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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: a national conversation

Report of findings from Phase one

September 2020

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Background and rationale to the research project

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].

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. This project aims to co-produce guidance with the physical activity and health sectors. This guidance will support high-quality physical activity experiences for people with long term health conditions that are consistent in their approach, safe and person-centred.

The work is underpinned by the following principles.

1. Explore and develop a deep understanding of current physical activity pathway for people with long term health conditions

2. Be driven by the wants/needs of the sector, a collaborative, coproduction approach will underpin this project.

3. Coproduce universal guidance that will support the wider physical activity sector (including healthcare, community and fitness/leisure services) to improve physical activity experiences for people with long term health conditions.

The delivery of this project has been adapted as a result of the Covid-19 pandemic. This report is based on the findings of phase one of a three phase project and has been led by the National Centre for Sport and Exercise Medicine – Sheffield, Sheffield Hallam University Advanced Wellbeing Research Centre and Clever Together. Phases two and three will be delivered in the Autumn and Winter of 2020/21 with findings of the overall project to be available for Spring 2021.

About the project partners

The National Centre for Sport & Exercise Medicine – Sheffield (NCSEM) is focused on the design, implementation and evaluation of whole-system approaches to increasing physical activity across the population.

NCSEM is committed not just to delivering its purpose, but to engaging the people it works with and for so that together, they can co-create new insight and recommendations to those who provide, design, commission and deliver sport, physical activity and health and care services.

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

In January 2020 Clever Together was commissioned by the National Centre for Sport & Exercise Medicine to design and host an online workshop to generate insight from those who have a passion for empowering and inspiring people with health conditions to be active, and looking at how the system can make this easier. This project was called #EasierToBeActive.

The aim was to use the insight generated to co-create guidance for the sport and physical activity sector so that we can improve the experience of being active for people with health conditions.

This report shares the insight generated from the national online workshop.

The first national online workshop, which ran from 16th March 2020 - 29th May 2020, created a space for everyone to anonymously contribute their ideas and experiences about how the system can make it easier to be active with a health condition.

The following paragraphs can only provide an introductory and high-level view of a wide-ranging discussion. More detail and nuance can be found in the full report. This summary has been written to orient readers to the key themes of the conversation.

Overview of participants and contributions

The online workshop was open to anyone with an interest to self-register and join the national conversation. Over 350 people logged in to share their ideas and to read and vote on what others had 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.

Key themes from the workshop

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.

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 want inclusive marketing that uses language and images that diverse populations can relate to. They also want 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.

Summary of recommendations

The disruption of COVID-19, the challenges around communications and promotion, and the relatively low levels of engagement overall had led to a change in the follow on phases of the project. As such the next phase will test and validate the themes that emerged from the first online workshop and to ensure that the groups who were underrepresented have their voices heard and reflected in the findings.

In phase two we need to engage:

- those with lived experience of health conditions and their carers
- people from BAME backgrounds, economically deprived communities, older people, and those who are digitally excluded.

Additional areas to explore:

- where any gaps may be 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

In order to achieve this, we will conduct a series of qualitative interviews with key stakeholders or underrepresented groups. The aim will be to sense check the emerging findings and themes from the first online workshop and explore any new or absent themes. Phase three would be a second online workshop to share and validate what we have learnt from the first online workshop and the qualitative interviews combined. This would also help to test messages and themes that could form part of the final guidance and open a discussion about what format would be most useful to the sector.

Holding a second online workshop is a valuable way to demonstrate, quickly and transparently, that we have really listened to what stakeholders have shared. It is also the first step in taking action to respond and continuing to engage the sport and physical activity sector to get their buy-in to the final co-produced guidance.

Lastly, a more coordinated and proactive approach to communications is needed to try and get as much reach as possible, especially as the focus would likely still be on generating interest remotely. It will be vital for us to work with the project partners to leverage meaningful engagement and ensure specific communications resource is allocated for the success of the project.

Introduction

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

There are often a range of barriers preventing people with health 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.

Physical inactivity is defined as 'doing less than 30 minute of physical activity per week in bouts of 10 minutes of at least moderate intensity[3]. It is well evidenced that being active can make a significant positive impact on people's health and wellbeing. It can also help to prevent or manage many long-term conditions and reduce the impact and severity of symptoms, while increasing quality and length of life overall.

More than 15 million people have a heath condition for which there is currently no cure, and the number of people with multiple health conditions continues to rise[4]. This group of people have significantly poorer quality of life, poorer clinical outcomes and longer hospital stays, and are the most costly group of patients that the NHS has to look after[5]. Treatment and care for people with health conditions is estimated to take up around £7 in every £10 of total health and social care expenditure[6].

In the UK, physical inactivity is the fourth largest cause of disease and disability, directly contributing to one in six deaths. Current inactivity trends combined with the increasing costs of health and social care have the potential to severely impact on public services and communities. Therefore, tackling physical inactivity is critical and will enable us to improve the health, wellbeing and quality of life of a significant proportion of the population in England.

Context

This is one of three projects commissioned by Sport England with a focus on getting people with long-term conditions more active. This programme of work emerged from discussion with system leaders at a round table event at the Elevate Conference in 2019.

The three components of this work are:

1. **Industry standards, regulation, and a workforce database** - led by the Chartered Institute for the Management of Sport and Physical Activity (CIMPSA)
2. **A position statement on medical risk** to provide confidence to healthcare professionals to signpost, refer or recommend physical activity to people with long-term conditions - led by the Faculty of Sport and Exercise Medicine (FSEM)

[2] https://www.gov.uk/government/publications/health-matters-physical-activity/health-matters-physical-activity-prevention-and-management-of-long-term-conditions
[3] https://www.gov.uk/government/publications/health-matters-getting-every-adult-active-every-day/health-matters-getting-every-adult-active-every-day
[4] https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition
[5] https://www.kingsfund.org.uk/sites/default/files/field/field_document/managing-people-long-term-conditions-gp-inquiry-research-paper-mar11.pdf
[6] https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity

3. **Co-production of guidance** to improve the experience of physical activity for people with long-term conditions - led by the National Centre for Sport & Exercise Medicine – Sheffield (NCSEM)

Our focus is on the third point above – the development of co-produced guidance. Sport England initially considered a quality assurance framework but agreed co-produced guidance would be a more desirable product given it would be less prescriptive in nature, reflective of what the sector needs, and more focused on what good practice is already happening and how this can be amplified.

This work recognises the significant progress made over the last decade in improving the experience and offer for people with health conditions to engage in physical activity, and highlights the many different entry points into physical activity for people with health conditions. For example, exercise referral schemes, signposting to community offers and social prescribing. It has also confirmed the complexity of the delivery system which covers self-guided, professional-led, volunteer-led and 'prescribed' activity.

However, many people with health conditions who may have taken the critical first step to engage in physical activity are being 'lost' in the journey to getting active through process failures including lack of signposting/referral to opportunities and certification that the individual is 'safe' or 'fit' to undertake such activities.

Sport England and Public Health England, along with many others in the physical activity sector from academic, practice and policy backgrounds, have looked in detail at the barriers people face to participating in physical activity, and particularly those with health conditions. There is some excellent work already happening to inspire and support people with long-term conditions to build physical activity into their lives, and this is evident in the We Are Undefeatable campaign[7].

We Are Undefeatable, which launched in August 2019, is led by a collaboration of 15 leading health and social care charities and aims to help those with conditions such as diabetes, cancer, arthritis and Parkinson's to build physical activity into their lives. The campaign was launched to inspire, reassure and support people to be active by showing people living with a variety of conditions – both visible and invisible – on their own journeys to being active.

NCSEM wanted to explore how the system itself could make it easier for people with health conditions to become active and stay active. When we refer to 'the system' we mean the structures, organisations, people and processes that offer physical activity opportunities.

The focus was not on the individual components that enable or restrict physical activity, but about the organised, structured offers of activity support and the interactions people with health conditions have within the system.

The focus of the work and the development of the guidance is for adults with long term health conditions. The inclusion of the needs of children and young people is out of scope for this work as it would have required the inclusion of many different stakeholders not least including education.

Project aims

The overarching aim of this project was to make it easier for people with health conditions to get involved in sport and physical activity, to help manage their conditions and reduce their symptoms so they can live longer, better quality lives.

[7] https://weareundefeatable.co.uk/

In order to achieve that, NCSEM wanted to:

- understand what was needed to create 'friction-less' experiences for people with health conditions interfacing with the system
- create consensus about what quality physical activity experiences look like for people with health conditions
- involve a wide community of stakeholders to co-create solutions
- generate new insight and recommendations to those who provide, design and commission physical activity and health and care services
- get the sector working together better to improve the interactions people with health conditions have within the sport and physical activity sector
- co-create guidance for the sport and physical activity sector to make it easier to be active with a health condition.

NCSEM knew there was a huge amount of collective experience, insight and dedication across the sport and physical activity sector and recognised the need to listen and learn – at a national scale – to get as many people's input and ideas as possible.

It was also essential to hear the voice of experts by experience – those people living with health conditions.

Methodology

The NCSEM and Clever Together worked closely and adopted a methodological approach based on co-operative inquiry[8]. Together we needed to reach a large number of stakeholders from different organisations and sectors. The NCSEM were guided by Clever Togethers expertise in the approach to conduct research 'with' rather than 'on' people, fully acknowledging their vested interests in improvement and the development of solutions. Clever Together aims for research that is both informative, in that it answers questions, and is transformative, in that it engages individuals in the co-creation of new knowledge. We do not stand back from the problems that our clients are seeking to understand; we are unashamedly interventionist in our desire to create lasting change.

Clever Together uses crowdsourcing as a qualitative research method. It provides the scaling potential of technology and the co-creative potential of co-operative inquiry while allowing us to create space to hear an individual's experience of their world. Crowdsourcing provides a model for participative problem solving by blending an open creative process with a traditional, top-down, managed process. In our experience, it is particularly useful for local knowledge problems, where the information required for action is spread among individual actors and sits outside the knowledge of any central authority.

Co-creation through online workshops

An online workshop is similar to a physical workshop but it's more flexible and inclusive, which is really important where you have people working across the country.

- Everyone can join to make their voice heard
- Everything shared in the workshop is anonymous; names are not attached to anything
- Everyone can read, rate and comment upon the ideas of others
- Everyone can join the online workshop from a PC, tablet or smart phone
- The online workshop is accessible 24 hours a day, 7 days a week
- People can 'buy into' change because they play a role in shaping it; innovation happens from the ground – up.
- People across the nation are brought together to work collectively towards a shared goal.

Platform design and ethical approval

The design of the workshop platform and the challenge questions[9] were co-created by the NCSEM project team working in partnership with Clever Together. As part of this process, ethical approval was sought and granted by Sheffield Hallam University Faculty Ethics Committee.

The online workshop asked those who registered their interest to share their views on four broad questions:

- **Making it easier to be active**
  What are the things that could be started, stopped or done differently to make it easier for people with health conditions to get active and stay active?
- **Our collective impact**
  How have you and/or your organisation succeeded in helping people with health conditions to be physically active? Or in what circumstances were you not able to help and why?

[8] John Heron (1996) Co-operative Inquiry: Research into the Human Condition

[9] Online workshops, like physical workshops, require questions to be posed to the participants to frame the conversation and present a challenge or issue that needs their feedback or support. These initial framing questions are referred to as "challenge questions".

- **Adapting to our current situation**
  How has your physical activity or the way that you are supporting others to be active changed during the COVID-19 lockdown period and how do you feel about it? What is helping, or could further help, improve the opportunities and experience for people with health conditions to be active?
  This seed question was added one month into the live conversation as a response to the increasing challenges of the COVID-19 pandemic.
- **Any other ideas?**
  What other ideas or comments would you like to share that could improve the experience of being active for people with health conditions?

Seed ideas[10] were created for the online workshop to get the conversation started and to set the tone for the quality and breadth of the discussion. These were informed by ideas shared during the Active Partnership Long Term Health Conditions Learning Community event on 4 February.

We added an 'About this project' tab to the online platform to replicate a participant information sheet. Before joining the online workshop, participants were specifically asked to confirm they had read the participant information and were happy to continue.

Participants were also asked if they would like to be kept informed about this project, including when the co-produced guidance is published. A separate list of the names and email addresses of people who responded 'yes' will be provided to NCSEM.

Use of a gateway questionnaire

Data about participants, including their protected characteristics, was also requested when they first joined the online workshop. The purpose of the questionnaire was:

- to help us better analyse the views shared in the online discussions, and
- to provide assurance about the reach and diversity of the discussions.

All participants were allocated a randomly generated user identification number, to allow for analysis of the workshop without identifying individuals.

Generating interest

It was vital to raise awareness of the project, and the online workshop specifically, with a wide range of stakeholders and experts by experience. Activity to generate interest in this work began in early 2020.

Working closely with Sport England and Public Health England, NCSEM began to spread the message about the #EasierToBeActive online workshop and how people could register their interest.

It was our understanding that Sport England would provide support with communications and engagement on the lead up to and throughout the online workshop, supporting with events, and facilitating connections with key people to ensure the project would land well and was linked in with the other two pieces of work.

[10] Seed ideas are ideas already pre-populated in the #EasierToBeActive online workshop to help stimulate, or 'seed' the conversation.

We had originally planned to run a number of physical events in March 2020 to bring everyone together to share the excitement about what was coming, capture ideas and feedback, and seek support as ambassadors for this project.

Sheffield Hallam University issued a press release[11] on 12 March, and the first online workshop launched on 16 March. Clever Together sent a launch email from the online platform, on behalf of Professor Rob Copeland and Dr Anna Lowe as project sponsors, along with individual login details to all those who had registered their interest.

Reminder emails were also sent throughout the conversation at timely intervals to keep people updated about what was being discussed and to encourage them to log in and contribute.

The impact of COVID-19

The first online workshop was due to launch at the Active Partnerships Convention on 16 March. Tim Hollingsworth, Chief Executive of Sport England, was going to speak about the project in his keynote speech and this would be followed by quick connect sessions with groups of convention attendees.

Unfortunately, due the impact of COVID-19, the convention had to be cancelled, along with plans for further physical conference sessions and face-to-face events. We had to radically revise our engagement plans.

Fortunately, one of the benefits of holding an online workshop is that it is accessible from any internet-enabled device, from any location, 24 hours a day, 7 days a week so it is not limited by physical restrictions and still accessible to those who were isolating.

However, there was still a need to be sensitive to the crisis situation and the immediate pressures that partners and organisations were under. It was decided not to actively promote the online workshop, including through social media, throughout much of March and April. This undoubtedly impacted on the engagement with the conversation during this time period.

In April 2020, the decision was made to extend the closing date of the online workshop and to add a new question to ask about how people were adapting their physical activity, or physical activity offers, in response to COVID-19 and their increased time at home. Many people, including those with health conditions, were finding new and different ways to get active, and we wanted to explore that while we had the opportunity.

It was a challenging time for everyone in the physical activity space and people with health conditions were more vulnerable than ever. So, in a time when it was not possible to travel or meet in person, we encouraged people to connect with each other and share their ideas virtually.

At this point, it was agreed we would not run a second workshop, and that extending the first workshop further to gather as much insight as possible would be the best use of time and resources given the circumstances.

The voices of people with long term health conditions was not as prominent as we would have liked during the first stage and this has partly influenced the decision to expand the project to include follow on phases. We need to ensure that these voices are heard to develop the project outputs.

The #EasierToBeActive project was raised and discussed on a number of webinars, largely arranged by Sport England and the Active Partnership Network. It featured in newsletters and blogs, was

[11] https://www4.shu.ac.uk/mediacentre/national-conversation-launched-make-it-easier-people-health-conditions-be-active

cascaded through email networks, and we had specific virtual sessions with the physical activity leads from the Richmond Group of Charities, and the Active Partnership Network. These communications increased contributions and in the last two-three weeks of the conversation saw the largest number of comments and votes throughout the time period that the conversation was live. This highlights the need for regular communications and promotions of the conversation.

Some gentle messaging on twitter was revived towards the end of the online workshop to encourage a final push of activity.

Approach to coding and analysis

Clever Together explore data using a thematic analysis approach[12] - a method for identifying, organising, analysing and reporting patterns or rich themes within qualitative data. All ideas and comments were coded against a ground-up thematic coding framework. This is a robust process of data clustering to make sense of the full conversation.

We use an established and rigorous approach to thematic analysis:

- familiarisation with the data – we read every idea and comment
- produce initial codes
- search for themes and sort codes into themes - many ideas and comments contain multiple ideas and themes
- review and refine themes to ensure that only those fully supported by the data are included in the final analysis
- define and name themes to ensure that each theme is named in such a way as to identify the 'essence' of what it represents, and
- produce draft frameworks based on the insight of the crowd.

More information on the coding frame used in this analysis is included below in the section on *Analysis and findings of the online workshop*.

Seed ideas and other comments by facilitators have been excluded from this analysis, although responses to those prompts have been included.

Our analysis considers the number and nature of comments in response to ideas, and the number of positive and negative votes cast. This has allowed us to draw out both the most popular ideas, as well as those that were most contentious.

[12] Similar to the approach by Braun and Clark (2006)

Participant analysis

All participants were asked to self-register to receive login details so they could join the online workshop.

There were 637 people who registered their interest. Over half (351, 55.0%) completed the gateway survey and logged onto the platform to share their ideas and to read and vote on what others had shared. Just under half (167, 47.0%) were active participants by sharing an idea or comment or voting on someone else's contribution.

The majority of participants (301, 92.3%) described their participation in the conversation as having a professional interest, with only 25 (7.7%) having a personal interest. It is worth noting that given one in three people in England have a health condition, some participants are likely to have had both a professional and personal interest in the conversation, but this was not directly captured.

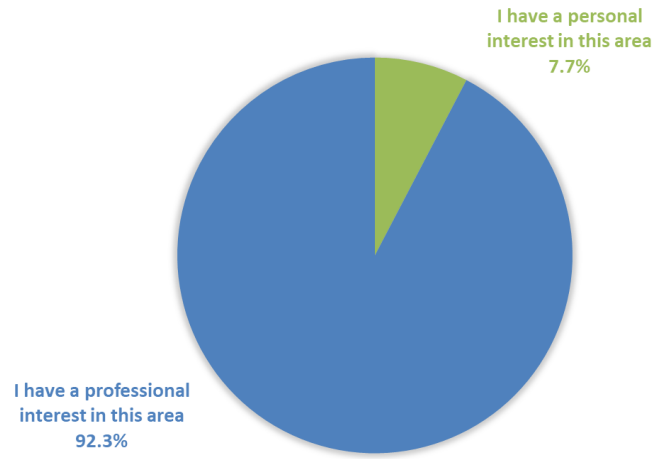

Figure 1: How participants best described their interest in the conversation

Of those who indicated they had a personal interest, 16 (4.9%) identified as having one or more health conditions. Because of the small number, we have not broken this group down any further as it would not help us to draw any meaningful conclusions. However, just under half of these participants listed multiple health conditions and the same proportion indicated they had a health condition other than the 11 conditions[13] we specifically listed in the gateway questionnaire.

Of those who indicated they had a professional interest, participation was greatest from sport and exercise professionals, fitness instructors and coaches (77, 25.6%), those who identified as 'Other' (64, 21.3%), and healthcare professionals (43, 14.3%). The 'Other' category included roles such as physical activity leads, programme managers, health and wellbeing/community/relationship/ lifestyle managers and advisors.

[13] Discussed and agreed with Public Health England

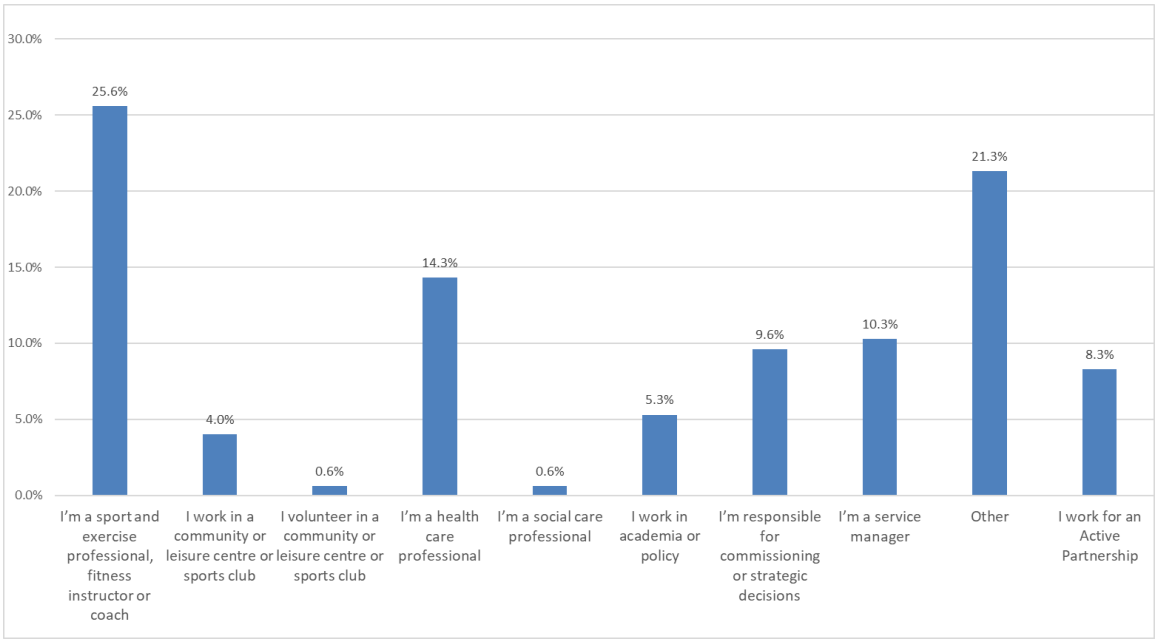

Figure 2: Primary role of those with a professional interest in the online workshop

This vast range of professionals were largely working across local government (70, 23.3%), voluntary or community organisations (50, 16.6%) and NHS funded health care providers (41, 13.6%).

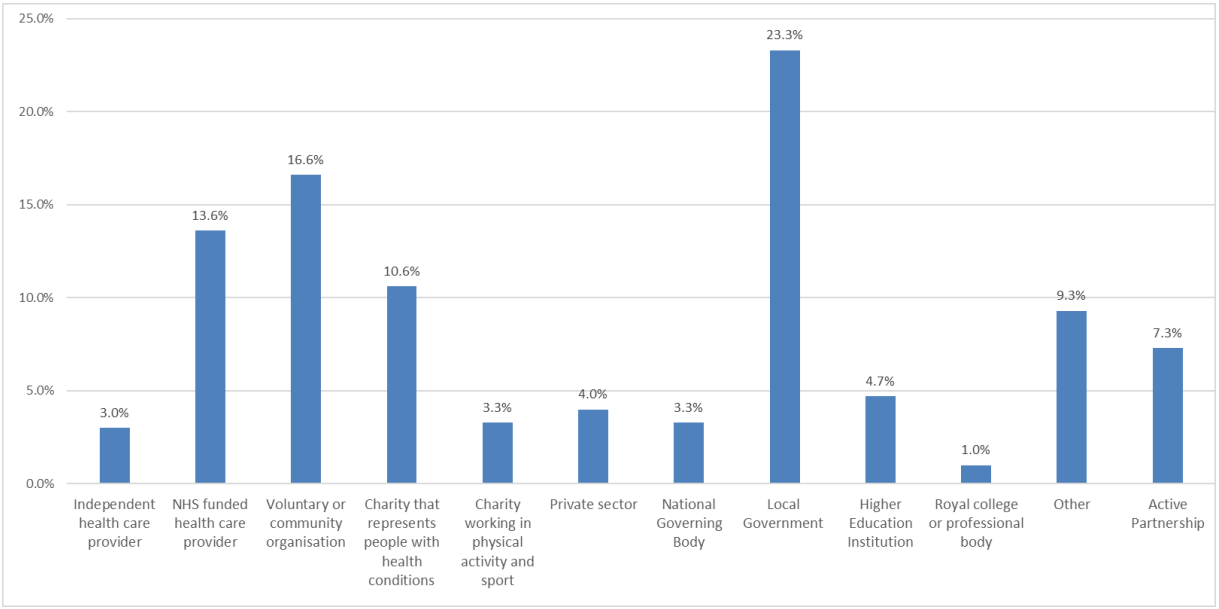

Figure 3: Primary work setting of those with a professional interest in the online workshop

We saw participation from across the country, as shown in Figure 4 below. The highest levels of participation came from North East & Yorkshire (70, 21.5%), which is not surprising given NCSEM's location and networks, and the South East (68, 20.9%) with comparatively less from the South West (27, 8.3%) and the East of England (28, 8.6%).

Figure 4: Where participants logged in to the online workshop from

Data about participants' protected characteristics was also analysed.

More women (225, 69%) joined the online workshop than men (96, 29.4%). Women were also more likely to be active participants than men (120, 36.6% and 44, 13.4% respectively).

Participation was highest from people between 30 – 39 years (99, 30.4%), closely followed by those aged 40 – 49 and 50 – 59. There was comparatively less participation from those over 60 (24, 7.3%) and under 29 (36, 11.0%).

The majority of participants identified as having a white ethnic background (311, 95.4%). We heard very little from those with a BAME background.

An intersectional analysis of the data on protected characteristics was not feasible because of the small numbers of individuals involved. It is worth noting that we did not ask for a measure of socio-economic status but this could be an area to further explore given some of the discussions in the conversation about affordability of services.

Contribution analysis

Participants were invited to respond to four challenge questions, 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.

Collectively, participants contributed 98 ideas and 192 comments and voted 888 times.

Participants shared their first-hand experiences of being active with a health condition or supporting others to do so, including their views on how the system operates and examples of what is working well and ideas for improvement. No attempt has been made to judge the veracity of people's claims; for the purpose of analysis, all contributions have been taken at face value. Where there are clear disagreements and differences of opinion about the topics being discussed, these have been reflected in the analysis.

Contributions from participants with health conditions

While there were limited contributions overall from participants with health conditions, the main focus was around intrinsic factors (33%) and specifically the desire for physical activities which enable social connection, belonging and fun. This was closely followed by systemic factors linked to pathways and referrals (26.7%) – including getting sign-off to participate, information to aid referral, links with community offers, and pathways based on individual needs – as well as service design (26/7%) – which is inclusive and accessible and allows options for individual choice.

Contributions from professional groups

Sport and exercise professionals, fitness instructors and coaches, who made up just over a quarter of the conversation, focused on healthcare professionals having the confidence and competence to talk to their patients about the importance of building physical activity into their lives. They raised ideas about service design (17, 29.3%) and ensuring activities are inclusive and accessible, evidenced-based and high quality. While healthcare professionals mostly discussed pathways and referrals (22, 42.3%) with a focus on medical screening and information needed to be able to refer.

Contributions from participants with protected characteristics

Acknowledging that many more women took part in the conversation, similar proportions of men (30, 8.5%) and women (78, 22.2%) contributed ideas around service design and in particular, ensuring services are person-centred and there is individual support available. While perhaps not linked to gender specifically, women were more interested in the information provided at the point of referral while men were proportionally more interested in physical assessment and triage and whether someone is deemed 'fit' for physical activity.

When considering age, those aged over 50 were most likely to have concerns with getting sign-off to participate in physical activity and more likely to talk about the need for individual support. Those under 50 emphasised the importance of healthcare professionals having the knowledge, confidence and the right attitudes to have conversations about sport and physical activity with people with health conditions.

Analysis and findings of the online workshop

The first online workshop attracted over 350 participants who shared over 1,100 contributions – a combination of ideas, comments and votes.

The majority of the contributions (40 ideas and 162 comments) were recorded in the "Making it easier to be active" part of the conversation, where participants shared a range of ideas on the barriers and enablers that can be encountered when navigating through the system on a journey to being more active. In the "Our collective impact" question (23 ideas and 9 comments), participants shared particular case studies and examples of successes in their work, while in the "Adapting to our current situation" question (22 ideas and 13 comments), participants shared examples of how they or their organisations have been adapting to the COVID-19 situation. In the "Other ideas" questions (13 ideas and 8 comments), participants offered additional ideas to improve the experience of being active.

Contributions across all four questions were coded with a consistent coding framework, which was developed through a grounded theory methodology. As contributions were read, themes were identified and ultimately organised in seven main categories. Where several themes were present in a single contribution, it was split and coded for each theme. This resulted in a total of 553 ideas and comments being coded in comparison to the 290 that were submitted.

As we share the findings of this conversation, it is important to point out that less than 5% of those who joined the conversation identified themselves as people living with a long-term condition. The dominant voices and viewpoints in this conversation reflect those of people who work within the system and take part in delivering services or helping people with long-term conditions in various capacities.

Emerging themes

Analysis of the conversation identified 23 themes that were organised into seven categories:

- Two overarching categories reflect the overall cultural environment as well as the integration of the entire health system.
- Four categories represent different touchpoints of the user with the system.
- One category reflects the intrinsic factors related to personal motivation that are at play when it comes to being physically active.

These include:

- **Intrinsic factors** – relates to personal factors that are at play when it comes to being physically active. Two of them surfaced in our conversation: the need for autonomy and empowerment and the need for social connection, belonging and fun.
- **Key actors** – relates to key actors within the system that people with long-term conditions encounter, such as healthcare professionals, instructors, receptionists, carers, etc. Three separate themes emerged which relate to the combination of confidence, competence and attitudes, the need for an inclusive workforce, and the need to support carers.
- **Pathways and referrals** – relates to the process of referrals and the pathways available to people with long-term conditions to access physical activity and follow a structured journey. Four separate themes emerged here: the need for an individualised pathway, access to information, the link with the community, and better triage.
- **Service design** – relates to the provision and design of services and includes eight separate themes: choice and person-centred design, affordability, accessibility, facilities, funding, innovation, individual support, and quality assurance.

- **Marketing and communications** – refers to communications efforts related to physical activity and targeted at people with long-term conditions. The conversation brought up four separate themes: education, messaging and language, channels, and the need for inclusive marketing.
- **Culture around sport and physical activity** – reflects the relationship our society has with physical activity, attitudes and prejudices around sport, limiting beliefs that seep through and are perpetuated throughout the system.
- **Integration and collaboration within the system** – reflects the need for integration between the various parts of the system and for collaborative approaches in designing pathways and services.

A more comprehensive explanation of each category and the associated themes can be found in Table 1 below.

Figure 5: Model to represent themes from the conversation

Table 1: Thematic coding framework used to analyse contributions in the online workshop

Category	Theme	Explanatory notes
Intrinsic factors (individual)	Autonomy and empowerment	Inspiring and encouraging self-management, and changes to mindsets
	Social connection, belonging, fun	Tapping into individual motivations and sense of camaraderie
Key actors	Support and education for carers	*The role of the carer in motivating and supporting activity*
	Confidence, competence and attitudes	*Knowledge, confidence and attitudes of healthcare professionals, social workers and trainers (incl. qualification frameworks and CPD)*
	Inclusive workforce	*Encouraging people with health conditions in the sport and physical activity workforce*
Pathways and referrals	Physical assessment, triage	*Process and ability to get sign-off or clearance to do physical activity*
	Information	*Having the information needed for referral about available and appropriate activities (session description, suitability, quality, instructors etc)* – *For healthcare professionals to refer* – *For self-referral (for people to choose activities)*
	Link with community (including social prescribing)	*Referring people to support in the community, including individual trainers*
	Individualised pathway	*Pathway based on the person's needs; balance between specialised and general pathways*
Service design	Individual support for users	*Importance of mentoring, peer-to-peer support, one-on-one with professionals*
	Facilities and environment	*Physical structure and set up*
	Quality assurance, evidence-based services	*Service evaluation and safety*
	Funding	*Lack of or need for funding; distribution and structure; means to a solution*
	Affordable services	*Affordability of the service*
	More choice and person-centred services	*Needs-based activity; options to allow the user to choose their preference*
	Inclusive and accessible	*Inclusive services; equitable in terms of accessibility*

Category	Theme	Explanatory notes
	Adaptable and innovative services	*New offers or ways of working to adapt to changes in situation*
Marketing and communications	Messaging and language	*How we talk about activity. Use of motivating and inclusive language and less-jargonistic or technical phrases*
	Education	*Raising awareness of the benefits of being active – improved health and wellbeing, reduced pain and symptoms, more risk in inactivity*
	Inclusive marketing	*Importance of imagery. Align with the values of the target audience.*
	Channels	*How messages are shared and promoted, effectiveness of variety of comms channels*
Culture around sport and physical activity		*Attitudes, prejudices and what we associate with sports and physical activity such as competition or needing particular skills that may put people off getting active.* – *Historical emotional or psychological feelings* – *Relationship with sport on a personal and societal level*
Integration and collaboration within the system		*Joined-up and integrated services (smooth transitions between services); Co-design with various stakeholders; Collaboration and knowledge-exchange between healthcare professionals, trainers.*

Table 2 below shows the weight of each category and sub-theme within the entire conversation based on the number of ideas, comments and positive votes it received. Although the volume of contributions is not a direct indicator of strength of feeling, it can be useful to understand the relative proportions of contributions across themes, as this can support the prioritisation of actions.

Themes within the category of service design were the focus of our online workshop, garnering the biggest number of ideas, comments and positive votes. Next in interest were themes within pathways and referrals, marketing and communications, intrinsic factors, key actors, integration and collaboration within the system, and culture around sport and physical activity.

Category and sub-theme	Weight in conversation
Intrinsic factors	**10.7%**
Autonomy and empowerment	6.2%
Social connection, belonging, fun	4.5%
Key actors	**9.8%**
Confidence, competence and attitudes	9.2%
Inclusive workforce	0.2%
Support and education for carers	0.4%
Pathways and referrals	**25.1%**
Information	9.7%
Link with community (incl. social prescribing)	5.4%
Physical assessment and triage	5.8%
Individualised pathway	4.2%
Service design	**29.8%**
More choice and person-centred services	8.7%
Individual support	4.5%
Inclusive and accessible	3.2%
Affordable services	3.8%
Funding for services	2.0%
Facilities and environment	1.8%
Adaptable and innovative services	4.0%
Quality assurance, evidence-based services	1.7%
Marketing and communications	**12.4%**
Education	4.1%
Messaging and language	5.2%
Inclusive marketing	1.4%
Channels	1.6%
Culture around sport and physical activity	**6.5%**
Integration and collaboration within the system	**6.6%**

Table 2: Weight of conversation by category and sub-theme

Intrinsic factors

The individual sits at the heart of any public service and at the beginning of any journey towards a healthier life. In about 10% of our conversation, participants with both personal and professional interests referred explicitly to the importance of intrinsic factors on the road to becoming more active. While there are many different components that affect personal motivation, two main themes came out of our conversation – 'autonomy and empowerment' and 'social connection, belonging and fun'.

Autonomy and empowerment

For people with long-term conditions, it is crucial that they feel empowered on their journey to becoming more active. The sense of personal empowerment and autonomy can be easily lost after a new health condition diagnosis due to fear and confusion about what it means for the future of the individual. This is why being informed and supported are key elements in empowering people with long-term conditions.

"Living well with a disability requires a sense of personal autonomy and empowerment ... It is not helpful to have a diagnosis and then be left high and dry with no real clear idea how to live well with it."

It is important to design environments and services in ways that allow users to be more confident and autonomous. This includes providing more choice of activities and information about them, making services inclusive and affordable, educating users on the benefits of physical activity and building confidence through every interaction with a health care professional, personal trainer, peer or other actor within the system.

"… we are individuals, allow us to be just that, create environments and cultures that provide us with options, give us confidence and help us to build capital regardless of where we live, how much money we have or who we know."

Empowering people also means identifying and removing the specific, individual barriers that stand in the way of each person with a long-term condition. This may require individual support at different stages of the journey. For some people, this may mean making them aware of the benefits of being more active, for others it may be about helping them find the right activity or helping them set realistic goals, track their progress and celebrate their improvements.

"Let's worry less about 'what' activity people do and instead focus our energy and funding into ensuring that more people feel empowered and inspired to move by 'the system' and everyone who has a role in it."

"We really need to focus on building self-worth and confidence in people … Let's focus on what really matters to people - what are the benefits that motivate them (pain reduction/kneeling down to be able to play with the grandkids… there will be lots of things that are so different). PA is just the conduit to other things and we need to keep that perspective."

The language, messages and images used in marketing materials, also have a big role to play in fostering the feeling of empowerment. These will be discussed further in the marketing and communications section, but we can acknowledge that inclusive imagery and language as well as messages that focus on how physical activity improves quality of life can act as motivation for people with long-term conditions.

"Being active for it's own sake won't be enough for many, if people are empowered to improve their on quality of life and manage their condition through physical activity they are much more likely to stick to it and create sustained behaviour change."

Some participants discussed the importance of incentives, particularly the provision of free services, and how they affect personal motivation. Several participants were of the opinion that 'free' activities offer no incentive or commitment to users as there is no additional loss/cost to remaining inactive and therefore it is better to charge a fee. Others pointed out, however, that while this may be true for people who can afford to pay for services, it is crucial that services are made affordable to all.

Social connection, belonging, fun

Participants talked a lot about the social aspects of physical activity. For many people who are just starting on their journey, it is not the activity itself that motivates them, but the social dimensions around it – overcoming loneliness, belonging to a community, interacting with peers and having fun. It was pointed out that, nowadays, many other pastimes compete for people's attention and if physical activity was not perceived as fun, it might be pushed aside for more enjoyable endeavours.

"Finding creative ways to engage people and then meeting them where they are at with a non-threatening, safe, progressive and appropriate offer has worked in my experience … The social, expressive and meaningful aspects of our sessions are the sizzle that sells the exercise content. People forget they are 'exercising'."

"We should stress the FUN element of exercising, especially in a group, meeting friends and sharing a joke. It's the camaraderie people enjoy. They don't always go for the health benefits!"

Many contributors to our conversation shared specific examples of how they incorporate social or creative activities into their services to motivate people – from coffee mornings, quizzes and social media challenges to singing and art. Some instructors, for example, start exercise sessions with a social chat with the group, acknowledging that the socialising aspect of the session is as important as the exercise.

"Not everyone is motivated to be active. We need to develop stealthy approaches to ensure people are motivated to be active without knowing. Art is a good example, using a narrative (story) to bring people on a journey helps because physical activity is secondary. Social support and that feeling of belonging is essential."

Being able to involve other family members can also be a great motivator. Several participants talked about how they would like to see more activities where they can participate with their children. Some service providers have created online videos specifically for families with options to exercise with teenagers or younger children.

"My ten year old is too young to be left at home alone while I go to a class. I'd love to take her along to a class we can do together. Helping her to stay fit is important to me and she is a great motivator for me."

"There is a definite gap in the market for whole family offers/solutions to enable all family members to get active together in a way that suits them."

A discussion emerged around team sports and the role they can play in motivating people to be more physically active. Some participants found individual sports to be too lonely, while team sports motivated them by making them part of a community. Other participants, however, expressed

concern over the ability to make a commitment to a team sport (due to the unpredictable nature of their condition), as well as the potentially discouraging aspects of competition. This discussion once again highlights the fact that there is no 'one-size-fits-all' answer to getting people more active, but individual preferences and barriers need to always be taken into account.

"Exercise and even physical activity have always sounded lonely and require a lot of self motivation. In my experience 'training', 'team sport' and a bit of competition are easier motivators, give you community and you are getting fitter while having fun, the exercise element becomes secondary for some."

The social aspects of physical activity are not only motivators but are also some of the important benefits of physical activity that lead to an improved wellbeing, which is why it is important to promote and educate users about them.

"The great news is that now there is better knowledge, insight into the physical activity offer they can tap into and its spoken about as an alternative way of improving some issue people may face such as wanting to be with people who they can relate to, reducing social isolation, improving confidence and mental wellbeing etc. a rounded approach to a person's wellbeing - not looking at it by a single issue."

Key actors

The people that those with health conditions encounter throughout the system can be a great source of inspiration and motivation or can unwittingly become a barrier preventing personal progress. This is why, almost 10% of the conversation focused on the attitudes, knowledge, and confidence of key actors such as healthcare professionals and trainers. Two other topics emerged as well, albeit briefly, that could be further explored in any additional phases of the project– the importance of an inclusive workforce and the need for education and support for carers.

Confidence, competence and attitudes

Many participants in our conversation talked about the lack of confidence they have encountered in health care professionals who hesitate to talk about or recommend physical activity due to a limited understanding of its benefits on overall health, the abilities of patients and trainers, and the opportunities available to patients. Education and training is needed to build confidence in HCPs. Additionally, participants suggested a more integrated approach to incorporating conversations about physical activity throughout the system by making it a necessary part of every interaction between a healthcare professional and a patient.

"More needs to be done to support health and social care workers inc GPs and social prescribers to understand the benefits of physical activity… [they] don't recognise or know the benefits and are therefore not confident to have those conversations with people."

"Health and social care professionals: there is a need to collectively address the confidence and competence of these professionals to have brief conversations with clients/patients/people about moving more. Starting from the top down, systems must allow for these conversations to take place; moving towards reframing movement as a core principle of supporting individuals

The training of health professionals is an important component of building their knowledge and confidence. Some participants in the conversation shared that they develop physical activity guides to inform healthcare professionals and support them in having conversations with patients.

"…health improvement needs to be acknowledged as a core and consistent part of the training of all health professionals. Messages from health professionals, even brief interventions, can be very powerful."

"Support others to champion, deliver and enable people to be active. We developed a local 'quick guide' for healthcare professionals, with local case studies and promotion on social media."

A few participants pointed to the risk of liability that may prevent some healthcare professionals from referring patients and to the need to better assess (possibly independently) the risk of exercising. This highlights the importance of the work to agree a position statement on medical risk, led by the Faculty of Sport and Exercise Medicine.

"…most aren't qualified to assess the risk for an individual of exercising and the current system doesn't give them the confidence to signpost or refer without fear of them being liable. This is such a tricky area that we haven't cracked mainly because of the worries about liability for both the 'referrer' and the 'receiver' (instructor or coach who may or may not be qualified or confident either!"

Participants also recognise the need for healthcare professionals to be role models themselves and inspire patients by setting a personal example.

"The NHS clinicians need to be encouraged and incentivised to be physically active themselves to be role models to patients."

"Too many times I have seen professionals i.e. nurses, doctors, social workers etc try to encourage those with health conditions to exercise however they do not believe in the process themselves."

Equally important to the training of healthcare professionals is the training and education of training providers. They need to develop the right competence and qualifications to support people with different abilities, to know how to modify exercises based on personal needs and to generally instil confidence both in people with long-term conditions and the healthcare professionals who refer them. Just like healthcare professionals, trainers, as well as other staff such as in reception areas, need to be able to talk to and motivate people, which may require specific training.

"I think community/private coaches/instructors should be supported more to understand conditions so they're not scared of including people who have high level needs."

"Facility/reception areas/teams - are often not prepared/trained to confidently communicate with people with communication challenges ie an exercise session for stroke survivors starts at the reception area/welcome and requires workforce to identify how to support these challenges."

"Participants to feel confident that coaches/leaders/instructors had skills to support 'me' specifically"

Some participants expressed concern about the lack of transparency and honesty for the level of qualifications of instructors, especially with the proliferation of online courses where there is a perception that anyone can become a coach.

"Instructor's qualifications need to be more transparent of what they are qualified to do and what they should not. Many personal trainers give incorrect dietary advice to people with long-term conditions. A nutrition module does not make you a registered dietician. Similarly, we should not be encouraging unqualified celebrity fitness 'experts', just because they have a large online following."

Attitudes and beliefs towards people with health conditions are also very important. Participants shared that they can be discouraged if they feel a lack of support or belief by the professionals they encounter. Empathy towards, and understanding of, people and their individual circumstances is an important step in building trust, confidence and motivation to engage in physical activity.

"Physical activity instructors/leaders: every leader - in particular - PTs/health trainers, must firstly learn about people not the activity. We need to challenge more how our physical activity workforce is person centred, that they therefore have empathy and understanding and support them to develop so they can build rapport and trust rather than the focus being on the activity they are delivering. The best instructors I have heard about are the ones who really care and quickly build a trusted relationships with the person who is involved in their session or programme."

"The workforce is one of the most important resources available and having the time to spend with referrals to build rapport / understanding, they can enable people to be active how they want to be. However some of the workforce can be a barrier especially to people who are inactive."

Inclusive workforce

The topic of an inclusive workforce was mentioned only on a few occasions. However, it may be important to explore further during the next phase of the project. Participants pointed out the need for both healthcare professionals and instructors to be able to understand the lived experiences of people with long-term conditions and one of the best ways to achieve that is to actually include

people with long-term conditions in the workforce. As well as to build a more representative workforce in general (such as in terms of age). This may require a concerted effort in recruiting, training and supporting a more diverse group of people to join the system.

"What we really need is a truly inclusive workforce. A number of years ago NGBs received funding to develop just that, I can't really see where that workforce is… What we need is a clear pathway in volunteering so disabled people can see their possible pathway into perhaps paid employment."

"The leisure industry is often managed by the younger population because the pay is so low but they don't have the life experience needed when dealing with the special needs / older population."

Support and education for carers

The role of carers was only briefly touched on in this conversation but that may be due to a lack of engagement from carers and the small number of participants from outside of the healthcare system. Nevertheless, the few contributions remind us of the importance of carers when it comes to motivating their loved ones and helping them sustain their journey. It may be worth exploring further the specific needs of carers in a future phase of the project and ways to help them provide better support to the people they take care of, as well as to help them be more physically active themselves.

"Some of the messaging around getting active needs to be aimed at carers as they often hold the key to getting people moving in the house, or getting them up and into the car for their weekly community activity. The impact and role of carers can often be forgotten but can be really valuable."

"Carers are vital in motivating their loved one, the majority of times they are the reason the individual has done so well. Educating them to assure them that exercising for the carer and person with LTC is something they can do together, activities such as housework chores can be a great place to start."

"Many people with LTCs will have carer/family member that provides support… Upskilling them to help support someone into physical activity could make a massive difference."

Pathways and referrals

A quarter of the conversation focused on the process of referrals and the pathways available to people with health conditions to access physical activity and follow a structured journey. Many service users and healthcare professionals encounter barriers at this point of the system that slows down their progress or diminishes their motivation. The lack of information, for example, was one of the biggest barriers and about 9% of the entire conversation focused on it. Lack of better physical assessment procedures and standards are another barrier as well as the need for more individualised pathways and a better connection with the services provided in the local community and social prescribing.

Information

Information is needed both for healthcare professionals to refer to local providers and for people with health conditions to select the most appropriate activity. Many participants share frustrations with the lack of information about the availability and quality of activities, experiences of trainers and the lack of descriptions of classes.

"Many patients were unaware of the local opportunities to them!"

"The individual should be able to get guidance about the activities intensity and how it works your body to allow them to make informed choices."

"Improving communication so people requiring support can access the services they need to."

For those living with health conditions, it is particularly important to be able to read a description or see a video of the class in order to decide whether it is something they are comfortable doing. Many people with long-term conditions find it daunting to just attend a session without knowing what to expect. Providing more detailed information about the content of classes and ability of instructors can alleviate existing anxieties, while information about the qualifications of instructors can give more confidence to healthcare professionals to refer. Some providers shared that they allow people to observe a class from outside the studio in order to help them decide if it would suit them.

"If like me you are unfit and uncoordinated going to an exercise class is really daunting… how about having a video of an actual class available for people to see online… Then I wouldn't be stepping completely into the unknow."

"Referral in to formal exercise schemes is inhibited by a historic lack of understanding, and confidence, as to the standards within the fitness industry, which have now been largely addressed and standardised."

The ability of local providers to promote their services in local medical practices is also very important to connect people with long-term conditions with available opportunities. There appear to be some bureaucratic barriers to this, such as not allowing self-employed exercise professionals to advertise nor allowing for paid services to be promoted.

"Having worked in cardiac rehab for 20 years and COPD rehab for 10 years I have not yet achieved getting a poster advertising these classes, which take place in the local leisure centre, to be displayed by a GP practise. This is because there is a fee element required for the classes… Locals miss out for this bureaucratic dogma."

"There are many community led activities available, but GP practices often don't promote these for fear of them not being tailored to condition-specific needs."

There were many suggestions for information technology solutions in the form of centralised databases and processes or websites and applications that healthcare professionals and users could access in order to see what options are available. At the same time, providers could use such platforms to input and update information about their offers. While such a system is desirable, the discussion suggests that its creation and maintenance is difficult and costly. An example from Active Suffolk shared in the conversation, included the employment of a part-time 'activity menu co-ordinator' who would look for physical activity sessions particularly suited to clients who had long term health conditions. The resulting database was useful and appreciated by many partners but the project had to be discontinued due to lack of funding.

"If all funded PA offers were required to share data about their offer, and if this data were aggregated, then there would be an awesome resource to help connect people with PA opportunities."

"If there was a way to search by patient postcode to bring up a list of PA opportunities locally that would be so helpful. Then if you could filter based on various parameters eg cost (eg. free/charge), or type/intensity (eg. chair exercises etc) etc. that would make it easier to navigate and find something suitable."

"There is difficulty with this information being kept up to date as well as how it is collected."

Participants in the conversation also pointed out that the limited time patients have with their GPs is often an obstacle to getting all the necessary information and advice. Many providers shared that they find group consultations or other group events as an effective way to overcome this barrier and inform people about the benefits of physical activity and the opportunities in the community. Another solution is to prepare ready-made resources that GPs can hand out to patients.

"The traditional one-to-one 10-minute appointment may no longer be suitable for complex consultations needed by people with long term conditions. Group GP appointments could be an effective way to give patients more information about their condition and how to be active, because they learn from the doctor and each other."

"We worked with an in-house graphic designed to create a "Ways to Move more in Camden" resource for healthcare professionals to be able to give out to patients. Healthcare professionals, particularly GPs, have little time to find out about local opportunities and so were hugely grateful to hear that we were creating a resource that they could give out to patients"

Link with the community and social prescribing

Participants discussed the importance of linking the healthcare process with various actors within the local community through social prescribing or additional mechanisms. Funding, support and active collaboration are needed to enable the development of more local offers and opportunities to help people with long-term conditions.

"Lots of healthcare professionals want to prescribe/promote PA. There are also lots of local/community-based PA opportunities. However, it's very difficult to link the two up, I know that social prescibing aims to reduce this issue but it can't be a solution for everyone. There need to be other mechanisms that help to close the gap between healthcare and community PA offers."

"Link personalised care into primary care networks and signpost to community-based activities and non-clinical services."

"Social prescribing is a linking mechanism and won't solve the problem alone. However, I do think that it is a critical link between healthcare and services."

Participants recognised the need to collaborate with other actors across the wider system, such as the voluntary and community sector, and enable them to take some of the burden away from primary and secondary care. They emphasised the important role of community partners in helping people with long-term conditions be more active by being able to understand and meet specific local needs.

"We need to keep the burden away from primary and secondary care - and manage a lot of this in the community (it's not rocket science, is it?!)."

"There is also an opportunity to create more of a place-based movement of wellbeing where community partners are at the heart of this type of initiative. Whether you have a health condition or not, coming together with your local community through a wellbeing movement may help with confidence of feeling as an equal with everyone else."

There were many examples shared by contributors in the "Our Impact" part of the conversation of how they make connections to and collaborate with the local community. These included working with local instructors to develop online classes, signposting to local support services and helplines, collaborating with mental health services to highlight the importance of physical activity, organising tours of local leisure centres, leading local health walks, and working with local partners to distribute physical activity resources such as well-being packs and exercise equipment.

Physical assessment and triage

Participants in the conversation expressed the need to make it easier to sign up to physical activity opportunities. This means removing the barriers related to getting medical clearance (such as healthcare professionals' confidence, as well as information barriers and fees) and simplifying and standardising the process of triage.

"If you have a health condition, it can be difficult to get medical clearance to participate in certain physical activities. Often this requires sign-off from a health professional, for a fee, who may not even feel qualified or confident to do this."

Some suggested the development of a tool for triage that could also be used by fitness professionals and remove the need for people to get clearance from their doctors. Other suggestions for making physical assessment and sign-off easier included the introduction of a grading system that signifies the level of support that people need, instead of labelling them with a condition. Another contribution shared the results of a county-wide consultation with key stakeholders where they agreed on a single-point of access with central triage from an appropriately trained person who could understand the individual's needs and the subsequent level of support required - from just going for a walk to attending a structured intervention.

"Disease specific models are expensive and is less sustainable. Focusing on functional capacity and having suitable support mechanisms more inclusive for anyone."

"All this is back to the fact the National Quality Assurance Framework for exercise referral is 2001 and could do with an update … Paying a GP to sign off a PAR-Q or allowing attendance is ridiculous as they know less about exercise and LTCs than the L4 instructor they are sending people back to!"

Contributors to the conversation also emphasised the need to reduce the fear of liability in healthcare professionals, providers and insurers by being able to properly assess risk. One

suggestion was for medical unions to put out a statement to say that the risk of being active at anything up to a moderate intensity (based on perceived rate of exertion not a particular type of activity) is low risk and unless an individual has certain contraindications they should be able to exercise without fear of an 'event'. Others highlighted the importance of empowering the individual in such matters by saying that it should be the responsibility of people with long-term conditions to decide or to at least empower them to be an active part of the decision.

"People are responsible for their own health and very capable to make informed decisions. GPs often don't know their patients well enough to inform local gyms but the risks of inactivity are far greater than being active. GPs won't hesitate to recommend exercise/ activity so why do we still need this?"

"People who are fit and healthy are told they need to see their GP prior to being able to exercise and this sends the wrong message … Patients who have a health condition but are safe and well-managed should not be asked to see their GP."

Individualised pathways

The theme of an individualised approach to supporting people with long-term conditions emerged throughout the data and in different categories. In this particular category it refers to the need for a person-centred approach that takes into account the individual's current context (starting with an appropriate physical assessment), needs, interests and preferences when creating a physical activity plan.

"Talk to people about the types of activity that may be right for them. Refer/signpost them to relevant support and services but remember they are often the experts of their condition and know their own limits."

"I know of a Staying Well referral programme that is now working on bringing physical activity in line and to the front…This means there is a lot of work in understanding the individual and their needs, whatever they maybe and working towards a plan that will support them."

A significant part of the conversation focused on the need for, and usefulness of, specialised, condition-specific pathways. Some participants recognised the benefits of condition-specific programs in connecting people with health conditions to peers and reducing the burden on secondary care with a step up or step-down service to manage or improve specific exacerbations of conditions. Specialised programs also help new users to gradually ease into a more general physical activity offer by providing condition-specific information and support that alleviates initial fears related to exercising.

Alternatively, other contributors emphasised the need to simply focus on encouraging more movement, commenting that the general exercise principles and intensities across the majority of health conditions are very similar. They also argued that condition-specific programs often have poor attendance and it may be more cost-effective to provide more general sessions.

"Providing specialist guidance can often make the difference to such people's success in moving more."

"We oversee the ESCAPE-pain programme which was designed for people with knee/hip osteoarthritic pain. Participants tell us that they particularly like it as they are scared that participating in other programmes may damage their joints. Following participation in the 6-week ESCAPE-pain programme any myths they may have had about safety to exercise are dispelled and many go on to join other general classes."

Ultimately, it is clear that people with long-term conditions want to have choice and agency when it comes to their individual journeys. In order for this to happen, they need to encounter competent

healthcare professionals who can have informative and motivating conversations about what is available and appropriate, and continue to support them as their capabilities and needs change.

"It would be really great to have a diagnosis and then have a kind of personal journey mapped out with a dedicated health professional who can guide that person to find ways of becoming active and staying active. This should not be a blanket pathway to being 'well' but rather a personal, more intuitive journey that supports someone to become healthier and as the person begins to feel more confident then that support can be reduced - but always available for the dark days that inevitably occur."

Service design

A third of the contributions in the conversation were related to service design, touching upon the need for accessible, inclusive, adaptable and person-centred services that people can afford and enjoy. What people with conditions want most is choice and services that are tailored to their individual needs.

More choice and person-centred services

The desire for individualised pathways continues with that for individualised services. For service users, this means having various options for activity that they can choose to engage with based on their physical activity levels, interests, and other needs and personal circumstances such as taking care of children.

Activities should be flexible, menu-based, focused on different delivery models, venues, times. For example, a flexible service may mean accounting for the unpredictable nature of some conditions by providing users with the option to freeze a membership for a period of time if needed. Person-centred services also mean services that are delivered by staff who can adapt them to fit the individual's particular needs and to achieve specific individual outcomes, whether it is improving strength, balance, the ability to walk or something else.

"We should move away from the generic form of changing the individual to fit the exercise and rather set the focus on changing the exercise to fit the individual."

"Every condition is different and everyone person is different. We need to have a flexible approach and a range of offers in order to meet the vast range of needs and challenges of people with long term health conditions that can vary day to day."

"…for me it is vitally important to have an instructor who can support someone into becoming confident about the choices they make about how active they can be and how they engage in sport and activities."

Many contributors shared their experiences with various forms of activities designed to appeal to and suit different audiences. For example, using dance for strength and balance for older people at risk of a fall; aquatic activities for low impact; providing low-intensity activities for those who do not require additional support; providing courses from Tai Chi, Yoga, Pilates, HIIT, to Seated Exercise and Active Story Telling – so that everyone can find something they like; designing classes for people with children; adapting group exercise formats through changes in the environment (such as levels of light, volume and space); providing choice of setting – outdoors vs. indoors vs. online or even having instructors visit people's homes.

"Needs to be a true sense that the activity, exercise or programme has been designed with the person in the centre and to benefit that person - not to increase KPIs, or to get people through the door."

The conversation reaffirms that it is not the particular activity that leads to success but the fact there was a choice and individualised approach for the person engaging with that activity. To achieve services that are truly person-centred, however, there need to be opportunities for feedback and co-design with people with long-term conditions.

Individual support

As a continuation of person-centred services, individual support refers to the importance of mentoring, peer-to-peer support and the opportunities to have one-on-one time with professionals. The focus is on having a person or several people who can provide continuous support, follow the individual's journey and assist them along the way - make regular check-ins, provide advice and encouragement during difficult moments, as well as acknowledge and celebrate successes.

Many contributors talked about the value of peers as they can be a source of motivation by sharing personal success stories. However, they also point out that peers need training to be able to provide support in the right way.

"Find Peer mentors to get out there and deliver their stories so that others can be caught up in their enthusiasm and seek to make change for themselves."

Some providers set up support calls on a periodic basis to offer words of encouragement and listen to what individuals have been doing to keep active. They also provide opportunities for one-on-one queries with coaches who offer tailored advice. Others shared examples of virtual buddy systems that link people with buddies and let them track each other's progress. Facebook groups were also mentioned as a way to connect people with health care professionals who can give them specific support.

"Building confidence in patients to allow them to change their behavior – having "physical activity clinics" where people can get support from professionals to keep them motivated, and give them tools to change their behavior. Have ongoing to support via phone or face to face meetings, rather than one off support. Ensure people are moving through the behaviour change cycle."

"We have facebook support groups set up for each area which have been really well received, and have started to invite other health professionals into the groups for additional support. They have been really useful in offering tips and sharing ideas and also for peer support / social contact with others."

Inclusive and accessible

The theme of inclusive and accessible physical activity is inevitably intertwined with the themes of person-centred services and individual support, as one naturally leads to the other. Nevertheless, a number of contributions referred specifically to the need for inclusive services, calling attention to recognising and overcoming barriers that may prevent individuals from accessing certain services and for making physical activity accessible even without an organised service.

For example, not having access to child-care may prevent some people from attending sessions. Not having access to computers or the internet or having low digital literacy may prevent others from partaking in online classes. Some users may require specialised or adapted equipment to take part in activities. Lack of transportation to and from activities can also be a barrier to participating. Informational and other resources may require translating for non-English users. Even walking activities may not be accessible for all people with long-term conditions and may require adaptation.

"Active Humber have developed an A5 leaflet supporting ideas for older people / people with health conditions with no access to online resources to be active at home. These have been delivered along with food packages, medicine deliveries, care packages etc."

"The biggest challenge has been with keeping older adults engaged due to issues with accessing online content and not having suitable devices. We are working with AgeUK in locating those most in need of support and hopefully getting them connected."

It is important for providers to ask the question of how they can make their services more inclusive, and for health professionals to make physical activity accessible even outside structured classes.

"The GOGA programme measures the impact of their funding across the UK. The programme is a great example of inclusive practices across the broad spectrum of supporting different groups, abilities, ethnicity's etc to become more physically active."

Affordable services

For services to be accessible they also need to be affordable. This issue was brought up several times when discussing barriers to physical activity.

As mentioned in the section discussing intrinsic factors, some contributors believe that free services may reduce motivation and adherence. However, cost clearly remains a barrier for many users, especially those on lower income as well as families who want to exercise together.

Making services affordable is an important step to making them truly inclusive and accessible. For example, the upsurge of free online classes during the COVID-19 crisis seems to have contributed to an increased uptake of physical activity by some people.

"I work for a leisure centre that runs an exercise referral scheme. This does not receive any funding and so we have to charge the participants. Although it is a reduced rate, it is still prohibitive for those on lower incomes, who also may have to pay for transport to get there. These are often the people who are most in need of the support and would benefit the most."

Funding for services

Throughout the conversation, some contributors referenced funding as a barrier to providing reliable and necessary services. Decreased funding leads to the closing of valuable services and programs, short-term funding prevents continuous programs from developing, while meeting the needs of the local community may require access to new funding.

"Short term funding means that services are often only available for a limited time and can be closed regardless of whether they are having successful outcomes or being well attended. This creates problems with continuity, engagement and referrals from health care professionals and can mean people accessing these services are left feeling without support."

The way resources are distributed was also discussed, with some participants sharing that resources are usually directed at fitness providers and may not reach the local communities where people may be able to provide a better offer. The distribution of government resources is also affected by how services are evaluated, so new and improved ways of measuring outcomes may be needed to accommodate the diversity of the service offer. Some contributors encourage funding to be devolved down to local areas and local Public Health teams who look at the evidence base and decide what is needed, rather than continue with the current top down approach.

"We know PA is effective and we know there are schemes out there doing wonderful things, but programmes are so heterogeneous that comparison is near on impossible and evidence of long-term impact weak. This means that bodies like NICE only advocate for schemes that have robust

evaluation attached (amongst other requirements). I also think that this requirement resulted in many organisation throwing money at M&E to appear to tick that box."

Some participants commented on the way funding is spent, expressing concern that the majority covers costs related to marketing, planning, external consultants and administrative costs rather than on getting people to be more active.

The availability of funding also affects the price of services which, as already discussed, can become a barrier for users to engage with physical activity. We should keep in mind that the funding of physical activity as a preventative measure is likely to save the health system millions in improved health and wellbeing of the population.

"I appreciate that the health service is under financial pressure, but I've seen from those that do attend, the cost savings their physical and mental improvement must be having on the health service. Funding for preventative measures would be beneficial in the long term."

Facilities and environment

Facilities, equipment and the overall environment people with conditions live in plays an important role in motivating them to engage in physical activity and in making it accessible and inclusive. Contributors shared a few ideas on how these could be improved.

"…for those who open up to the idea [of physical activity] the available environments need to be right, accessible and motivating."

Those who manage exercise areas should consider that light, sound, windows, mirrors in these areas may need to be adjusted to accommodate people with different long-term conditions. For example, some people with mental health challenges may not want to see themselves; autistic and neuro-diverse people may be sensitive to light or sound or other stimuli; layouts may need to change to accommodate multiple wheelchair users. Attention should be paid to waiting areas and parking spaces, as well as providing transportation to and from exercise centres.

"At Swim England we have been working with operators to look at creating pools that are accessible and attract people with health conditions."

"Providing more transport solutions, or having better links with transport providers would allow a better experience for participants."

Providing access to equipment such as exercise bands, badminton, foot golf, table tennis, bean bags etc. – can also enable and encourage physical activity. Some participants shared examples that they deliver exercise equipment, including adapted bikes to people to enable them to go out cycling.

Contributors also pointed to the importance of building improved city infrastructure to encourage physical activity. For example, reducing motorised traffic and encouraging walking and cycling, providing better transportation to leisure centres, and ensuring that outdoor areas and parks are appropriate for people with health conditions, with enough benches, rests stops, and public toilets.

Once again, involving people with long-term conditions in the creation of facilities and infrastructure is crucial.

"Facilities need to be coproduced with the community, not with swimming clubs and equipment manufactures."

Adaptable and innovative services

As the COVID-19 crisis hit the world, it became clear that systems and services need to be able to adapt. Contributors to our conversation shared how they have innovated and adapted their services in order to be able to meet the changing needs of the people they serve.

The most common innovation is the adoption of online tools to promote physical activity. Many providers have started producing online classes and publishing them on platforms like YouTube and Facebook. Some instructors have started teaching classes on Zoom and fitness centres are streaming live classes online.

For those who do not have access to online resources as well as for older people, some providers have created and distributed leaflets with ideas for physical activity.

Some participants shared that as they have found their days less full, they have discovered new and engaging exercise resources such as Virtual Treadmill Runs on YouTube.

"We found the home exercise packs are really engaging for clients. They enjoy tracking their RPE and making their weekly timetable with the instructor. The video calls are great and we are building the amount of clients able to embrace this technology. We still use hard copies and post out for those unable to use or access technology. Service is running well and clients and instructors have adapted and adopted the service well."

A shared case study from a UK wide program called Get Out Get Active (GOGA)[14], shows that to be truly adaptable, providers need to embrace a multi-faceted approach in supporting people with long-term conditions. Examples from the program include tailored activity programs, outreach telephone calls, exercise postcards, delivered activity packs, designated social media accounts for daily ideas, blogs, mailing lists, Corona-kindness website, and delivering equipment for home workouts.

Outside the COVID-19 context, providers shared other ways of how they have been innovative in supporting people to be more active such as working with partners in the community to reach people with long-term conditions, offering outdoor sessions, incorporating social activities into the exercise sessions, and expanding offers to cover not only physical activity but also nutrition and mental health workshops.

"We have run an exercise referral scheme at Central YMCA for the last 23 years called Positive Health for clients who are HIV +. What has made it sustainable is responding to the ever-changing face of the condition. Initially we focused on the physical activity side of things. Over the last few years we have run nutrition workshops as well as mind coaching workshops to manage stress and anxiety."

Quality assurance and evidence-based services

Some participants referenced the need for quality assurance and evidence-based services. The most common context was the distribution of funding and being able to assure healthcare professionals and people with health conditions of the quality and safety of services.

Some participants suggested the creation of a common dataset to demonstrate impact. Others talked about independent assessment of the quality and safety of activities or introducing a common

[14] http://www.getoutgetactive.co.uk/

framework to quality assure activities. The issue of unqualified instructors who produce online videos was also mentioned.

"When there is so much well-researched evidence around safe, effective and fun exercise, why do governmental agencies such as Sport England continue to fund unsafe activities that don't even follow the most basic of guidance eg start with a warm up."

"The quality assurance bit is tricky, who are we quality assuring for? Funders? Individuals? Do they want to see the same things?"

Some participants, however, pointed out that evaluation of activities should be the responsibility of the sector and should occur at a local level since what works in one area may not work in another. Evaluation should also include methods other than randomised controlled trials (RCTs) and quantitative research to capture the wider impact in communities.

"There is so much more to learn about interventions that RCT's and quantitative research just don't capture. Sadly we exist in a society with organisations that value this kind of research and responds to head counts and number churning as a means to recognise value."

"There is a real challenge in getting the right evidence to prove effectiveness and sometimes no evidence is mistaken for lack of evidence - as seen in the development of NICE guidance for physical activity. We need to get the balance right and encourage universities to evaluate real community-based interventions as opposed to just controlled trials that may not work if upscaled or applied in different locations."

Marketing and communications

About 13% of our conversation touched more broadly on the topic of marketing and communications. This section covers principles that can be employed by various actors at a local or national level. Participants in our conversation talked mostly about the need for education, the importance of language, messaging and inclusive marketing, as well as the importance of using various channels to reach people with long-term conditions.

Education

A big part of empowering and motivating people with long-term conditions includes educating them on the benefits of physical activity, diffusing their fears related to engaging in physical activity, and providing information on how to engage with physical activity taking into account various personal factors. Many participants shared the sentiment that there has not been enough education of the general public on these topics.

"I believe a main barrier/reason for lack of participating is the fact that most people do not realise the importance of being active through their life, not just when their health deteriorates, and also how to be active to benefit their health….We need to educate not only the importance but how they can get their exercise day-day in order to help them implement that change for a reason in their lives."

In order to achieve this, contributors thought it was important to have both big, national campaigns such as *We are Undefeatable* and *This Girl Can*, as well as local campaigns that focus on local needs. They also emphasise the importance of educating people early on in their lives, as well as modernising the look and feel of campaigns.

"If people aren't educated early enough, about what physical activity is and the benefits, that seed will be harder to plant later on. If there is a concerted public health, education and NHS plan to challenge and educate people at every opportunity to make behaviour change. That will help lower health conditions and also make it easier to get people with health conditions to be more active."

Participants noted that one positive implication of the COVID-19 crisis had been the national attention given to the importance of physical activity. Many contributors discussed that a key activity for them during the crisis has been informing and educating people on the benefits of and opportunities for physical activity.

"In the light of the current COVID-19 pandemic, where exercise once a day is a key part of Government messaging, maybe this will begin to get individuals and professionals to understand how important physical activity is for a healthy population, regardless of condition and even if there are specific limitations for individuals."

Education should go beyond talking about physical activity in isolation and be part of a wider conversation about how all aspects of lifestyle fit together to achieve physical and mental health.

"Salt information, healthy eating, medication compliance are all areas we explore and try to link together to help the patient see how everything fits together."

A few contributors shared the sentiment that there is enough information out there and most people are already educated. However, there is a gap between knowing and doing that needs to be addressed.

"I think the very fact that people over report how active they are gives a strong indication that they understand that physical activity is important. It's similar when people under report smoking or drinking because deep down they know it's not as healthy. Therefore, I think that it's a more complex issue than just knowledge."

"The gap to bridge is the one between being aware & feeling that you can do something about that."

Messaging and language

Contributors shared some specific ideas on the types of messages they believe are most effective as well as the importance of language used throughout the system.

There was a general consensus on the need to be less prescriptive when it comes to physical activity. Instead of talking about the specific types of activities, their duration, intensity or the need for them to be organised, contributors believe that sending the message to "move more and sit less" would be more effective. They also suggested to avoid jargon and the medicalising of physical activity by removing terms like 'exercise on prescription', 'exercise referral', and 'risk', from how we talk about it.

"Encouraging and empowering people to move. However they choose and however they can. We should talk more about the risk of not moving."

"100% agree with changing terminology. Terms like exercise and leisure can build barriers - For example 'Who has the time for leisure?' 'Exercise is for fit people?' 'Leisure is expensive?'"

Hearing personal stories from people with long-term conditions and how their lives have been transformed is powerful, because it shows tangible benefits that improve people's quality of life, such as pain reduction or being able to play with grandkids. The focus of the messaging should be on building self-worth, independence and confidence and showing that physical activity is a conduit to improving other valuable aspects of one's life. Messaging should also be aimed at carers as they often hold the key to getting people moving.

"Hearing how a patient / client was helped when they discovered x, y or z isn't as powerful as hearing first-hand how somebody's life has been totally transformed by finding an activity that they enjoyed and could undertake on a regular basis."

Participants highlighted that it is also important that various professionals in the system are on the same page when it comes to the messaging and language they use, in order to increase its impact.

"..It's vital that we all know what we are encouraging, selling, commissioning and what we are seeking to promote and achieve ie sit less move more, be more physically active, participate in structured exercise, participate in evidence based programmes (or programmes informed by elements of the evidence), or use physical activity to increase social interaction ++ The sector and commissioning is not clear about these things…"

Inclusive marketing

A few contributions touched on the topic of inclusive marketing with participants expressing general concern that imagery and language remains exclusive. With the exception of national campaigns like *We are Undefeatable* and *This Girl Can*, general sports marketing still portrays the same type of individual.

"Marketing for these facilities does still feature (mostly) young, slim, attractive models (male and female) which (I believe) is making some people feel this is not for them or where they belong. I

appreciate some facilities are starting to use more inclusive marketing but I think this still has a very long way to go to attract all individuals whose physical and mental health is a barrier for them in the first place."

Participants encouraged the creation and use of inclusive image banks, developing guides for reaching and talking to people with long-term conditions (such as those developed by GOGA), as well as partnering with providers to help them co-create services and marketing that are appealing to people with long-term conditions. Education of gym operators and senior decision-makers in the advertising industry may be necessary to shift their attitudes and perceptions towards what is "athletic" and "brave" and support them in developing more inclusive campaigns.

"Agree with the points on inclusive marketing and imagery in particular. It feels frustrating that we are still talking about inclusive imagery after several years of recognising that this is a huge barrier to people who are inactive. The question is why leading gym operators still seem to default to traditional 'athletic' type images? Is there more bravery needed by this group of marketing professionals and senior decision makers in leisure operators? What change needs to happen within the marketing of physical activity in general to ensure it is inclusive?"

Channels

Based on the experience of participants running their own information campaigns, it is clear that in order to be successful, providers need to employ a variety of channels and be creative and collaborative when trying to reach people with long-term conditions.

Some of the most popular digital channels used were YouTube, Facebook, Zoom for live sessions, and dedicated websites. Mailing lists were also mentioned, as well as designated Twitter accounts.

When it comes to offline channels – face-to-face interaction was utilised when dropping off food parcels or essential items. Phone calls were also used to check on people and encourage them to be active. Postcards and activity packs were delivered through mail. Activity cards have also been distributed via partners such as school game coordinators.

"Different ways of communicating have different success - e.g. radio has helped reach individuals in some areas, leaflets drops through housing associations, food banks etc."

Communication through different channels should be integrated. For example, an information website may lead to a Facebook support group which may share information about online classes on YouTube.

Because of the COVID-19 crisis, official government channels and communication (including messages coming directly from the prime minister) have been employed and deemed effective in raising awareness about physical activity. Participants wonder how such tactics can be utilised in the future.

"Suddenly because we are being told we can do something just once a day and the PM said it is for exercise then we're doing it. I'm seeing so many people walking and cycling and it is lovely. Let's build on this."

Culture around sport and physical activity

Our perceptions and attitudes, our actions, and how often we talk about physical activity, be it in a national campaign, at the doctor's office or around the dinner table is inevitably influenced by the predominant culture around sport, health and wellbeing. And vice versa. Participants in the conversation talked about the importance of culture and its power to shape policies, interventions and thinking.

"Government must acknowledge and not just pay lip service to the importance of cultures that promote healthy behaviours. This means everything from how we plan and fund our infrastructure, education, law and order, welfare etc."

Participants highlighted that culture change 'from the top' was needed. There were discussions about the role of commissioners in supporting a cultural shift by funding services beyond those associated only with personal responsibility and action, and the role of GPs and practices in actively promoting physical activity like they do smoking cessation or breast cancer screening.

The need to build more physical activity into the education curriculum was also raised, with suggestions to encourage students to be more active both at primary and secondary school and to assess schools, as part of their OFSTED rating, on how they achieve this. While it was acknowledged that the experience of physical education at an early age can shape attitudes towards physical activity later in life, some participants felt the notion of being active has had to be reinvented due to the competitive nature of sport and hangovers from bad experiences of school PE classes.

"Prevention is better than cure. Education at a primary school age I believe is vital in educating the effects of physical inactivity. PE remains a low priority in primary schools, and it lacks any education around PA, exercise, physiology etc."

The culture surrounding physical activity also influences the way we design our cities and public spaces which in turn influences our opportunities to be active.

"…how do we build on the benefits of reduced motorised traffic in our towns and cities which has contributed to reduced air pollution and increased cycling and walking? Reframing the way we think and feel about both of these will be central to building improved infrastructure and improving attitudes towards being more active in our everyday lives."

Participants spoke of the need to reframe how we talk about physical activity and raised some important questions about whether the healthcare system medicalises physical activity in a damaging way and how terminology is perceived – "Who has the time for leisure? Leisure is expensive? Exercise is for fit people?"

Others questioned who can talk about physical activity and when, and how we can encourage GPs to talk about physical activity as a regular part of their meetings with patients. Given the recent national attention on the importance of physical activity for our health and wellbeing, others wanted to build on this messaging and further embed physical activity into all of our conversations.

"I remember once asking the local director of public health why physical activity wasn't mentioned in a presentation on the different strands of support, only to be told it came under weight management!"

Attitudes and beliefs around how we see people with long-term conditions also need to be examined as well as how these are perpetuated through culture. There appear to be implicit beliefs about who can be physically active and what being physically active looks like. One participant

suggested we should reframe what achievement in physical activity looks like - from winning an Olympic medal in a competitive sport discipline to being able to play with your grandchildren.

"One of the reasons I think we have low levels of physical activity is because traditionally we have only focussed on competitive sport - and that does not appeal to a wide range of people - but it's what they then think physical activity is."

"YES! None of us aspire to becoming Olympians."

Integration and collaboration within the system

One of the overarching categories that emerged in the conversation was the need for integration of different services, collaboration with all actors within the system and partnering with other initiatives related to physical activity and improving wellbeing. This is necessary if we want to achieve effective, efficient and person-centred services, where people with long-term conditions can be informed and move easily through the system to make progress towards the achievement of their personal goals.

"Everything is a link in a chain, one missing link has the potential to discourage action."

"This needs to be a whole system approach that starts with the individual."

Participants reflected on the need to join up all parts of the system, to see more collaboration and co-design between clinical teams and leisure teams, and to ensure there are processes in place to enable this. To connect and build upon each element of the system, streamlined processes, tools for collaboration, information sharing, and knowledge exchange between different stakeholders need to be developed and implemented. For example, one participant raised the idea of a "health passport" which they were piloting to help record individuals' journeys with physical activity. It includes information on the person, their exercise adaptations, contacts for their physio team/doctor and aims to help with transferring between services.

"We often come up with ideas or solutions that are purely based on assumptions but perhaps only focus on one element of the individual's journey…We need to work out what the whole process might look like first and then judge whether we have all of the components, or perhaps just some and then determine what needs to be developed to fill the evident gaps."

"It's a long hard process to change health systems and often relies on individual people who are physical activity advocates in health settings. Nationally we could do better by building physical activity prompts into processes."

Participants discussed the need for relevant stakeholders to be involved in identifying local needs and barriers, designing services and making decisions about what may work for their communities. It was felt that efforts should be harmonised across the wider sports, health and wellbeing system – from physical activity education in school to sports advertising and various other national and local efforts towards improving health and wellbeing.

"There is an opportunity to develop a truly collaborative and codesigned wellbeing service. Involve all key stakeholders within a community (Health professionals, exercise specialists, Researchers, Sports and medicine Drs., service users, commissioners etc.) and come up with a service that is person and placed led."

There was discussion about professionals needing to be clear on their role within the system and aware of other actors who can assist them when needed. Knowledge-exchange is crucial to increase competence and confidence for healthcare professionals, instructors, receptionists, gym owners, etc. and improve services for users.

"12 month project - brought together everyone from hospital gerontologist to the community connectors. Led to a better understanding of why physical activity is important and what's available across the Borough. SPA delivered workshops for the social prescribing team (community connectors) meant that they were better able to support older adults into physical activity."

Most importantly, participants felt that people with health conditions need to be at the centre of the entire system, which should be made flexible and adaptable enough to address individual needs. This may require a change in mindsets, devolved models of funding and decision-making as well as the ability to escalate issues to the level of government.

"We need a clearer, collective approach across sectors that identifies the vital changes that need to be made to have the biggest impact on activity levels. Then together calling for these changes to legislation, lobbying government, updating policies to ensure people with long term conditions are given the best opportunities to do the activity they want."

"We need to be more holistic as a system."

Conclusions

In any situation, creating a psychologically safe space to hear the collective wisdom of people is a positive act. This workshop created that space and people responded enthusiastically. More than 350 people took part in the workshop, and nearly half of those actively participated in the conversation about making it easier to be active with a health condition.

But creating a space for questions and answers also creates an expectation that something will be done. Participants took the opportunity to share their views but they also wanted assurance that it would be taken seriously.

Analysis of the contributions in the online workshop identified five cross-cutting themes that were reflected throughout the whole conversation and 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.

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 want inclusive marketing that uses language and images that diverse populations can relate to. They also want 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.

Every part of the system has a role to play, but as this analysis itself reveals, it is also impossible to examine in isolation of other parts. The need for social connection is an intrinsic motivator, a message in a marketing campaign, and a factor in designing services. Quality assurance is necessary for healthcare professionals and people with health conditions to make informed choices and is also relevant in the distribution of funding. The need for information, innovation and inclusivity is evident across service design, referrals, marketing, development of the workforce and the delivery of services.

Many ideas were raised in the workshop, but they are not a simple to-do list. Inevitably, some participants will have put forward suggestions for change that someone, elsewhere in the system, is already working on.

Some of the proposed actions in this report will require strategic commitment, and engagement at every level of the sector.

A one-off workshop which generates ideas can begin to change a community for the better; an ongoing process of meaningful engagement, reflection and action could be transformational.

Organisations create their future with the tools they use to solve their problems. The core demand of this workshop – that the system makes it easier to be active with a health condition – has already begun to be addressed by listening to the voice of the sector and those with lived experience of health conditions. Phase two will test these findings with a purposive sample of stakeholders from organisations representing policy, health, leisure, training providers, community and charitable organisations.

Recommended next steps

Together, NCSEM and stakeholders from across the sport and physical activity sector and beyond, have generated a significant amount of collective insight to better understand and seek to solve some truly complex issues around how the system can make it easier to be active with a health condition. However, given the disruption of COVID-19 and the relatively low levels of engagement overall, this project will benefit from a further phase of work to validate the themes that emerged from the first online workshop.

Figure 6. Overall project flow

Below we have set out some groups that need more targeted engagement, some additional areas to explore, and some mechanisms to achieve this that will be considered in phase two.

Additional groups to engage

It has always been vital that this conversation was as large and diverse as possible, and while we heard from a range of people with a professional interest in this area, we did not hear enough from those with lived experience of health conditions and their carers to feel confident that our findings reflect their voice and experience. It will be so importance to continue to work with the Richmond Group of Charities to engage these groups in particular. We would also like to hear more from people from BAME backgrounds, economically deprived communities, older people, and those who are digitally excluded.

We therefore recommend targeting these groups as part of any additional phases of this project to ensure their voices are heard and reflected in the findings.

Additional areas to explore

While it will be important to test and refine the themes that emerged from the first online workshop, there is also a need to canvas opinion on where any gaps may be.

Some topics were touched on in this first online workshop that we feel warrant further exploration. These include the importance of an inclusive workforce that represents those that it serves, the

need for more education and support for carers, and the impact of socio-economic status and health inequalities on the experience of being active with a health condition.

This supplementary insight would help to provide additional layers of assurance to our analysis.

Qualitative interviews

Conducting a series of qualitative interviews would be a useful way of 'digging deeper' with key stakeholders or underrepresented groups, sense checking the draft findings from the first online workshop and exploring any new or absent themes.

These insights would provide an additional dimension to the project –more substance, bring the coding to life, and build on the findings from the first national conversation.

Communications

The most critical part of taking people on a journey and getting their buy-in is creating interest so that we can generate insight.

In phase one of this project, there were significant challenges around communications and engagement. The impact of COVID-19 made it difficult to develop both sensitive and hard-hitting messages, but this was exacerbated by a lack of communications support, not being able to utilise existing networks, and not being able to promote the project for a number of weeks.

For any further phases of this project, a more coordinated and proactive approach to communications would be needed to try and get as much reach as possible, especially as the focus would likely still be on generating interest remotely. It will be vital for NCSEM to work with the project partners to leverage meaningful engagement and ensure specific communications resource is allocated for the success of the project.

Phase three

The purpose of a second online workshop would be to further validate, check and challenge what we have learnt from the first online workshop and the qualitative interviews combined, and to test messages and themes that could form part of the final guidance It may also be an opportunity to test what format would be most useful to the sector.

Holding a second online workshop is a valuable way to demonstrate, quickly and transparently, that NCSEM has really listened to what was shared with them. It is also the first step in taking action to respond and continuing to engage the sport and physical activity sector to get their buy-in to the final co-produced guidance.

Appendix 1: Participant data tables

Participants have been categorised as those who logged into the online workshop and completed the gateway questionnaire. We do not have any data for those who registered but never logged in. Participants are broken down by their interest in the conversation, work setting, location, and protected characteristics.

Because of the sensitive nature of some of data, for example on protected characteristics, cells with 12 or fewer participants have been expressed as ≤12. Only available data has been reported. Cells with no data are marked with a dash.

Where there are notable differences in responses between groups, these have been described in the report.

Participation rates

1. Participants by participation in conversation

Participation	No. of participants	% of participants
I have a professional interest		
I'm a sport and exercise professional, fitness instructor or coach	77	23.6%
I work in a community or leisure centre or sports club	≤12	3.7%
I volunteer in a community or leisure centre or sports club	≤12	0.6%
I'm a health care professional	43	13.2%
I'm a social care professional	≤12	0.6%
I work in academia or policy	16	4.9%
I'm responsible for commissioning or strategic decisions	29	8.9%
I'm a service manager	31	9.5%
Other professional interest	64	19.6%
I work for an Active Partnership	25	7.7%
I have a personal interest		
Someone with a health condition(s)	16	4.9%
A carer, family member or friend of someone with a health condition(s)	≤12	0.3%
Other personal interest	≤12	2.5%

2. Participants by primary work setting (for those with a professional interest)

Primary work setting	No. of participants	% of participants
Independent health care provider	≤12	3.0%
NHS funded health care provider	41	13.6%
Voluntary or community organisation	50	16.6%
Charity that represents people with health conditions	32	10.6%
Charity working in physical activity and sport	≤12	3.3%
Private sector	≤12	4.0%
National Governing Body	≤12	3.3%
Local Government	70	23.3%
Higher Education Institution	14	4.7%
Royal college or professional body	≤12	1.0%
Physical activity insurer or underwriter	-	-
Other	28	9.3%
Active Partnership	22	7.3%

3. Participants by location

Region	No. of participants	% of participants
National		
East of England	28	8.6%
London	36	11.0%
Midlands	45	13.8%
North East & Yorkshire	70	21.5%
North West	32	9.8%
South East	68	20.9%
South West	27	8.3%
International		
Scotland	≤12	2.1%
Wales	≤12	3.1%
Other country	≤12	0.9%

Protected characteristics

4. Participants by age

Age	No. of participants	% of participants
20 – 29	36	11.0%
30 – 39	99	30.4%
40 – 49	92	28.2%
50 – 59	72	22.1%
60 – 69	20	6.1%
70 +	≤12	1.2%
Prefer not to say	≤12	0.9%

5. Participants by sex

Sex	No. of participants	% of participants
Female	225	69.0%
Male	96	29.4%
Prefer not to say	≤12	1.5%

6. Participants by gender

Gender	No. of participants	% of participants
The same as the sex I was registered at birth	318	97.5%
Different to the sex I was registered at birth	≤12	0.6%
Prefer to self-describe	≤12	0.3%
Prefer not to say	≤12	1.5%

7. Participants by ethnicity

Ethnicity	No. of participants	% of participants
Asian or Asian British, includes any Asian background, for example, Bangladeshi, Chinese, Indian, Pakistani	≤12	1.5%
Black, African, or Black British or Caribbean, includes any Black background	≤12	0.6%
Multiple of Mixed background, includes any Mixed background	≤12	0.9%
White, includes any White background	311	95.4%
Other Ethnic Group, includes any other ethnic group, for example, Arab	-	-
Prefer not to say	≤12	1.5%

Appendix 2: Gateway questionnaire

The gateway questionnaire is a series of questions that participants complete as a gateway to the online workshop. The purpose of the questionnaire was:

- to help us better analyse the views shared in the online discussions, and
- to ensure we have attracted a representative mix of people to the discussions.

1. **I have read the participant information (under the 'About this project' tab) and am happy to continue**
   Yes

2. **How would you best describe your participation in this conversation?**
   2.1. I have a personal interest in this area
   2.2. I have a professional interest in this area

3. If 2.1, **I'm joining primarily as…**
   a. Someone with a health condition(s)
   b. A carer, family member or friend of someone with a health condition(s)
   c. Other

4. If 2.1a, **What type(s) of health conditions do you have? Please tick all that apply.**
   - Anxiety/Depression
   - Arthritis
   - Asthma
   - Cancer
   - COPD (Chronic Obstructive Pulmonary Disease)
   - Dementia
   - Diabetes
   - Heart disease/stroke
   - High blood pressure
   - Multiple Sclerosis
   - Parkinson's Disease
   - Other, please specify…

5. If 2.1a, **Does your condition or illness\do any of your conditions or illnesses reduce your ability to carry-out day-to-day activities?**
   - Yes, a lot
   - Yes, a little
   - No
   - Prefer not to say

6. **In the past week, on how many days have you done a total of 30 mins or more of physical activity, which was enough to raise your breathing rate?** This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places but should not include housework or physical activity that is part of your job.
   - 0 days
   - 1 day
   - 2 days
   - 3 days

- 4 days
- 5 days
- 6 days
- 7 days

7. If 2.2, **What is your primary role?**
- I'm a sport and exercise professional, fitness instructor or coach
- I work in a community or leisure centre or sports club
- I volunteer in a community or leisure centre or sports club
- I'm a health care professional
- I'm a social care professional
- I work in academia or policy
- I'm responsible for commissioning or strategic decisions
- I'm a service manager
- Other, please specify..

8. If 2.2**, What is your primary work setting?**
- Independent health care provider
- NHS funded health care provider
- Voluntary or community organisation
- Charity that represents people with health conditions
- Private sector
- National Governing Body
- Local Government
- Higher Education Institution
- Royal college or professional body
- Physical activity insurer or underwriter
- Other

9. Where do you live?
- England
  - East of England
  - London
  - Midlands
  - North East & Yorkshire
  - North West
  - South East
  - South West
- Northern Ireland
- Scotland
- Wales
- Other country

10. What is your sex?
- Male
- Female

11. Is your gender the same as the sex you were registered at birth?
- Yes

- No
- Prefer to self-describe
- Prefer not to say

12. What is your age group?

- Under 20
- 20 - 29
- 30 - 39
- 40 - 49
- 50 - 59
- 60 - 69
- 70+
- Prefer not to say

13. Which one of the following best describes your ethnic group or background?

- Asian or Asian British, includes any Asian background, for example, Bangladeshi, Chinese, Indian, Pakistani
- Black, African, Black British or Caribbean, includes any Black background
- Multiple of Mixed background, includes any Mixed background
- White, includes any White background
- Other Ethnic Group, includes any other ethnic group, for example, Arab
- Prefer not to say

14. Would you like to be kept informed about this project, including when the co-produced guidance is published?

Yes/No