of professionals was to provide empowerment and guidance to support people with long term conditions to make decisions, rather than being prescriptive.

> *Going back to ask a man or woman on the street if they believe activity is good for them, they already know that. Don't make people feel guilty about it, empower them and enable them in a medically oriented but safe and fearless way to then arrive at their own decision and then let the professionals help them develop the habit. [I1]*

> *You take people's own responsibility away, we all know how we feel and whether we're, do you feel good today to go out for a 10-minute walk, do you not? We take that away, we go no, the doctor will decide whether you can exercise, actually everyone's an expert on their own wellbeing and we take that empowerment away from individuals to go, you can be active, you can go out for a walk, it's totally safe for you to do that. And we medicalise them and then they expect that magic pill or something and that whole culture I think is the biggest thing [GI1]*

Acknowledge & Understand Circumstances

An important finding was the need for professionals to take the time to acknowledge and understand the challenges that a person with a long-term condition faced. This was especially necessary since all long-term conditions effected people differently, as well as their personal circumstance being different. Participants reported that there were different challenges to increased activity faced be people, especially in relation to having a long-term condition, therefore it was important for professionals to take the time to understand the challenges and how to support people to fit physical activity into their lives. Professionals should acknowledge that physical activity is not important for everyone and that they need to understand when the time is right to promote physical activity for a person.

> *I know I'd had a conversation with a guy, I was working with Macmillan Cancer and I was talking and I was waxing lyrical about the benefits of physical activity. And I said to this guy, oh, you should be active, blah-blah-blah, and he said why do I want to be active, I said oh well, you know, it'll help you live longer and blah-blah-blah,*

he went why do I want to live longer, and I had nothing I could say to that. His life has got a world of pain in it that physical activity isn't going to help with that, all the issues that he's got, he's struggling to feed himself and all the rest of it, so I think that then it changes your mindset in what physical activity is. [G15]

It's very much focused around health isn't it? And I think people aren't necessarily active for their health are they, they're active for, there are so many reasons why you might be active, it might be for social, might be for just enjoyment or whatever, there are so many different reasons an individual might want to be active for and I think it's about making that message meaningful for that individual. Rather than, because you'll probably get, you will get a small percentage of the population that are hugely motivated by health factors, but yeah I guess it's about how we use that message to make it more meaningful in other aspects as well. I don't have the answer though. [GI1]

Suitable Opportunities

To ensure that a person with a long-term condition can be physical activity it was reported that there needs to be a range of suitable opportunities made available. There is no one opportunity that would be suitable for everyone, therefore again people with long-term conditions needed opportunities for them to choose from to find a physical activity that suited them.

Yeah, it's opportunity and whatever, if the opportunity is structured and they feel they want to take that then great and they know where that is. If the opportunity is unstructured and they're comfortable in that place, then great, let them go there. I don't think it's either/or, I think there's room for both. [GI5]

we've got classes that are under capacity, so it's not necessarily that the opportunities aren't there in the local area. It's about well what actually will get people to those opportunities? [GI 4]

Inclusive

Physical activity pathways needed to be inclusive to make it easier for people with long-term conditions to be physically active. This means ensuring that services should accommodate different people with different health conditions. Services should be physically accessible and through the language used to promote services. To ensure inclusive services participants discussed the need for and use of co-design with people with long-term conditions to ensure physical activity opportunities were inclusive. Within this theme, lower-order themes were created including, co-design, accessible language, and removing barriers of accessibility. The following section will provide more detail and quotes related to these themes.

Co-design

To ensure services and pathways were inclusive, participants discussed the need for co-designed sessions to give people with long-term conditions a voice about how physical activity opportunities should be designed and delivered. Participants discussed from their own experiences the benefits of using co-design to design services and ensure that they are suitable and inclusive for people with long-term health conditions.

I think in terms of involving or user involvement, people with lived experiences is really, really key to making sure that person-centred approach is adopted. [FG1]

I think what we're learning through the pilot is that that co-design is important. Because I think if you get the co-design right at the beginning and then you begin to explain, you begin to build in the cost to that co-design and you engage in looking at that process early on, then there's a better understanding about why something costs that much, what that leads to and how that all works and in a better, they have the option then of themselves deciding whether they want to do that or not. So I think that person-centred co-design builds everything else beyond it. So if you can get the person-centred bit right then you get the accessibility right and then you can understand the affordability and then the quality assurance. [GI5]

Accessible Language

Participants discussed the need to ensure that marketing and communications are appropriate for people with long-term health conditions. Participants felt that this is a challenge and that typically physical activity messages are not appropriate for people with long-term conditions. Physical activity messages were reported to need to be more inviting and make activity seem like something that is more achievable for people with long-term health conditions.

we work with a professional marketing business around what we're doing and even they still, out of choice, as soon as you mention the word physical activity will produce some image from the gym or a football match and, you know, people who look nothing like them and we've been working with them for years. [GI5]

if we make the solution, make physical activity as terrifying as going for a check-up, then we're going to put it in the wrong box aren't we? So we've got to be gentle with the narrative really and talk it up. We could really speed up your recovery here if you can just get outdoors and get yourself out of breath four times a week, that would be great. [I1]

Removing Barriers of Accessibility

To ensure physical activity opportunities are accessible to all, participants discussed the need to explore and understand the barriers that a person may face. Consideration needs to be given to the physical barriers that a person with a long-term condition may face when attending facilities (e.g. wheelchair ramps). Due to the pandemic, there has been an increase in the use of digital opportunities, which has meant there are also potential digital barriers that need to be considered by physical activity providers to ensure their opportunities are inclusive.

We've done Zoom meetings and things and some people have access to befriending phone call services and things, but that often isolates the ones who aren't online as well [FG1]

Accessibility in terms of thinking about the, thinking about a ramp or that kind of physical view of accessibility. Unless you've got that way in which the person can bring the cared for person with them, all that type of stuff, or then something can be simply not accessible for them as well. [I6]

Influencers

This theme was additional to the 5 I framework developed from the phase one findings. Participants in phase two spoke about the areas that influenced an individual to be more active and cited two main networks – professionals and the networks surrounding the individual such as their peers, family and friends. The skillset of the professional workforce be that knowledge or personality was identified as important. Personal networks of friends and family also influence a person's ability to participate and undertake physical activity opportunities.

Professional Workforce

The skills and ability of the professional workforce around a person with a long-term condition, which included healthcare professionals, leisure instructors and volunteers, were reported to influence their levels of physical activity. The skills and qualifications of the workforce influenced physical activity opportunities, particularly in relation to ensuring that the workforce felt confident and qualified to be able to work with different long-term conditions. As well as typical physical activity qualifications, participants emphasised the importance of people having the personal skills, and ability to listen and empathise with a person who has a long-term condition. Having people in the workforce that had lived experiences of different long-term health conditions was also important, as a person with a long-term health condition may feel more comfortable working with someone that understands what they are going through.

> *The biggest qualification from our point of view for group leaders has been that lived experience of similar, having mental illness themselves and being able to relate to the position that the person's in, whereas if we got an exercise tutor in or anything like that, it hasn't landed as well. So, upskilling that individual who is the group leader already to then do incidental informal physical activity, games or whatever, has been the route to the success of it really and then having that lived experience has been the biggest key from our side. [FG1]*

> *That point around social skills and empathy is really important. As [colleague's name] said you could have all the qualifications you like, but if you haven't got any of those social skills you'll not be able to translate them, you'll not be able to connect with the person in front of you, or the group that you're in, you're trying to convey. [GI 4]*

Individual Networks

Participants discussed the need to recognise the personal networks around a person with a long-term health condition, including their friends, family, and carers. Consideration needs to be given to the people that support a person with a long-term condition, for instance carers, and to ensure that services cater for the needs of carers as well as the person with a long-term condition. It was generally acknowledged that if a service was hard for a carer to attend, then they would be unlikely to want to support a person with a long-term condition to attend. Participants also discussed the importance of ensuring there is a social aspect to a physical activity opportunity, as people would be more likely to return to an activity if they have built rapport with the other attendees. This aspect had been lost during the pandemic, as social activity has been curtailed.

They're so interlinked that I just think there needs to be a really, whatever journey or route in that people are taking to understand that for both these people and the carers that that other person influences so much what they are and aren't able to do from like a transport perspective, the time, everything from their fear in taking part as well. Carers are often very worried about not being able to care if they were to get hurt and also I'd imagine that a carer could be a barrier to somebody with a long term condition getting active, because they would also worry that their job would be more difficult if that person with a condition were to get hurt as well. [I6]

Once people are there, we'll do annual surveys and people, some of the main feedback is that people go week in week out to see their friends and they've made those friends over a period of time. Same reason why people will go to our rehab specific classes like cancer rehab. They've developed relationships with those people over a period of time. [GI4]

Informed

The need to ensure that everyone was informed about the benefits of physical activity and opportunities for a person with a long-term health condition to be active was important. People with long-term conditions need to understand why and how to be active, as well as professionals needing to understand how they can support them. Sub themes include system and individual. The system should ensure the network around a person with a long-term condition is informed about how to support them to be more active whilst individuals need to be informed about their long-term conditions and how,, why ands where they can be more active. The following section will provide more detail and quotes related to these themes.

System

The system around a person with a long-term condition needs to be informed about how they can support a person to be active. It was discussed how there is a need for healthcare professionals and exercise professionals to work together to educate and inform each other about how they can support a person with a long-term condition to be more active. It was felt that not all healthcare professionals were knowledgeable about the benefits of physical activity for long-term conditions, and that they provided an opportunity to discuss and promote physical activity to a person with a long-term health condition. For exercise professionals it was reported that they were not educated specifically on how to work with a person with a long-term condition, and that it was of their own volition to find education opportunities.

What I found was if you wanted to become a swimming teacher or a fitness instructor or a coach or anything like that, you could do all of those things and the core knowledge was there. And if you wanted to know more about working with people with disabilities, it was a bolt on qualification. It was something else [I1]

So the coaching side are trying to learn from the health professionals, and the health professionals are trying to learn from sports coaches about, because sports coaches have been nervous about people with health conditions, because they won't want to put them at harm or at risk; whereas the occupational therapists and physios will be nervous about delivering physical activity, again because they don't feel confident or competent and they don't want to do harm or be at risk. So

there's that risk mitigation in the middle, which actually the research suggests the risk is very low for long-term health conditions. There's only a very small percentage that need managed care. [I5]

Individuals

A person living with a long-term health condition needs to be informed about how, where, and when they can be more physically active. It was discussed how it is important to ensure a person with a long-term condition understands how they can safely be active, as well as being informed about how to choose an appropriate activity for themselves, as it is likely that a person maybe apprehensive about being active if it was to make their condition worse. As well as understanding how to be active, a person also needs to understand the potential implications of physical activity for their condition and how to monitor this if necessary.

I guess it's just aware and also raising awareness of like you're saying contraindications for that condition for that individual as well isn't it and highlighting what they need to be aware of, particularly just thinking diabetes for example they might need to consider their blood sugar levels. An individual might not be aware that that's the case, but if there's an app or something specifically. [GI1 APN]

Integrated

Participants discussed the need for all services within a physical activity system to be integrated to ensure physical activity opportunities are easier to access for people with long-term conditions. Challenges were reported by participants to being able to work successful with other partners within the system, but all were striving for there to be a seamless integrated offer for people with long-term conditions to be more active. Within this theme, lower-order themes were created including, the barriers to integration and the enablers to integration. The following section will provide more detail and quotes related to these themes.

Barriers to Integration

For a person living with a long-term condition to be active, it was reported that there were a number of people/providers (e.g. leisure providers, healthcare professionals) involved in providing physical activity opportunities, and that within this system there was a disconnect between services. People/services having their own agenda and the short-term nature of funding within the physical activity system created challenges for services to collaborate and integrate. Due to these barriers, participants reported having to prioritise proving the success of their services to secure future funding, rather than working collaboratively. A lack of knowledge of the physical activity opportunities available and concern about risk mitigation when working with people with long-term conditions was also a barrier to integration within the service.

a lot of the time one of the issues that you have with collaborating is that everyone has their own agenda and everyone's, well, sometimes not willing to take on other people's agenda in order to address the actual issue, or an organisation may want

to focus on what is on their agenda more, even though the collaboration sounds a good idea they still always want to focus on that aspect and I think, yeah, you're right in saying that, that that's always going to be a barrier, so where groups can work more collaboratively that obviously would benefit [FG1]

I've certainly worked in other areas where that isn't the case and it is very much I want to see figures, I want to see a hundred people are coming through that. Well, how do you know if a hundred people's good, bad or indifferent, you don't, but it just sounds good, and trying to change that on its head, it's definitely hard and it is, it's just very much in terms of luck of the draw and who you're working with at that time, who's elected. [GI5]

We have underutilised capacity for instance in the sector, which could be used for physical activity, so making that, highlighting that to health commissioners, highlighting that to the healthcare local providers, social prescribing world for instance. So there's plenty of underutilised space. We've got 60,000 personal trainers out there, professionals that could be helping people become more active. So it's that, that accessibility part is probably the first thing I'd say. [I4]

Enablers to Integration

Participants discussed how there were factors which enabled integration within the physical activity system, allowing for collaboration between services and enable physical activity opportunities for people with long-term health conditions. Specific examples were discussed, including the impact of the NHS's long-term plan and other initiatives which meant participants felt that there was more freedom and recognition for the need to promote physical activity. Relationships between organisations within the system were also reported to enable integration between organisations to promote physical activity opportunities.

Relationships mainly, and I think that goes, and it goes down to individuals who are able to demonstrate that empathy we spoke about. It is their links with the local authority. It's their communication channels with local healthcare. Those are the things that keep coming out to say this is how we can replicate that. And some evidence base as well. Some are doing it better than others, but looking at things like social value. [I4]

I think that long term plan did help because it put prevention in the agenda didn't it for secondary care as well as, instead of that prevention was kicked around wasn't it between public health and primary care, no that's you, no that's you. OK no one will do it. But I think now it's put it in everybody's agenda, [GI1]

Outputs

At the end of the interviews participants were asked about how would be best to share any future recommendations with people working within the physical activity system. A number of participants emphasised the need for any future outputs to be short and accessible, potentially in the form of an infographic. It was also acknowledged that any outputs needed to be applicable and accessible to a range of audiences, from people living with long-term conditions, to charities, and healthcare professionals, which participants felt that an infographic could do.

> *if the findings can be fed in in like an infographic or more of an engaging way. It's something that then can be passed on to different charities or health organisations and they can use it in their own internal meetings or reaching out to participants for physical activity opportunities and stuff like that, but I just think having an infographic just really paints a picture a bit better and makes it less wordy and stuff like that and I think that can go a long way at hitting more target audiences. [FG1]*

Although participants acknowledged the need for outputs to be short and accessible, it was also felt that they needed to be based on evidence and to ensure that it is clear to the reader where the evidence has come from to support the need for people to be more active.

> *I think some really clear and good tools around long term conditions and the evidence as you've spoke about [Interviewer 2]. And we really like the stuff that's coming through from [unclear 0:59:11] and we use that a lot because it's really clear, it's really clear where that information is coming from, so it's evidence based and the statistics are really clear and there's the bit that's OK here's information you could give to professionals, here's information you could give to patients. [GI1]*

One participant spoke about the importance of creating an opportunity for people working in this system to speak and learn from each other, as it was felt that confidence to work with people with long-term conditions comes from experience.

> *In terms of guidelines for top tips, I think there's a lot of stuff out there already, which is great, but I think confidence to do this work doesn't come from reading a fact sheet. You need to be in it. Not even actually physically doing it, but have the mechanism to talk to other coaches in the same boat and that can be virtually through a virtual community or some kind of networks or gatherings or whatever it is that you could do in terms of learning from each other. [I5]*

Conclusions

Qualitative interviews and focus groups have allowed us to further explore the themes identified from the first online conversation and attempt to ensure representation and contributions from system leaders identified in collaboration with the project steering group. The in-depth discussions with stakeholders from across the system were framed using the cross cutting themes (5 I's) from phase one. The phase two findings reconfirmed that need for pathways to be individualised, inclusive, and integrated and for people with a long term condition to be informed about how they can be active safely with their long term condition and the choices that are available to them to be active. Phase

two also highlighted the influences surrounding the individual that may impact on activity. Above all the findings from phase two highlight the need to ensure pathways are person-centred to support and facilitate more people with long term conditions to be more active.

Phase two participants represented professional organisations from charitable, statutory, and commercial sectors. It did not include the voice of the person with a long term condition. The final phase should prioritise engagement with people with a lived experience or those caring for people with a long term condition. Furthermore, participants in both of the phases so far have told us what needs to be done to create a frictionless experience to being more active. However, we need to create an understanding of how we can turn this what into a reality in order to support the sport, physical activity and health sector to integrate better and provide and promote opportunities for people with a health condition to be more active and stay well, health and happy.

Recommended next steps

A final phase of the project will be held in May 2021. This phase (phase three) will aim to check and challenge what has been heard in phases one and two. In phase three we will also focus on exploring participants views on how the 'what' that was identified in the first two phases can be turned into a reality.

A key recommendation from phase one was the need to host a conversation that was as large and diverse as possible. This was also highlighted in discussions with the steering group and from feedback from our wider project partners. In phase one, the voice of people with lived experience of long term conditions was relatively small (7.9% of participants identifying as having a long term condition). In phase three there will be a focus on engaging with people with experience of or those caring for people with a long term condition.

Through phases one and two we have developed a network of people engaged and interested in being kept informed about the #EasierToBeActive project. In the final phase it is important that we reconnect with these and ask them to ask as advocates for the project to connect with stakeholders in their local areas and networks, particularly to reach people with a personal interest. We also need to utilise our connections with the Richmond Group of charities to connect with groups.

Analysis of the contributions identified five cross-cutting themes that were reflected throughout the whole conversation. They cover the intrinsic factors linked to motivation and the various user touchpoints within the system, right through to the wider system and cultural environment.

Appendix 1

#EasierToBeActive

Introduction

- Provide an overview of the purpose of the project, referring to the two page summary of the project and highlight aims, process of data collection for phase one and a summary of findings.
- Explain that we would like to understand more about the part of the system that they and their organisation represents and also identify; any gaps in the findings from phase one and identify potential solutions to the challenges raised (e.g. what should be amplified, stopped or changed).
- Explain each set of questions will focus on the themes from phase one.
- Explain about voluntary nature of consent, ability to withdraw at any time, consent procedure.
- Check the participant agrees to have the discussion recorded.
- Verify consent at appropriate times throughout the interview

Interview Themes

Intrinsic factors – In the first phase of our work, various individual factors were identified such as the need for social connection, belonging and fun.

- From your point of view how do the practices you see in the part of the system you represent, influence someone with a long term condition to become more active?
- What role would/could/should your part of the sector play in influencing these intrinsic factors?
- Prompts - what should be amplified? Stopped? changed? Or started? What priority would you give to this?

Key actors – findings suggested that the workforce is not representative of the people it seeks to support in terms of people with LTCs.

- What are your thoughts on whether the diversity of the workforce reflect the people using it, e.g. BAME, older people?
- How might this be an issue?
- Prompts - what should be amplified? Stopped? changed? Or started? What priority would you give to this?
- What would a more inclusive and diverse workforce look like from a:
- Qualifications perspective?
- Knowledge and expertise perspective?
- Empathy or expert by experience perspective?

Pathways and referrals – findings focussed on the use of pathways for people with long-term conditions to access physical activity and follow a structured journey.

- What do you feel structured and unstructured journeys into activity could/should look like for people with LTCs?
- How do specialist pathways make it easier or indeed challenge people with a health condition to be more active?
- What is/should/could be the role of structured pathways?

- What good examples of pathways or open access have you seen in your sector or in other sectors that would facilitate people with a health condition to be more active?

Service design – The findings from phase one relate to the provision and design of services and suggests eight separate areas that influence someone engaging with physical activity to improve their health: choice and person-centred design, affordability, accessibility, facilities, funding, innovation, individual support, and quality assurance.

- Thinking about four of these - person-centred design, accessibility, innovation, and quality assurance – how do these aspects play into the way that your organisation or key partners focus on service design?
- Prompts - what should be amplified? Stopped? changed? Or started? What priority would you give to this?

Marketing and communications – referred to how communications promoting physical activity are targeted at people with long-term conditions.

- Do you think we need to change the way we communicate with people with a LTC to inspire and empower them to be more active?
- If so, what do you think we should do / focus on?
- Do you have any examples of where this has worked well or not worked so well?

Integration and collaboration within the system – this theme referred to a system which isn't joined up and is therefore difficult for individuals to navigate.

- What examples are you aware of where the collaborations between different sectors/orgs aren't working?
- Can you tell me anymore about why there are barriers for this?
- Thinking about solutions to this, can you provide any examples of the collaborations between different sectors/organisations that are working better?
- Can you tell me why it's working and what the mechanisms are for this?

New ideas and final questions
Impact of health inequalities

- What are your thoughts on how health inequalities and socio economic status impacts on a person with a long term condition and their ability to be active?
- How might your part of the system work differently to address health inequalities?

Additional information

- Is there anything missing in what we discussed that you think would be pivotal in making it easier to be active for people with health condition?

Future guidance / resources
We are aiming to coproduce guidelines or information that the health, sport and physical activity system can use to make it easier for people with a health condition to be active.

- What resources and mechanisms do you think would help make the guidelines actionable for the systems we have been discussing, (you may want to consider the needs of your organisation and partners more broadly in your response)?

Participant Information
Check the following are recorded from the consent process -
Organisation
Role within organisation
Key responsibilities in organisation