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Cornwall Council Active Travel Social Prescribing Pilot - Final evaluation report

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CORNWALL COUNCIL
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Active Travel England

About Cornwall Council

Cornwall Council is a unitary authority which governs the county of Cornwall, South West England. Their vision and approach for creating a reliable, efficient, safe, healthy, inclusive, and carbon neutral transport system is presented in their Local Transport Plan to 2030[1]. The Council is implementing a range of actions which align with this Plan, including the Cornwall Active Travel Social Prescribing pilot.

About CAST

Led by the University of Bath, the UK Centre for Climate Change and Social Transformations (CAST) is a collaboration between Bath, Cardiff, Manchester, and East Anglia universities, and the charity Climate Outreach. The Centre aims to be a global hub for understanding the profound changes required to address climate change. We research and develop the social transformations needed to produce a low-carbon and sustainable society. Our experts include psychologists, sociologists, political scientists, engineers and organisational specialists working across multiple scales (individual, community, organisational, city-region, national and global) to identify and experiment with various routes to achieving lasting change. CAST is funded by the Economic and Social Research Council (ESRC). For further details on CAST see: https://cast.ac.uk/

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The Cornwall Active Travel Social Prescribing pilot, including this study, was funded by Active Travel England. The Cornwall pilot was one of eleven active travel pilots that took place across England.

[1] See: Local Transport Plan - Cornwall Council

Summary

Cornwall Council worked with researchers from the Centre for Climate Change and Social Transformations (CAST) to evaluate the Council's Active Travel Social Prescribing pilot. The aims of the pilot were to promote increased levels of physical activity through walking, wheeling and cycling, support modal shift to active travel, address barriers to using active modes, and demonstrate links between infrastructure provision and social prescribing schemes. The 3-year pilot (2022 – 2025) was conducted in Bodmin, St Austell and Penzance.

There were two components of the intervention: 1) a range of activities offered by 17 community-based providers, such as guided walks or cycling coaching sessions; and 2) one-to-one support by Council Health Improvement Practitioners, who worked with the pilot participants to identify their specific needs, highlight the benefits of active travel, and connect them to activity providers in their area.

This report presents the findings of an evaluation study which measured the pilot outcomes. Five data sources were used to evidence these outcomes: 1) a pre- and post-intervention survey which explored participants' travel behaviours, perceptions of active travel, and health (n=38); 2) interviews with participants about their experience of the pilot (n=7): 3) a qualitative feedback survey with activity providers and the pilot delivery team (n=14); 4) monitoring data on the number of activities and participants; and 5) case studies which illustrate how the intervention supported participants to engage in active travel (n=40).

Our findings indicate several positive outcomes for the participants: reduced psychological barriers to using active travel; increased uptake of active modes, particularly cycling; increased activity levels and improved physical health; more social interaction and improved wellbeing; and reduced inequalities in access and mobility. Almost every metric suggests the pilot was effective in achieving its aims, although some findings are not statistically significant due to the small sample size for the survey. In terms of the number of people ($n \leq 1992$) supported to engage in active travel activities, the pilot exceeded all its targets within the delivery period.

Key learnings from the pilot implementation include: 1) participants with complex needs require time and one-to-one support to reach their active travel goals, whereas others only require connecting with local activity providers - the intervention model allowed flexibility so that provision could be adapted to the individual; 2) this flexibility was augmented by a broad range of activities, through funding multiple providers, which allowed participants to follow a progression pathway; 3) collaboration and knowledge sharing among the providers created local referral networks and communities of practice; 4) expanding the referral routes increased the potential for reaching the target groups, including those less likely to engage.

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1 Overview of the Cornwall ATSP pilot

The Cornwall Active Travel Social Prescribing pilot was one of eleven pilots that took place across England from 2022 – 2025. The pilots were funded by Active Travel England[2] and they explored how walking, wheeling[3] and cycling activities can be socially prescribed[4]. Individual pilots investigated the outcomes of active travel social prescribing (ATSP) in their specific region and context, and collectively they formed part of a national evaluation of ATSP that was conducted by Sheffield Hallam University, on behalf of Active Travel England.

A grant of £844,641 was awarded to Cornwall Council in 2022 to carry out a three-year 'test and learn' pilot. The pilot was managed by Cornwall Council's Public Health team and delivered by Healthy Cornwall[5]. The pilot delivery team included the ATSP pilot Project Manager (Natalie Russell), a Public Health Practitioner (Intermediate) who evaluated the pilot (Helen Frankland), and three Health Improvement Practitioners (Louise Argent, Carol Gill and Kate Jilbert). The pilot was overseen by a steering group comprising members of the Public Health, Active Cornwall, and Transport teams in Cornwall Council.

The aims of the Cornwall ATSP pilot were to: 1) promote increased levels of physical activity through walking, wheeling and cycling; 2) support modal shift to active travel[6]; 3) address specific needs identified in local communities; and 4) demonstrate links between infrastructure provision and social prescribing schemes. An evaluation study measured the outcomes for the pilot participants (referred to as 'clients' in this report), including uptake of active travel, changes in their attitudes towards using active modes, and health and wellbeing benefits. This report is the second of two which presented the evaluation study findings; the first was a process evaluation (October 2024) which can be accessed here.

1.1 Active travel in Cornwall and the pilot locations

Cornwall residents regularly walk, wheel or cycle for leisure, yet only 10.1% of adults in Cornwall walk for travel at least three times per week, compared to 15.1% of adults in

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[2] See: Active travel social prescribing pilots: local authority allocations | Active Travel England.
Also see: Walking and cycling prescription trial funding allocations published - GOV.UK (www.gov.uk)

[3] 'Wheeling' refers to the use of mobility aids for getting around, such as a wheelchair or a rollator. It describes the action of moving at a pedestrian's pace. It does not include riding an e-scooter or a bicycle. See: Active Travel Definitions: Walking, Wheeling, and Cycling (wheelsforwellbeing.org.uk)

[4] Social prescribing is an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing. See: NHS England » Social prescribing

[5] Healthy Cornwall is the health programme delivery branch of Cornwall Council. See: Home - Healthy Cornwall

[6] 'Active travel' refers to modes of travel that involve a level of activity. It means getting about in a way that makes you physically active, like walking, wheeling or cycling. This is distinct from walking, wheeling or cycling for leisure or sport. See: Department for Transport https://www.gov.uk/government/publications/active-travel-local-authority-toolkit/active-travel-local-authority-toolkit#:~:text=What%20active%20travel%20means.%20Active%20travel%20refers%20to%20modes%20of#:~:text=What%20active%20travel%20means.%20Active%20travel%20refers%20to%20modes%20of

England. Similarly, only 0.6% of adults in Cornwall cycle for travel at least three times per week, compared to 2.3% of adults in England[7]. People with long-term health conditions are less likely to use active travel. These disparities highlight a strong need for interventions in Cornwall to encourage individuals to incorporate active travel into their everyday lives. The Cornwall ATSP feasibility study, conducted by Sustrans in 2022, identified three locations as suitable for the pilot: Bodmin, Penzance, and St Austell and the China Clay Area. These three areas have high levels of deprivation and entrenched health inequalities. Moreover, they have varying levels of existing active travel infrastructure and social prescribing networks.

1.2 Description of the Cornwall ATSP pilot intervention

The Cornwall pilot used a co-production approach, collaborating with organisations that provide activities which meet local needs and engage 'hardly reached' members of their communities. There were two components of the intervention. The first was a range of active travel activities provided by 17 community-based providers; see Appendix 6.7.2 for a brief overview of their activities, or the ATSP pilot delivery report for in-depth case studies of their work with clients. The second component was one-to-one support by a Council Health Improvement Practitioner, who provided tailored sessions with clients to increase their knowledge of, and motivation for, active travel. These practitioners identified the specific needs of each client, agreed active travel goals, and linked them to the activity providers.

1.3 ATSP pilot eligibility criteria and intended outcomes

The pilot was targeted at individuals who may benefit from tailored support to use active travel. Patients registered with GPs in Bodmin, Penzance, and St Austell could be referred by their GP or a social prescriber. The referral routes were expanded during the pilot to include activity providers, Allied Health Professionals, Healthy Cornwall, and employment workers. The eligibility criteria and the intended outcomes for clients are presented in Table 1.

Table 1, Pilot target groups/eligibility criteria and the intended outcomes

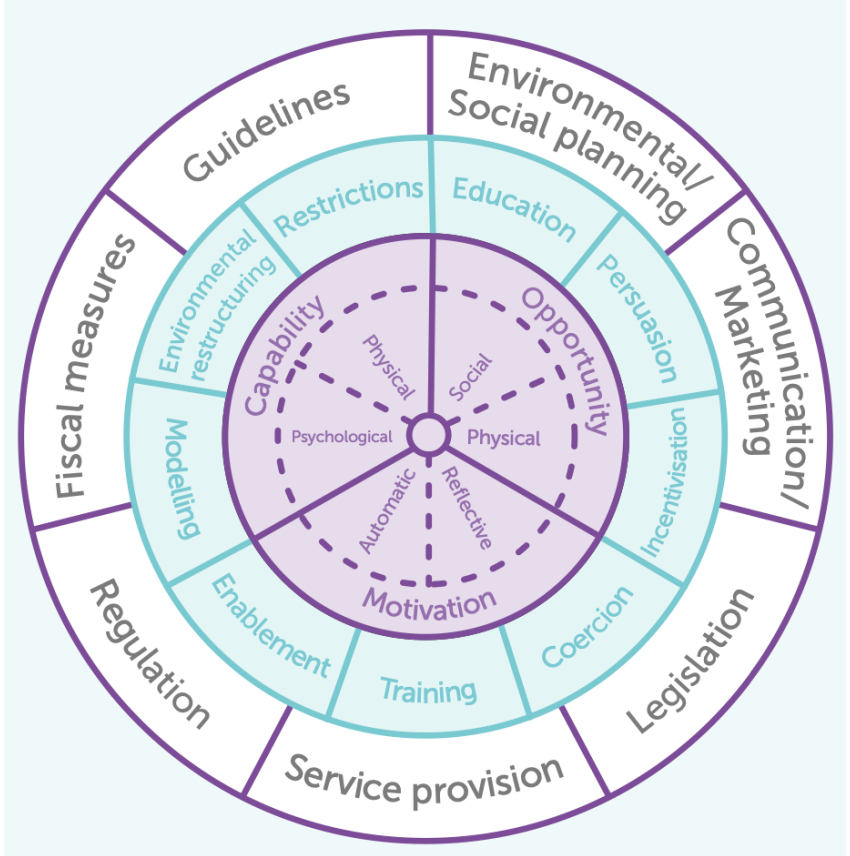
The target groups of the ATSP pilot:	Intended outcomes:
– Adults seeking to improve their mental health and wellbeing – Adults with poor physical health (including long-term health conditions) – Disabled people (adults) – Unemployed adults – Adults aged 50+	– Reduced psychological barriers to using active travel – Increased physical activity – Fewer motorised vehicles and trips – Reduced inequalities in access and mobility – Improved physical health – Improved wellbeing/mental health

[7] Office for Health Improvement and Disparities (2024). Public health profiles, 2019/20. https://fingertips.phe.org.uk/

1.4 Theoretical framework – the COM-B Model and Behaviour Change Wheel

The theoretical framework used for the evaluation study was the COM-B model and Behaviour Change Wheel[8], a widely used model for designing interventions and informing policy. According to the model, one or more of its components (i.e., an individual's capability, opportunity or motivation) must be changed to facilitate effective and long-standing behaviour change. The blue circle presents nine intervention functions which support behaviour change; the Cornwall ATSP pilot used modelling, enablement, training, incentivisation, education, persuasion and environmental restructuring. Finally, the outer circle of the wheel identifies seven policy categories that can enable or support these intervention functions.

Figure 1, The COM-B model and Behaviour Change Wheel



[8] Original article: Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6:42. https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-6-42

Guide for the COM-B Model of Behaviour Change: https://social-change.co.uk/files/02.09.19_COM-B_and_changing_behaviour_.pdf

2 Evaluation study methodology

This section describes the data collection activities used to measure and evaluate the pilot outcomes. Data was collated from multiple sources, analysed, and then used to evidence the success of the pilot against the 'Cornwall ATSP pilot logic framework' (Appendix 6.7.1).

2.1 Research questions

The logic framework presents five research questions to guide the pilot evaluation:

1. Have the pilots led to improved mental and physical health?
2. To what extent have the pilots influenced attitudes and behaviour towards active travel?
3. Who has (and has not) participated in the pilots?
4. What interaction has there been with behaviour change and infrastructure?
5. What can we learn about the delivery of social prescribing pilots?

These research questions were used to determine which questions to include in the surveys and interviews.

2.2 Research ethics committee review

The proposal for the Cornwall ATSP pilot evaluation study was reviewed by the University of Bath Biomedical Research Ethics Committee; approval was received on 13th November 2023 and remained valid until 31st July 2025. The REC reference number is 0996-968. Monitoring data and case study data, collected by the Council's ATSP pilot delivery team, is not subject to research ethics review and was fully anonymised before sharing with Mark Wilson, the external evaluator.

2.3 Pre- and post-intervention survey with clients

Clients referred to the Health Improvement Practitioners (n=97) were invited to take part in the evaluation study. The clients who agreed (n=67)[9] were asked to complete a questionnaire survey before and after they were prescribed the pilot activities to measure any changes in their travel behaviours, their attitudes towards active travel, or their health and wellbeing. The clients completed these surveys in conversations with their Health Improvement Practitioner. A control group of Cornwall residents (n=300), who did not receive the active travel intervention, also completed the pre-intervention survey to compare their responses with the clients. The pre-intervention survey was run between January – August 2024 and constitutes the baseline for comparison with post-intervention survey data, which was collected between August 2024 – March 2025. Most of the survey questions were duplicated from the template provided by

[9] Participation in the evaluation study was not a condition of taking part in the pilot. Not all clients supported by a Health Improvement Practitioner chose to take part in the evaluation study.

Active Travel England[10]. The Cornwall pilot evaluators included some additional questions to explore the clients' experience of taking part, their health outcomes, and a potential carbon emission reduction from mode shift. Pre- and post-intervention findings for the clients (n=38)[11] are presented in detail in Appendix 6.1 and the comparison of clients with the control group can be found in Appendix 6.6. The survey protocols can be found in Appendices 6.8.1 and 6.8.2.

2.4 Semi-structured interviews with clients

The survey findings are supported by semi-structured interviews with clients (n=7) which provided in-depth qualitative data on their experiences of taking part in the pilot. These interviews explored whether participation has influenced clients' attitudes and behaviours towards active travel, or resulted in improvements in their physical or mental health. The clients completed these interviews with the Council's internal evaluator for the pilot, Helen Frankland, between September 2024 – February 2025. The interview findings are presented in detail in Appendix 6.4 and the interview protocol can be found in Appendix 6.8.3.

2.5 Qualitative survey with activity providers and the ATSP pilot delivery team

Active travel activity providers (n=7), social prescribers and link workers (n=3), and members of the Council's ATSP pilot delivery team (n=4) were asked to complete an online qualitative survey on the success of the pilot in achieving its outcomes and the key learnings. This survey was conducted between April – May 2025. The survey findings are presented in detail in Appendix 6.5 and the survey protocols can be found in Appendices 6.8.4 – 6.8.6.

2.6 Monitoring data and case studies

There are two additional sources of data which have been used to evidence the outcomes and key learnings. The first is monitoring data of client referrals and the provision of active travel activities, compiled by the ATSP pilot Project Manager. The second is case studies developed by the ATSP pilot Project Manager and several of the activity providers (see the ATSP pilot delivery report for in-depth case studies compiled during the pilot).

[10] Active Travel England provided this survey template to ensure standardisation of questions across the eleven pilots for the national evaluation of active travel social prescribing. Researchers at Sheffield Hallam University conducted the national evaluation, on behalf of Active Travel England.

[11] Of the 67 clients who completed the pre-intervention survey, 38 completed the post-intervention survey. This is an attrition rate of 43.3%. High attrition rates are common in intervention studies, particularly if the participants have a long-term health condition. Where possible, the Health Improvement Practitioners asked the clients for their reason(s) for dropping out of the pilot and the evaluation study; the most common were deteriorating mental health, family or caring commitments, medical treatment which prohibited active travel (i.e., an operation), and inclement weather.

3 Evaluation using the Cornwall ATSP pilot logic framework

This section evaluates the success of the pilot in meeting its objectives, as detailed in the ATSP pilot logic framework (Appendix 6.7.1). The empirical data collected in the evaluation study is presented in detail in Appendices 6.1 – 6.6; section 3 summarises this data to evidence the pilot's activities, outputs, outcomes and impacts.

3.1 Activities

The first component of the Cornwall ATSP pilot intervention was community-based provision of walking/wheeling and cycling activities; 17 activity providers took part. Nine providers delivered walking/wheeling activities, including led walks, educational walks that teach individuals to walk with poles, and the provision of equipment to facilitate walking for travel. Five providers delivered cycling activities, including one-to-one and group coaching sessions to build confidence, bike maintenance workshops, and bike/e-bike loans. One provider created active travel maps for the local area. The remaining two supported a homeless community and a learning disabilities community to engage in active travel. These providers were awarded grants through the ATSP Fund. An overview of the 17 providers and the activities they offered can be found in Appendix 6.7.2, and the ATSP pilot delivery report presents in-depth case studies of the providers' work with clients. The primary mechanisms of their activities for influencing behaviour change can be found in Appendix 6.7.5 (i.e., the COM-B model).

The second component of the intervention was one-to-one support from a Health Improvement Practitioner. In their sessions with clients, the Health Improvement Practitioners highlighted the benefits of active travel and used behavioural science techniques such as intention formation and self-monitoring of behaviour. They identified the specific needs of each client and linked them to the most appropriate activity provider(s) in their area. The Health Improvement Practitioners could also issue incentives which enable active or sustainable travel, such as Beryl Bike minutes[12] or temporary bus passes. The number of sessions with each client varied, depending on the individual's needs and goals, but ranged from one to four sessions. In total, 97 clients received support from a Health Improvement Practitioner.

3.2 Outputs

Table 2 shows the original output targets for the Cornwall ATSP pilot and the final number of participants in pilot activities, or the final number of bike loans, co-designed events, or case studies. All pilot targets were met and exceeded, by some margin, within the delivery period (2022-2025).

[12] Beryl Bikes is a shared-mobility provider operating in Cornwall and other locations in the UK. See: Cornwall | Beryl

Table 2, Cornwall ATSP pilot output targets and the final numbers of participants or activities

Description of output	Target for the pilot (2022-2025)	Final numbers (June 2025)
Direct participants in social prescribing activities (number of people)	990	≤1992[13]
Cycling activities (number of people)	108	666
Cycle loan provision (number of loans)	130	1306
e-bike loan provision (number of loans)	140	422
Walking/wheeling activities (number of people)	124	957
Co-design events (number of events)	24	99
Case studies (number of case studies)	18	40

It is important to highlight some further outputs which emerged during the pilot (Table 3). These additional outputs will likely reinforce the legacy of the pilot by increasing awareness of active travel services and infrastructure, equipping clients to engage in active travel, and upskilling community-based organisations to support people to use active modes.

[13] This figure is not calculated by totalling the number of participants from the walking/wheeling or cycling activities in Table 2. It is calculated by tallying the number of unique individuals supported by the Health Improvement Practitioners or one of the 17 activity providers. Some clients took part in multiple activities, with different providers. The activity providers did not provide lists of their participants' names, and so the ATSP pilot delivery team was unable to identify which participants took part in multiple activities. Thus, there is a risk of double counting in this figure and this is why the 'equal to or less than' symbol (≤) is used.

Table 3, Additional outputs of the Cornwall ATSP pilot

Description of additional output	Final numbers (June 2025)
Special promotion (number of people) – Outreach activities to promote engagement in active travel	161
Volunteers trained (number of people) – Volunteers working with active travel groups and activity providers in the three pilot areas	73
Equipment bought for clients (number of people) – e.g., waterproof clothing, high visibility clothing, appropriate footwear	41
Participants supported to use public transport (number of people): – St Petrocs - accompanying participants on bus/train journeys to build confidence x 86 – Provision of temporary bus passes x 91	177
Creation of new active travel maps (number of maps): – Publicly available maps x 8 (Sustrans x 3, Volunteer Cornwall x 3, Eden Project x 2) – Bespoke maps for individual clients x 26 (Sustainable Penzance)	34
Active Travel Workbook (number of workbooks) – This tool was designed by Carol Gill, one of the Health Improvement Practitioners, to support clients to reach their active travel goals	1

3.3 Outcomes

As presented in section 3.2, the pilot engaged a considerable number of people in active travel activities (n≤1992). The clients who chose to take part in the evaluation study (n=67) and who completed the post-intervention survey (n=38) are much smaller samples. The rest of the findings presented in this report are based on these sub-samples of the larger cohort that engaged in the pilot. We do not have sociodemographic data for the larger cohort to determine whether the evaluation study participants are representative of this cohort. Nevertheless, we can infer the outcomes for the evaluation study participants would be comparable for the larger cohort, because the activity providers worked with local health and social care practitioners to identify people who meet the pilot eligibility criteria and would likely benefit from support to engage in active travel. There were seven outcomes listed on the Cornwall ATSP logic framework (Appendix 6.7.1).

3.3.1 Comparing clients' travel attitudes, behaviours, and health with the control group

One objective of the evaluation study was to ascertain whether clients (n=67) differ from a control group of Cornwall residents (n=300) in terms of their travel behaviours or health and wellbeing. This comparison was conducted to identify inequalities in terms of perceptions, capabilities, and barriers to uptake of active travel. For walking/wheeling, there was no difference between clients and the control group in their awareness of local routes, their attitude towards walking/wheeling as a form of transport, nor their confidence, although clients feel less safe. For cycling, however, clients reported statistically significantly lower ability levels, they feel less safe, and have less confidence. For travel behaviours, there was no difference between the clients and the control group for walking/wheeling journey frequency or distance, although clients cycle less frequently, and the distances are shorter. There was no difference in the frequency of car journeys, although clients travel less frequently by public transport. A lower proportion of clients do physical activities such as going to gym or playing sports than the control group. Clients experience poorer physical health by every metric we measured; a higher proportion have a long-term health condition, they have higher levels of pain and lower energy levels, and they require more GP appointments and hospital visits. Given the pilot eligibility criteria, this is not surprising, but it does highlight the need for targeted support for these individuals to reduce such health inequalities. In terms of wellbeing, clients reported lower levels of life satisfaction, but higher levels of peer support for using active modes (Appendices 6.6.2 – 6.6.6).

3.3.2 Reduced psychological barriers

The first intended outcome of the pilot was to reduce psychological barriers to active travel. Clients reported more confidence and feeling safer when walking/wheeling and cycling in the post-intervention survey, compared to the pre-intervention survey, although these differences are not statistically significant. Clients also reported a more favourable attitude towards walking/ wheeling and cycling as forms of transport, but again, these differences are not statistically significant. Their awareness of walking/wheeling routes in their local area increased, and their awareness of cycling infrastructure was statistically significantly higher in the post-intervention survey. Similarly, clients (n=6) described greater awareness of local active travel infrastructure in the interviews, as well as having a more positive perception towards active travel (n=5). Most survey respondents (71.1%) identified 'exploring or learning about my local area' as a benefit of taking part in the pilot, and one stated: *"I love going out on my bike. I still get nervous, but I now go out on my own. That was unheard of before."* Activity providers/pilot delivery team members also observed increased confidence among clients to use active modes (n=4) and reduced psychological barriers (n=3) (Appendices 6.1.2, 6.4.1, 6.4.4, 6.2.3 & 6.5.1).

3.3.3 Increase in people walking/wheeling and cycling

Changes in travel behaviour during the pilot were explored. Clients reported more walking/wheeling journeys per week and slightly longer distances in the post-intervention survey, but these findings are not statistically significant. The pilot had a stronger influence on cycling behaviour; clients reported statistically significantly more journeys by bike per week in the post-intervention survey, and they also cycled longer distances. Bike ownership increased and the proportion who never use a bicycle fell from 78.9% to 55.3% over the intervention period, which suggests the pilot successfully engaged clients with a lower propensity to cycle. All interview participants described increased levels of walking/wheeling and/or cycling, for instance: *"I try to go at least twice and then sometimes on a xxxx depending on, you know, if we all can get together…I take myself off for a couple of hours on a Sunday, if the weather's nice, and I just ride all around everywhere."* Two activity providers/pilot delivery team members described how their clients had established new habits around active travel (Appendices 6.1.1, 6.4.1 & 6.5.1).

3.3.4 Mode shift/fewer motorised vehicles and trips

A core objective of the pilot was to encourage a shift away from cars to active modes of travel, particularly for short journeys. Clients reported fewer car journeys each week in the post-intervention survey, as well as travelling shorter distances by car each week; the mean combined distance for car journeys fell from 67.6 to 50.7 miles per week. However, these findings are not statistically significant. Six interview participants described mode shift, for example: *"So now I've been going out on my bike more. So, instead of like jumping in the car to go down to the village shop, I've been either walking or going out on the bike."* Four of those involved in the pilot delivery also observed mode shift among their clients (Appendices 6.1.1, 6.4.4 & 6.5.1).

3.3.5 Increased physical activity

The survey measured engagement in physical activities and sports as a potential spillover effect of increased active travel. Over the intervention period, there was an increase in the number of clients who cycled, went to the gym, played football or racquet sports, went running, or did another physical activity. Notably, the proportion of clients who had not done any physical activity in the past four weeks decreased from 36.8% to 23.7% over the intervention period, which suggests the pilot encouraged those with a lower propensity to do physical activity to be more active. All interview respondents described being more active: *"I've found myself actually prompting myself to actually go out walking on my own now…I'm increasing my steps. I'm not finding I'm just staying in on my days off now."* Six clients described an increase in their physical activity in the survey qualitative feedback and four activity providers/pilot delivery team

members also highlighted increased levels of physical activity among their clients (Appendices 6.1.3, 6.4.1, 6.2.3 & 6.5.1).

3.3.6 Reducing inequalities in access and mobility

Cornwall is a predominantly rural area which experiences transport-related social exclusion due to infrequent public transport services and challenging terrain for using active modes[14]. This can constrain access to local services, education and employment opportunities. Half of the survey participants (50.0%) reported accessing other social support services (i.e., in addition to the ATSP pilot) as one benefit of taking part. Three interview participants described how engaging in the pilot activities had connected them with other community-based services: *"Some of the people involved in the [walking] group…they go to the (long-term health condition) meetings….I started to go to those and of course I've picked up information regarding (long-term health condition) and how to try and control it."* Five activity providers/pilot delivery team members emphasised reduced inequalities as a tangible outcome, for instance, by removing cost as a barrier to using active modes (Appendices 6.2.3, 6.4.4, 6.5.1 & 6.5.2).

3.3.7 Improved physical health

The survey findings were mixed for this outcome, with some clients reporting better health and others reporting worse health in the post-intervention survey. There was a decrease in the difficulty clients experienced with their energy levels, but this difference was not statistically significant. The qualitative findings, however, provide a clearer picture; seven clients emphasised physical health improvements in the post-intervention survey. All interview participants described feeling healthier and highlighted measurable indicators such as weight loss or increased fitness: *"When I started walking, I couldn't walk from xxxx down to the xxxx without puffing. Now I could almost run it and that's the difference…I couldn't get up the hill, but I can now, I'm not puffing."* Five of those involved in the pilot delivery also observed physical health improvements for the clients they supported (Appendices 6.1.4, 6.2.3, 6.4.1 & 6.5.1).

3.3.8 Improved wellbeing and mental health

The survey included six metrics which relate to wellbeing and mental health. Clients reported statistically significantly higher levels of life satisfaction in the post-intervention survey, as well statistically significantly higher levels of feeling that the things they do in life are worthwhile. Most clients (86.8%) identified 'spending more time outside' and 'more opportunities for social interaction' as important benefits of their participation in the pilot. All interview participants

[14] See: Wilson, M., and Whitmarsh, L. (2023). Cornwall Council behaviour change and engagement programme – survey of residents

described improved wellbeing as an important outcome: *"It's not just the [physical] health benefits that you get from the walking, it's the social element and, as a result of that, the mental health element…I've found my whole life has got a lot better as a result of what I've been doing with the groups."* Three interview participants mentioned easier access to nature as a positive outcome. Activity providers/pilot delivery team members also described clients' improved wellbeing (n=4) and increased social interaction (n=3) (Appendices 6.1.5, 6.2.3, 6.4.1 & 6.5.1).

3.4 Impacts

There are six impacts listed on the Cornwall ATSP logic framework (Appendix 6.7.1). The seven outcomes (sections 3.3.2 – 3.3.8) and the first two impacts (sections 3.4.1 – 3.4.2) can be evidenced at the participant level using data collected in this evaluation study. However, the remaining four impacts (sections 3.4.3 – 3.4.6) relate to broader scales such as community or system levels. This evaluation study did not collect empirical data relating to community or system level impacts, which typically require population level data and tend to be observable over longer time periods than the pilot duration. Thus, the success of the pilot in achieving these four impacts is more difficult to evidence and must be inferred from comparable studies, rather than directly verified with empirical data from this evaluation study.

3.4.1 Individual financial savings

A sizeable minority of clients in the post-intervention survey (42.1%) identified 'saving money (e.g., on petrol or diesel)' as a benefit of taking part in the pilot. One activity provider reported that their clients had saved money on car fuel, and two interview participants also described financial savings: *"It doesn't cost anything to walk. It's the one thing you can do that doesn't cost money."* However, the interviews also revealed that some clients in rural areas require a car to access active travel routes and activities, and so any financial savings on fuel are likely to be marginal for these individuals (Appendices 6.2.3, 6.5.1, 6.4.1 & 6.4.2).

3.4.2 Decrease in patient admissions and Accident & Emergency visits

Clients reported fewer GP appointments and hospital visits in the post-intervention survey, although these differences are not statistically significant. The reduction in GP appointments and hospital visits was most noticeable among those who require a greater degree of health care (i.e., individuals who need more GP appointments or they visit hospital very frequently). This suggests the pilot was particularly successful in improving the health of clients with more severe conditions. Many clients have several long-term health conditions and an important finding from the interviews was that taking part in the pilot resulted in improvements for multiple conditions, for example: *"My goal initially was to get my blood sugar level down to a suitable [level], and I managed that, I did that. But then when I realised the other benefits that were coming*

out of it…now it's 'I want to lose weight'. So going on the walk, it's helping that" (Appendices 6.1.4 & 6.4.1). The efficacy of an active travel intervention to simultaneously tackle multiple health conditions, both physical and mental, is a particularly strong justification for the community-based approach used in the Cornwall pilot, and for active travel social prescribing more generally.

3.4.3 Financial savings for the health and care system

The evaluation study did not produce data to directly indicate financial savings for the health and care system. We can infer that the positive physical and mental health outcomes described in sections 3.3.7 and 3.3.8 would ultimately reduce the need for health and social care in the client sample (n=38). One activity provider made the link between a healthier communities and reduced demand on health care, as did this client in the interviews: *"If people are more active, then potentially they're not going to have as many long-term [health] conditions….but long term, I think it would benefit the national health and the environment"* (Appendices 6.5.1 & 6.4.1). A reduction in GP appointments and hospital visits would, across the entire pilot cohort (n≤1992), entail financial savings for the health and care system in Cornwall, although these savings would be offset against the cost of the pilot. Similarly, any longer-term Council programme to prescribe active travel interventions would entail a financial cost to be factored against current health care provision for the target groups. This is not to say there would not be financial savings, given the promising cost-benefit analysis of active travel interventions in previous studies[15]. Moreover, financial costs are considered alongside other societal aims in health and social care policy, such as the potential of a programme to reduce health inequalities or address the social determinants of poor health[16].

3.4.4 Reduced mortality

The evaluation study did not produce any data to indicate reduced mortality. Although improved physical and mental health from using active modes has a clear association with

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[15] Chapman, R., et al., (2018). A Cost Benefit Analysis of an Active Travel Intervention with Health and Carbon Emission Reduction Benefits. *Int. J. Environ. Res. Public Health*, 15(5), 962; https://doi.org/10.3390/ijerph15050962. The authors found the benefit/cost ratio of the programme (over 10:1) is well in the range to justify the investment involved, taking into account health and injury savings and the value of carbon emission reductions.

[16] See: UK Government (2017). Chapter 6: social determinants of health - GOV.UK
Also see: BMJ Commission on the Future of the NHS (2024) NHS and the whole of society must act on social determinants of health for a healthier future | The BMJ
Both articles emphasise the significant potential for improving health and wellbeing, as well as reducing health inequalities, by identifying and taking action on the social determinants.
The National Institute for Health and Care Research also has a strong emphasis on social determinants.
Also see The Health Creation Alliance for system-level approaches on the prevention of ill health.

reduced mortality[17], there is insufficient empirical data from this study to make any robust inferences.

3.4.5 Wider economic benefits

Wider economic benefits is a broad category that could encompass several possible impacts. One impact is the ATSP Fund grants that were awarded to activity providers (Appendix 6.7.2), some of which are charities or community interest companies that rely on volunteers and external funding to provide valuable services in their local communities, particularly for 'hardly reached' individuals. Another economic benefit would be increased access to employment or education opportunities among clients, as they have statistically significantly lower levels of employment, household income, and educational attainment than the control group. One interview participant described how taking part in the pilot encouraged them to seek volunteering and employment opportunities: *"I don't work, but funnily enough through walking, I'm now going to look for a part time job…so that's given me the confidence to [look for work]."* Four clients used active travel for commuting in the past month and two of these clients noticed a significant increase in their use of active travel for this purpose (Appendices 6.6.1, 6.4.4 & 6.2.2). If the experience of these evaluation study participants is reflected across the entire pilot cohort (n≤1992), some individuals and communities may experience wider economic benefits through increased access to employment and education.

3.4.6 Environmental benefits

Previous studies have found multiple environmental benefits from shifting to active travel, such as reduced traffic congestion (and the associated reduction in noise and air pollution) and reduced carbon emissions[18]. One client emphasised the environmental benefits of reducing car use: *"When I joined it, I didn't think about transport and reducing my…the fumes, the miles in the car….it's going to have a massive impact on everything, you know, on the environment because you're not using…the emissions"* (Appendix 6.4.1). The behavioural outcomes described in

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[17] See: Panter, J., et al. (2018). Using alternatives to the car and risk of all-cause, cardiovascular and cancer mortality | Heart. *Heart*, 104(21). https://doi.org/10.1136/heartjnl-2017-312699
Also see: Dinu, M., et al. (2019). Active Commuting and Multiple Health Outcomes: A Systematic Review and Meta-Analysis. *Sports Med* 49, 437–452. https://doi.org/10.1007/s40279-018-1023-0
Both articles find reduced mortality from uptake of active travel.

[18] See: Ding, D., et al. (2024). The co-benefits of active travel interventions beyond physical activity: a systematic review. *The Lancet Planetary Health*, 8(10), e790 - e803, https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(24)00201-8/fulltext
Also see: Brand, C., et al. (2021). The climate change mitigation effects of daily active travel in cities - ScienceDirect. Transportation Research Part D: Transport and Environment, 93, 102764, ISSN 1361-9209. https://doi.org/10.1016/j.trd.2021.102764
Both articles find carbon emission reductions from active travel. In their systematic review, Ding et al. (2024) also identified reduced air pollution (i.e., reduced particulate matter, reduced NO_2 emissions).

sections 3.3.3 and 3.3.4 (i.e., an increase in people walking/wheeling and cycling, together with a mode shift away from private car use) would entail a reduction in carbon emissions. Although the increase in cycling frequency and distance was statistically significant, the increase in walking/wheeling frequency and distance was not, nor was the decrease in car journey frequency and distance. This lack of statistical significance constrains our ability to quantify a carbon emission reduction due to mode shift among the client sample.

4 Key learnings from the Cornwall ATSP pilot

This section builds on section 3 by highlighting some key learnings from the pilot. These include identifying the barriers and enablers of active travel for the target groups, the uptake of active travel for specific journeys, how the pilot model allowed provision to be tailored to clients' needs, and how challenges in the pilot delivery were overcome.

4.1 Barriers to clients' uptake of active travel

One of the pilot aims was to identify the barriers to active travel experienced by clients and, where possible, remove those barriers. Clients reported a range of barriers such as physical health conditions or low fitness levels, mental health conditions, or a lack of confidence (survey n=8, 5, 5; interviews n=3, 3, 3): *"I remember years ago going with one [cycling] group but then I felt terrible because they were so fit…I felt pressured, put me off. I thought I'd lost all confidence in everything. Not just maybe cycling, but everything."* Other barriers relate to personal circumstances, such as day to day commitments or caring responsibilities (survey n=8; interviews n=5). A third category of barriers reflects the challenging travel context in Cornwall, namely road safety concerns, a lack of/poorly maintained active travel infrastructure, and steep hills (survey n=6, 4, 2; interviews n=5, 2, 4). Notably, inadequate public transport services were also mentioned, highlighting that the use of active travel can interact with other modes of transport (survey n=4; interviews n=4). The activity providers and pilot delivery team emphasised the same barriers, although cost was mentioned as an additional constraint (e.g., purchasing an e-bike is prohibitively expensive for some clients; n=4). Clients reported that the pilot was most effective in overcoming 'low fitness levels' and 'low confidence to use active travel'. The pilot therefore aligned with the addressing the most prevalent barriers, which were physical or psychological (Appendices 6.2.4, 6.4.2 & 6.5.2).

4.2 Effectiveness of the pilot in supporting clients to achieve their active travel goals

Most survey participants 'strongly agree' (55.3%) or 'agree' (23.7%) that activity provider support helped them to reach their active travel goals. The aspects of support which clients found most helpful were encouragement (81.6% of clients), learning active travel routes (52.6%) and learning new skills (42.1%). Clients also acknowledged the support they received from their Health

Improvement Practitioner (survey n=4; interviews n=5): *"She rings every month or so…and sometimes we see her on our (provider) walk… that shows a relationship she has with people. She has a way of bringing out what they don't even know they need, and that's a gift."* A key dimension of this support was the capacity to adapt the provision to an individual's needs, as highlighted by several activity providers/pilot delivery team members (n=6): *"The clients get more specific interventions to their needs. We had a lot of vulnerable clients who [are] hard to reach and therefore, we could tailor the support they received to what they really needed."* This flexibility can be attributed to the pilot intervention model, which combines one-to-one Health Improvement Practitioner support (i.e., identifying a client's needs and connecting them with appropriate local providers) with a broad range of activities for varying ability levels (i.e., 17 different providers). Thus, clients with complex needs could receive more one-to-one support, whereas those who required less support could simply be connected with an activity provider.

Another positive outcome of the pilot was the collaboration and communities of practice which emerged among the activity providers through regular knowledge sharing meetings. This created local referral networks which allowed clients to follow a progression pathway, whereby those who experienced marked improvements in their confidence and ability could then be linked to a different provider who offered more advanced activities (n=6): *"The whole programme has been an excellent example of bringing different providers together. I have a far better idea of which groups are able to provide what support in the Clays area specifically, and across Cornwall more generally"* (Appendices 6.2.1, 6.4.5, 6.5.1, 6.5.3 & 6.5.4; also see the case studies in the ATSP pilot delivery report).

4.3 Enablers of active travel – increasing capability, opportunity and motivation

The enablers of active travel relate closely to the intervention model, described in section 4.2. Although the delivery partners may not have used the COM-B theoretical model in their intervention design, their provision and their focus on clients' needs activates all three behavioural components of the model. This starts with increased opportunity to engage in active travel, with an activity provider having a conversation with a client to discuss any concerns they may have and then encouraging them to 'give it a go and see if you like it' (survey n=7; interviews n=7): *"So (walking provider) arranged for us to have a taster session. Well, she actually arranged two…the second one I joined them, and it was brilliant!"* Activity providers/pilot delivery team members also highlighted how the intervention creates opportunity (n=6): *"They have given people a positive experience of walking a path, they know new routes and have enabled people to understand that walking is possible."* Intervention functions such as enablement (e.g., taster sessions for different ability levels), persuasion (i.e., encouragement), and education (e.g., raising awareness of local active travel routes) are all important for increasing opportunity.

Throughout the pilot, the activity providers and Health Improvement Practitioners worked with clients to increase their physical and psychological capabilities, using intervention functions such as education, modelling, and training (e.g., improving skills and fitness levels, demonstrating road awareness, raising confidence). Clients themselves identified this learning process and their strengthened capabilities (survey n=4; interviews n=6): *"I'm learning something every day, every time we go out…I still struggle to get up hills and stuff but, if it's a nice day, I think no, I will cycle there, I can do that."*

Finally, most clients cited potential physical health benefits as their initial reason for engaging in the pilot. However, their experience of the pilot activities provided additional motivations, such as making social connections and improving wellbeing (survey n=4; interviews n=7): *"I've done these walks…we've got our own little WhatsApp group there and I've already made contacts, sort of friends…and so I can't wait to do this coming Friday one."* Five activity providers/pilot delivery team members also emphasised this link between social interaction and increased motivation as an important enabler (Appendices 6.2.3, 6.4.1 & 6.5.1).

4.4 Behaviour change and the context of active travel journeys

One of the pilot's core aims was to encourage uptake of active travel. Of the 38 clients who completed the post-intervention survey, 31 reported using active travel in the past month. Most (87.1%) used active modes for leisure and exercise which, although undoubtedly beneficial for those individuals in terms of improving physical health and wellbeing, is distinct from using active modes as a means of travel[19]. Other journey purposes were also important; for example, 80.6% of clients used active travel for going to the shops, 48.4% for visiting family or friends, and 16.1% for the school run. Only 12.9% used active travel for commuting, although most clients were not in employment or education during the pilot and so would not need to commute. Clients were asked about the extent to which they had noticed a change in their use of active travel for these journey purposes. Over half of clients (54.8%) had 'moderately' or 'significantly increased' their use of active modes for leisure or exercise, compared to 29.1% for going to the shops, 12.9% for visiting family or friends, and 6.5% for commuting. There was no clear change in active travel behaviour for the school run (Appendices 6.2.2 & 6.6.1).

[19] 'Active travel' refers to modes of travel that involve a level of activity. It means getting about in a way that makes you physically active, like walking, wheeling or cycling. This is distinct from walking, wheeling or cycling for leisure or sport. See: Department for Transport https://www.gov.uk/government/publications/active-travel-local-authority-toolkit/active-travel-local-authority-toolkit#:~:text=What%20active%20travel%20means.%20Active%20travel%20refers%20to%20modes%20of#:~:text=What%20active%20travel%20means.%20Active%20travel%20refers%20to%20modes%20of

In summary, increasing the use of active modes for leisure or exercise for most clients, as well as increasing the use of active travel among a smaller cohort, should be viewed as successful outcomes of the pilot. For some clients, gaining confidence to use active modes initially for leisure or exercise could be a stepping stone for integrating active travel into their everyday life. One suggestion for further tailoring the support to clients' needs is to identify the journey purposes and routes that clients would like to use active modes for, and adapting the provision so they gain direct experience of using active travel for those specific journeys.

4.5 Challenges in the delivery of the pilot and the referral process

Activity providers and the pilot delivery team did encounter some challenges, which is to be expected in a 'test and learn' intervention. During the pilot, the delivery team incorporated an 'adapt' dimension, given that 'test and learn' is an iterative cycle and improvements can be made based on initial learning. Many activity providers (n=6) found this process of adapting their provision to be beneficial, not only for the clients but also for themselves (i.e., they were not overly constrained in how they delivered positive outcomes for clients): *"We felt like the acceptance of feedback and the ability to change our project following participant feedback was incredible. Both, the members of the group [clients] and us as provider felt very heard and listened to."* The most prevalent challenge was that clients with complex needs require more time and more one-to-one support to reach their active travel goals, which highlights the need for adequate time and capacity among activity providers and Health Improvement Practitioners to offer that support (n=6).

A further challenge was that referrals from social prescribing networks were initially low, either due to underdeveloped referral partnerships or networks, or due to a lack of awareness among social prescribers of the pilot and its aims. This was addressed early in the project by the pilot's steering group and delivery team, by expanding the referral routes to include activity providers and Allied Health Professionals (n=8). Expanding the number of referral routes increased the potential for reaching more clients and was particularly important for supporting clients in areas where social prescribing networks were less developed. Activity providers/delivery team members (n=6) suggested that better initial engagement with social prescribers and GP surgeries would have improved the referral process from the outset, in terms of generating awareness of the pilot and its aims, as well as fostering a shared understanding of the concept of active travel (i.e., not just increasing physical activity levels, but also providing potential co-benefits for clients and communities, such as reduced health inequalities or better access to employment opportunities; n=2).

Suggestions for ensuring the legacy of the pilot include providing additional funding for activity providers where possible (n=8), continuing coordination and knowledge sharing between activity providers (n=6), improving active travel infrastructure (n=5), and ensuring long-term referral partnerships for community-based support services (n=3) (Appendices 6.5.3, 6.5.4, 6.5.5 & 6.7.3).

5 Limitations of the evaluation study

There were three main limitations of the evaluation study. The most important is the small sample size for client survey (pre-intervention n=67; post-intervention n=38) and there are three reasons for this small sample. First, the pilot delivery and evaluation team decided to only recruit evaluation study participants from clients (n=97) who were supported by a Health Improvement Practitioner, and so there was no recruitment through activity providers (who supported a much larger cohort of ≤1992 clients). The premise of this decision was that data collection would be more robust if the survey was conducted with clients in a conversation with their Health Improvement Practitioner, rather than clients completing the survey independently. Second, participation in evaluation study was optional and 30.9% chose not to take part in the survey. Finally, there was a relatively high attrition rate of 43.3%. High attrition rates are not unusual in intervention studies, particularly if the participants have a long-term health condition, and so a high drop out rate was anticipated. As presented in sections 3.3 & 3.4, most indicators from the survey suggest positive outcomes in terms of clients' uptake of active travel and the associated health benefits, but the impact of the small sample size is that the majority of findings are not statistically significant at the $p = .05$ threshold. If recruitment for the survey had been extended to the entire pilot cohort (n≤1992), it is very likely that more results would have been statistically significant.

A second limitation is the small sample size for interviews (n=7) and this is due to two reasons. First, interview participants were recruited from clients who had completed the post-intervention survey (n=38) and so the initial sample size was small. Second, there was limited interest among clients to take part in an interview, perhaps reflecting research participant fatigue. The interviews provided valuable insights into the clients' experiences of the pilot, but the evaluation team acknowledge a potential self-selection bias in this small sample. The impact on the data is that more engaged clients may have chosen to take part in an interview and so would likely have a more favourable view of the pilot and its outcomes than clients who chose not to take part in an interview.

A third limitation relates to the control group, which was recruited via a market research company. Although the sample size (n=300) is adequate for statistical analysis, the control

group would ideally be matched with the clients on postcodes areas for direct comparability[20]. Moreover, the control group did not complete the post-intervention survey as the market research company was unable to provide a repeated-measures sample for the six-month intervention period. Only two market research companies were able to provide a Cornwall sample matched to these specific postcode areas for a repeated-measures design, and these companies were significantly more expensive and beyond the budget of this evaluation study. In terms of the impact on the data, this control group is still considered to be a valid reference for identifying active travel and health inequalities in the three pilot areas. Previous research has shown that people across Cornwall experience similar challenges in using active modes, such as a lack of active travel infrastructure, road safety concerns, steep hills and long distances[21]. The control group participants who live in the three case areas are therefore considered likely to have broadly similar travel behaviours and experiences of active travel to those who live in other locations in Cornwall.

[20] Only 40 of the control group participants live in Bodmin, St Austell or Penzance.

[21] See previous CAST reports on engaging Cornwall residents in low-carbon behaviours, including active travel:
Wilson, M., and Whitmarsh, L. (2023). Cornwall Council behaviour change and engagement programme – survey of residents.
Wilson, M., and Whitmarsh, L. (2024). CAST-the-centre-for-climate-change-and-social-transformations-Cornwall-Council-report-Behaviour-change-interventions-to-encourage-uptake-of-e-bike-shared-mobility-in-Cornwall.pdf

6 Appendices

Appendices 6.1 – 6.6 present empirical data collected in this evaluation study. Appendix 6.7 contains the pilot logic framework, a description of the activity providers and the referral routes, the literature review, and the intervention functions using the COM-B model. Appendix 6.8 is the data collection protocols.

6.1 Changes in clients' travel attitudes, behaviours and health over the intervention period (pre- and post-intervention survey; quantitative)

The first appendix presents results from the pre- and post-intervention survey (see Appendices 6.8.1 and 6.8.2 for the survey protocols). Of the 67 clients who completed the pre-intervention survey, 38 completed the post-intervention survey. Within-group analysis was used to identify any changes over the invention period in clients' travel behaviours, their attitudes towards active travel, their engagement in physical activity, and their health and wellbeing. The statistical tests used were Paired-samples t-test, Wilcoxon signed-rank test, and McNemar's test.

Table 4 presents an overview of the survey structure and indicates which question blocks were included in the pre- and post-intervention surveys.

Table 4, Pre- and post-intervention survey on travel behaviours and attitudes

Block	Theme	Sub-themes	Survey
1	Referral route	Date of referral, referral route, Health Improvement Practitioner	Pre-
2	Travel behaviour	Journey frequency: car, taxi, bus, train, bike Journey distance: walking/wheeling, bike, car; car ownership	Pre- & Post-
3	Perceptions of active travel	Awareness, ability, attitude, confidence, safety Bicycle ownership	Pre- & Post-
4	Physical activity	Frequency of walking/wheeling and other sports/activities	Pre- & Post-
5	Health	Health condition, level and cause of pain, energy level, GP & hospital visits	Pre- & Post-
6	Wellbeing	Wellbeing indicators x 4, peer support indicators x 2	Pre- & Post-
7	Sociodemographic	Age, gender, ethnicity, education, income etc.	Pre-
8	Open feedback	Qualitative feedback on the clients' experience of the pilot	Pre- & Post-
9	ATSP activity participation	Which active travel activities the clients received and from which service provider	Post-
10	Evaluation of the ATSP pilot	Measuring the impact of service provider support in meeting active travel goals	Post-
11	Impacts on travel behaviours	Journey purpose, barriers to uptake, co-benefits	Post-

6.1.1 Travel behaviours

The survey explored clients' travel behaviours for the following modes: walking/wheeling, cycling, private car, taxi, and public transport.

Walking/wheeling

Two clients reported in the post-intervention survey that they had not done a continuous walk/wheel that lasted at least ten minutes in the past four weeks. For those who had walked/wheeled in the past four weeks, Figure 2 shows there was no statistically significant change in their walking/wheeling frequency over the intervention period (Wilcoxon signed-rank test). Over half of clients walk/wheel five or more days per week.

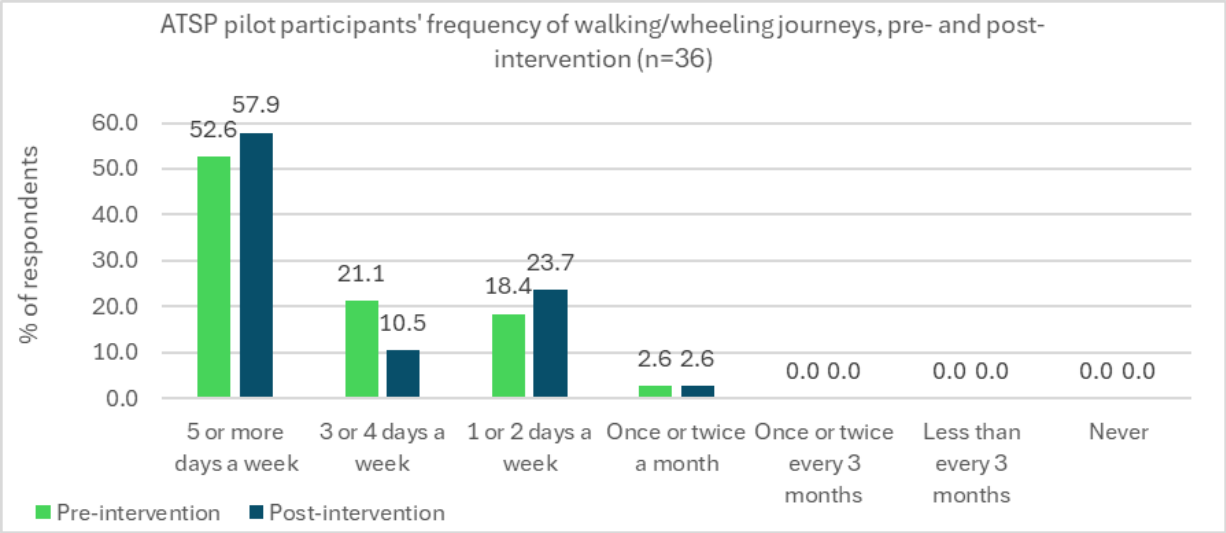


Figure 2, ATSP pilot participants' frequency of walking/wheeling journeys (pre- and post-intervention survey)

Cycling

Clients were asked how often they use a bicycle (Figure 3). Clients cycled statistically significantly more frequently in the post-intervention survey, compared to the pre-intervention survey[22]. The proportion of clients who never use a bicycle fell from 78.9% to 55.3% over the intervention period, which suggests the pilot successfully engaged clients with a lower propensity to cycle.

[22] A Wilcoxon signed-rank test revealed a statistically significant median increase in clients' cycling frequency in the post-intervention survey, compared to the pre-intervention survey, z = -2.691, p = .007. The median response in both surveys was 'never'.

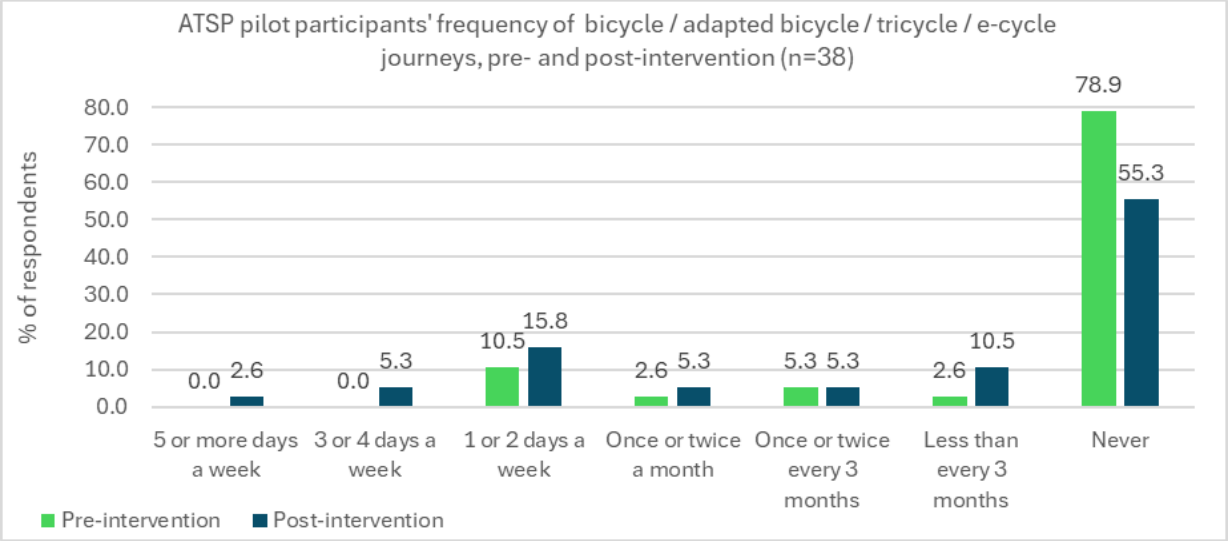


Figure 3, ATSP pilot participants' frequency of journeys using a bicycle/adapted bicycle/tricycle/ e-cycle (pre- and post-intervention survey)

Table 5 shows the proportion of clients who own a conventional or adapted bike increased from 28.9% to 39.5% over the intervention period, whereas the proportion who do not own a bike fell from 44.7% to 21.1%. This would suggest taking part in the pilot encouraged some clients to buy a bike. However, this difference was not statistically significant (McNemar's test).

Table 5, ATSP pilot participants' bicycle ownership (pre- and post-intervention survey)

	Pre-intervention (n=38)		Post-intervention (n=38)	
Bike ownership category*	Frequency	Valid %	Frequency	Valid %
I own a conventional bike or an adapted bike	11	28.9	15	39.5
I own an e-bike (i.e. an electric bike)	6	15.8	6	15.8
I own a bike but it is in disrepair	1	2.6	0	0.0
I do not own a bike	17	44.7	8	21.1
Not applicable	4	10.5	11	28.9

* Participants could select multiple options

Travel by car

Figure 4 shows a decrease in the frequency of clients' private car journeys in the post-intervention survey, compared to the pre-intervention survey, but the difference is not

statistically significant (Wilcoxon signed-rank test). Over 40% of clients use their car five or more days per week. There was no difference in clients' levels of car ownership between the pre- and post-intervention survey.

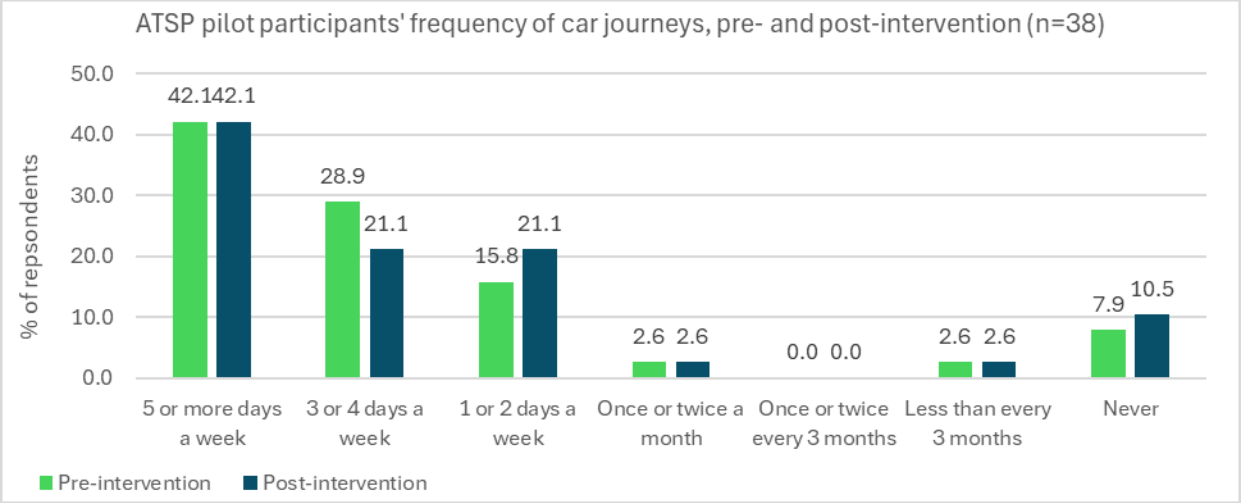


Figure 4, ATSP pilot participants' frequency of car journeys (pre- and post-intervention survey)

Private car is the dominant mode of transport in Cornwall[23] and so two further questions were included to compare car travel with active modes. The first aimed to validate the results for journey frequency presented in Figures 2, 3 and 4. The clients were asked *how many journeys* they made last week by car, bike, or walking/wheeling (as opposed to *how many days* per week they travel using these three modes). Clients reported statistically significantly more cycle journeys per week in the post-intervention survey, compared to the pre-intervention survey[24] (Figure 5). They also made more walking/wheeling journeys and fewer car journeys, but these findings are not statistically significant (Paired samples t-test).

[23] See: Wilson, M., and Whitmarsh, L. (2023). Cornwall Council behaviour change and engagement programme – survey of residents

[24] A Paired samples t-test revealed clients reported more weekly journeys by bike in the post-intervention survey (1.03 ± 2.19), compared to the pre-intervention survey (0.26 ± 0.83), a statistically significant difference of 0.77 (95% CI, 0.10 to 1.43), $t(37) = 2.330$, $p = .025$

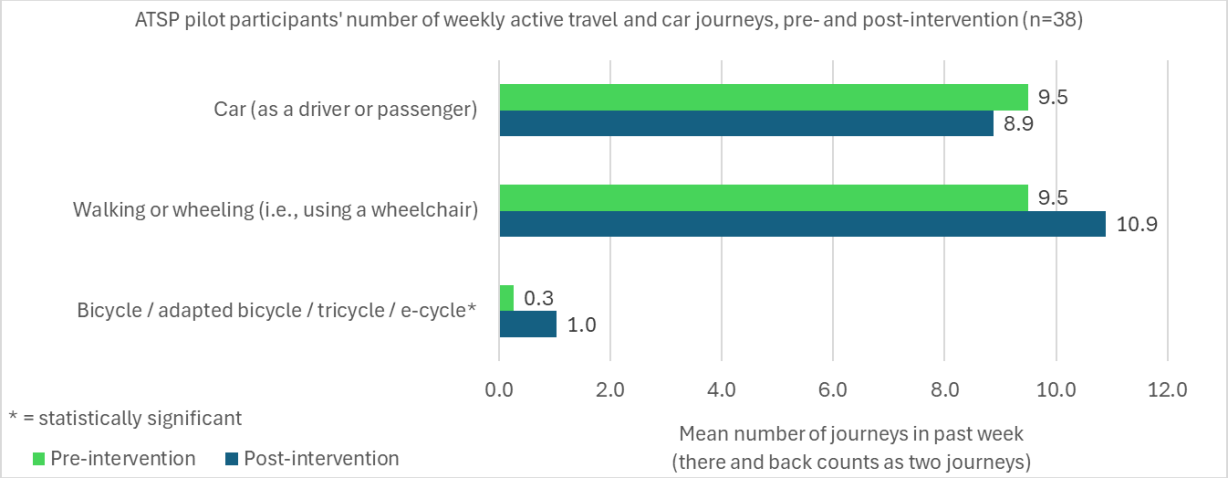


Figure 5, ATSP pilot participants' number of weekly active travel and car journeys (pre- and post-intervention survey)

The distances travelled by active modes and car were also explored. Figure 6 shows the clients reported statistically significantly longer distances by bike in the past week in the post-intervention survey, compared to the pre-intervention survey[25]. There was also an increase in the combined walking/wheeling distance in past week, as well as a decrease in the combined car journey distance, but these findings are not statistically significant (Paired samples t-test).

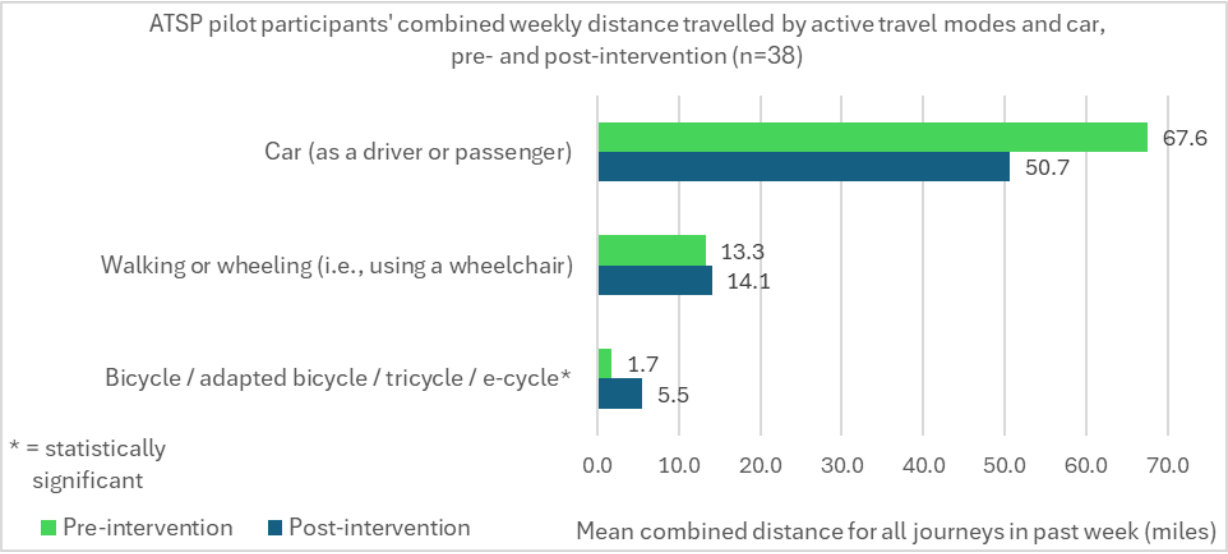


Figure 6, ATSP pilot participants' combined weekly distance travelled by active modes and car (pre- and post-intervention survey)

[25] A Paired samples t-test revealed clients reported cycling longer combined weekly distances (miles) in the post-intervention survey (5.51 ± 11.62), compared to the pre-intervention survey (1.70 ± 5.36), a statistically significant difference of 3.81 (95% CI, 0.09 to 7.53), $t(36) = 2.079$, $p = .045$

Travel by public transport

Table 6 shows an increase in the frequency of clients' bus or coach journeys in the post-intervention survey, compared to the pre-intervention survey, but the difference is not statistically significant (Wilcoxon signed-rank test). The proportion of clients who use a bus on weekly basis increased from 13.2% to 18.4% over the intervention period.

Table 6, ATSP pilot participants' frequency of bus or coach journeys (pre- and post-intervention survey)

	Pre-intervention (n=38)		Post-intervention (n=38)	
Frequency category	Frequency	Valid %	Frequency	Valid %
5 or more days a week	0	0.0	1	2.6
3 or 4 days a week	2	5.3	1	2.6
1 or 2 days a week	3	7.9	5	13.2
Once or twice a month	8	21.1	9	23.7
Once or twice every 3 months	5	13.2	4	10.5
Less than every 3 months	8	21.1	6	15.8
Never	12	31.6	12	31.6

Similarly, Table 7 shows an increase in the frequency of clients' train or tram journeys in the post-intervention survey, compared to the pre-intervention survey, but the difference is not statistically significant (Wilcoxon signed-rank test). Only one client uses trains on a weekly basis.

Table 7, ATSP pilot participants' frequency of train or tram journeys (pre- and post-intervention survey)

	Pre-intervention (n=38)		Post-intervention (n=38)	
Frequency category	Frequency	Valid %	Frequency	Valid %
5 or more days a week	0	0.0	0	0.0
3 or 4 days a week	0	0.0	1	2.6
1 or 2 days a week	1	2.6	0	0.0
Once or twice a month	2	5.3	4	10.5
Once or twice every 3 months	6	15.8	5	13.2
Less than every 3 months	15	39.5	19	50.0
Never	14	36.8	9	23.7

Travel by taxi

Table 8 shows a decrease in clients' frequency of taxi journeys in the post-intervention survey, compared to the pre-intervention survey, but the difference is not statistically significant (Wilcoxon signed-rank test). Over 60% of clients never use a taxi.

Table 8, Frequency of taxi or private hire rental journeys (pre- and post-intervention survey)

	Pre-intervention (n=38)		Post-intervention (n=38)	
Frequency category	Frequency	Valid %	Frequency	Valid %
5 or more days a week	1	2.6	2	5.3
3 or 4 days a week	2	5.3	0	0.0
1 or 2 days a week	0	0.0	0	0.0
Once or twice a month	2	5.3	2	5.3
Once or twice every 3 months	1	2.6	0	0.0
Less than every 3 months	8	21.1	11	28.9
Never	24	63.2	23	60.5

6.1.2 Perceptions of active travel

This section presents changes over the intervention period in the clients' attitudes towards active travel as a form of transport, their awareness of active travel routes in their local area, and their confidence and safety perception when using active modes.

Walking/wheeling

Table 9 shows an increase in clients' awareness of walking/wheeling routes in their local area in the post-intervention survey, compared to the pre-intervention survey, although this difference is not statistically significant (Wilcoxon signed-rank test). Notably, the proportion who know 'a great deal' about local walking/wheeling routes increased from 28.9% to 39.5% over the intervention period.

Table 9, ATSP pilot participants' awareness of walking/wheeling routes in their local area (pre- and post-intervention survey)

	Pre-intervention (n=38)		Post-intervention (n=38)	
Level of awareness	Frequency	Valid %	Frequency	Valid %
A great deal	11	28.9	15	39.5
A fair amount	10	26.3	12	31.6
Just a little	14	36.8	11	28.9
Heard of them, know nothing about them	2	5.3	0	0.0
Never heard of them	0	0.0	0	0.0
Don't know	1	2.6	0	0.0
Not applicable	0	0.0	0	0.0

Table 10 shows mixed results in the clients' level of confidence when walking/wheeling in their local area, with some reporting an increase in confidence but others reporting a decrease in confidence. However, this difference is not statistically significant (Wilcoxon signed-rank test). The majority of clients are either 'very confident' or 'fairly confident' when walking/wheeling.

Table 10, ATSP pilot participants' confidence when walking/wheeling in their local area (pre- and post-intervention survey)

	Pre-intervention (n=38)		Post-intervention (n=38)	
Level of confidence	Frequency	Valid %	Frequency	Valid %
Very confident	16	42.1	12	31.6
Fairly confident	12	31.6	20	52.6
Not very confident	7	18.4	4	10.5
Not at all confident	2	5.3	1	2.6
Don't know	0	0.0	0	0.0
Not applicable	1	2.6	1	2.6

Figure 7 also shows mixed results, this time in terms of clients' perception of safety when walking/wheeling in their local area. Some reported feeling safer, whereas others reported feeling less safe, although this difference is not statistically significant (Wilcoxon signed-rank test). The proportion of clients who feel 'fairly safe' increased from 39.5% to 52.6% over the intervention period.

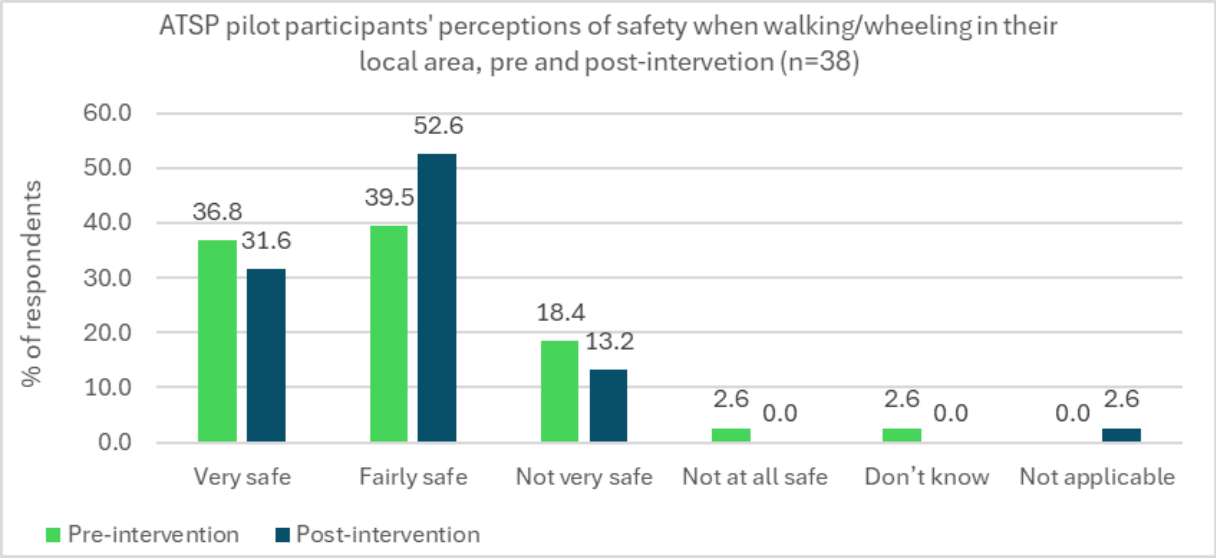


Figure 7, ATSP pilot participants' perception of safety when walking/wheeling in their local area (pre- and post-intervention survey)

Table 11 shows some clients have a more favourable attitude towards walking/wheeling as a form of transport in the post-intervention survey, compared to the pre-intervention survey, although this difference is not statistically significant (Wilcoxon signed-rank test; Paired samples t-test). One positive finding is that the proportion of clients with a 'fairly' or 'very' unfavourable attitude towards walking/wheeling fell from 15.8% to 5.3% over the intervention period.

Table 11, ATSP pilot participants' attitude towards walking/wheeling as a form of transport (pre- and post-intervention survey)

Attitude towards walking/wheeling	Pre-intervention (n=38)		Post-intervention (n=38)	
	Frequency	Valid %	Frequency	Valid %
Very favourable	20	52.6	19	50.0
Fairly favourable	11	28.9	14	36.8
Neither favourable nor unfavourable	1	2.6	3	7.9
Fairly unfavourable	4	10.5	2	5.3
Very unfavourable	2	5.3	0	0.0
Don't know	0	0.0	0	0.0
Not applicable	0	0.0	0	0.0

Cycling

Figure 8 shows an increase in clients' perception of their cycling ability in the post-intervention survey, compared to the pre-intervention, although this difference is not statistically significant (Wilcoxon signed-rank test). Notably, the proportion of clients who feel 'very able' to cycle increased from 5.3% to 18.4% over the intervention period.

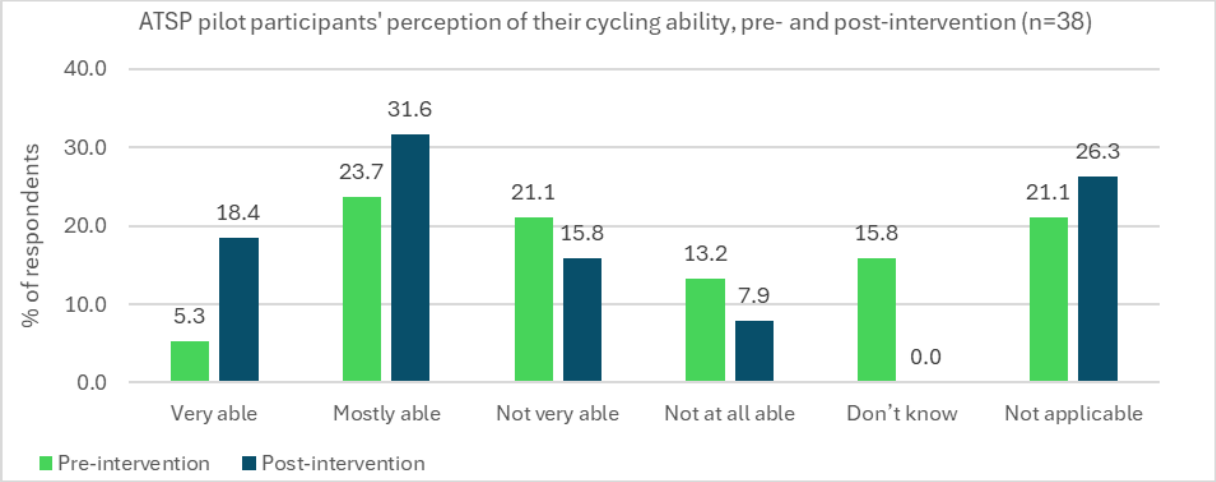


Figure 8, ATSP pilot participants' perceptions of their cycling ability (pre- and post-intervention survey)

Figure 9 shows clients' awareness of cycling infrastructure in their local area (e.g., cycle lanes, cycle routes, cycle storage, cycle hire, adapted cycling, e-cycling) was statistically significantly higher in the post-intervention survey, compared to the pre-intervention survey[26]. The proportion of clients who stated they know 'a fair amount' about local cycling infrastructure increased from 26.3% to 34.2% over the intervention period. However, the proportion of clients who stated 'not applicable' increased from 15.8% to 31.6% over the intervention period, which indicates some clients may have decided cycling is not feasible for them.

[26] A Wilcoxon signed-rank test revealed a statistically significant median increase in clients' awareness of cycling infrastructure in their local area in the post-intervention survey, compared to the pre-intervention survey, $z = -2.049$, $p = .040$. The median response in both surveys was 'just a little'.

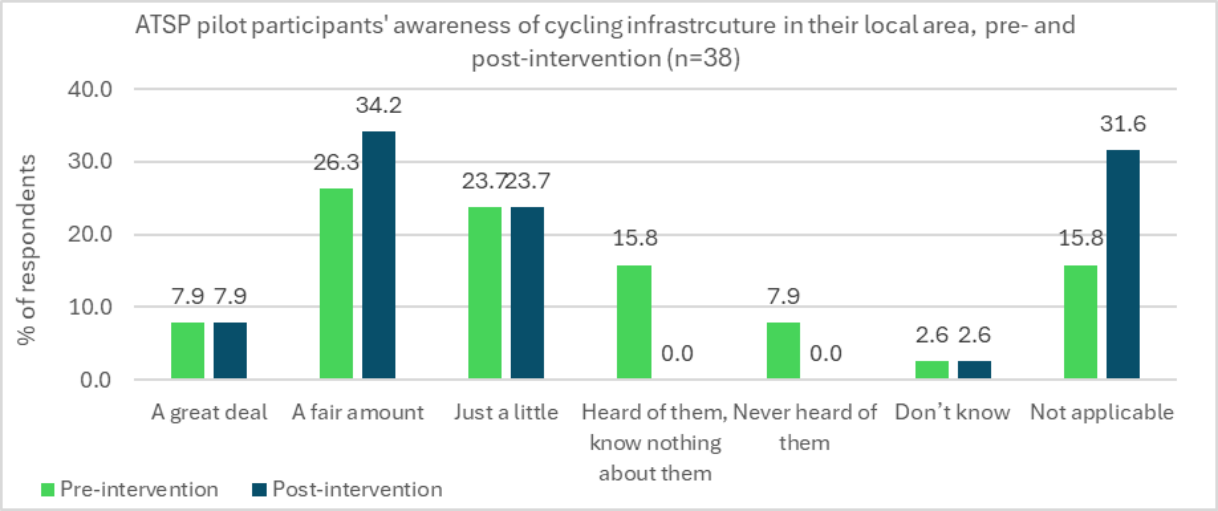


Figure 9, ATSP pilot participants' awareness of cycling infrastructure in their local area (pre- and post-intervention survey)

Figure 10 shows an increase in clients' confidence when cycling/e-cycling on roads in their local area in the post-intervention survey, compared to the pre-intervention survey, although this difference is not statistically significant (Wilcoxon signed-rank test). The proportion of clients who feel 'fairly confident' increased from 15.8% to 26.3% over the intervention period.

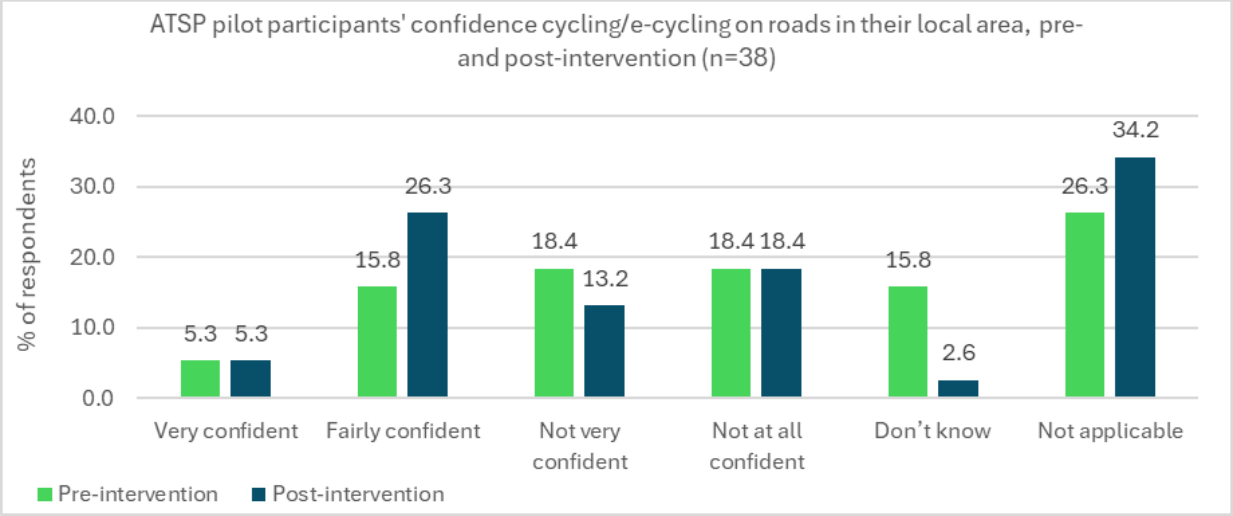


Figure 10, ATSP pilot participants' confidence when cycling on roads in their local area (pre- and post-intervention survey)

Figure 11 shows clients' perception of safety when cycling/e-cycling on roads in their local area increased in the post-intervention survey, compared to the pre-intervention survey, although

this difference is not statistically significant (Wilcoxon signed-rank test). The proportion of clients that feel 'fairly safe' increased from 13.2% to 28.9% over the intervention period.

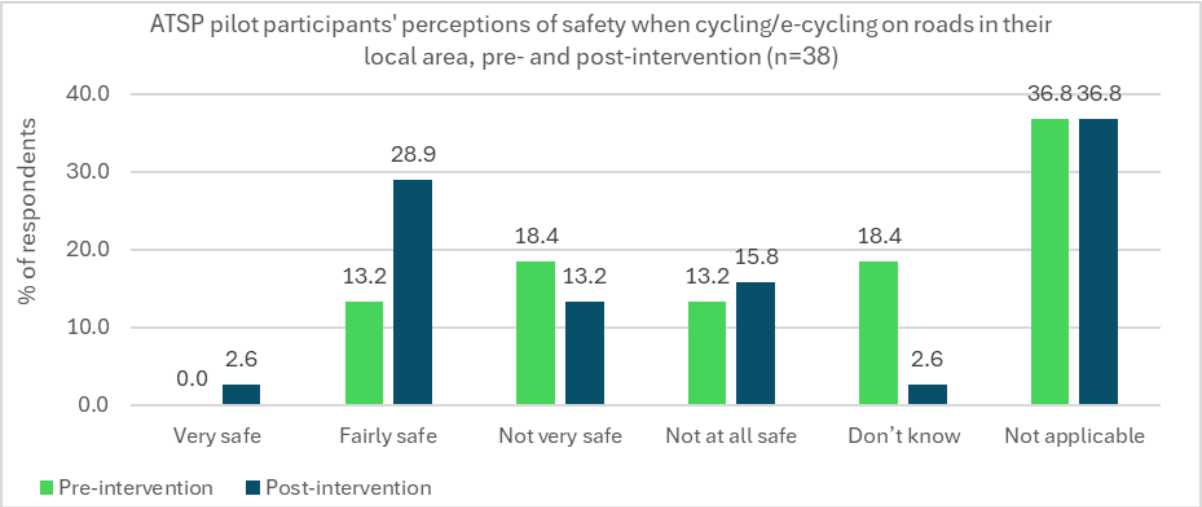


Figure 11, ATSP pilot participants' perceptions of safety when cycling/e-cycling on roads in their local area (pre- and post-intervention survey)

Table 12 shows some clients have a more favourable attitude towards cycling as a form of transport in the post-intervention survey, compared to the pre-intervention survey, although this difference is not statistically significant (Wilcoxon signed-rank test; Paired samples t-test). The proportion of clients with a 'very favourable' attitude towards cycling increased from 28.9% to 36.8% over the intervention period.

Table 12, ATSP pilot participants' attitude towards cycling as a form of transport (pre- and post-intervention survey)

	Pre-intervention (n=38)		Post-intervention (n=38)	
Attitude towards cycling	Frequency	Valid %	Frequency	Valid %
Very favourable	11	28.9	14	36.8
Fairly favourable	13	34.2	9	23.7
Neither favourable nor unfavourable	2	5.3	4	10.5
Fairly unfavourable	2	5.3	3	7.9
Very unfavourable	4	10.5	1	2.6
Don't know	1	2.6	3	7.9
Not applicable	5	13.2	4	10.5

6.1.3 Physical activity

Clients were asked which physical activities or sports they have done in the last four weeks. Table 13 shows an increase in the number of clients who cycled, worked out, played football/rugby or racquet sports, went running, or did another physical activity in the post-intervention survey, compared to the pre-intervention survey. However, the number of clients who went swimming or did aerobics decreased slightly in the post-intervention survey. Notably, the proportion of clients who had not done any physical activity decreased from 36.8% to 23.7% over the intervention period, which suggests the pilot encouraged those with a lower propensity to do physical activity to be more active. However, this difference was not statistically significant (McNemar's test). The sample sizes for each activity were too small to conduct meaningful statistical analysis.

Table 13, Physical activities or sports the ATSP pilot participants have done in the last four weeks (pre- and post-intervention survey)

	Pre-intervention (n=38)		Post-intervention (n=38)	
Activity or sport	Frequency	%	Frequency	%
Swimming	7	18.4	4	10.5
Cycling	6	15.8	12	31.6
Workout at a gym / Exercise bike / Weight training	3	7.9	6	15.8
Aerobics / Keep fit / Gymnastics / Dance for fitness	6	15.8	5	13.2
Running / Jogging	0	0.0	1	2.6
Football / Rugby	0	0.0	1	2.6
Badminton / Tennis / Squash	0	0.0	2	5.3
Exercises (e.g., press-ups, sit-ups)	2	5.3	2	5.3
Other activity	9	23.7	11	28.9
I have not done any of these activities	14	36.8	9	23.7

Clients were also asked how frequently they had undertaken these physical activities or sports; Table 14 shows clients typically do these activities 1 or 2 days a week. There was a slight increase in frequency of aerobics, but a slight decrease in frequency of swimming. The sample sizes for each activity were too small to conduct meaningful statistical analysis.

Table 14, Median frequency of physical activities or sports the ATSP pilot participants have done in the last four weeks (pre- and post-intervention survey)

Activity or sport	Pre-intervention (n=38) Median response	Post-intervention (n=38) Median response
Swimming	1 or 2 days a week	Once or twice a month
Cycling	1 or 2 days a week	1 or 2 days a week
Workout at a gym / Exercise bike / Weight training	1 or 2 days a week	1 or 2 days a week
Aerobics / Keep fit / Gymnastics / Dance for fitness	Once or twice a month	1 or 2 days a week
Running / Jogging	-	1 or 2 days a week
Football / Rugby	-	1 or 2 days a week
Badminton / Tennis / Squash	-	1 or 2 days a week
Exercises (e.g. press-ups, sit-ups)	3 or 4 days a week	3 or 4 days a week
Other activity	1 or 2 days a week	1 or 2 days a week

6.1.4 Physical health

The survey included eight questions which explored the clients' physical health. Table 15 shows most clients have a long-term health condition lasting, or expected to last, 12 months or more. There was a slight decrease in the number of clients who reported having a long-term health condition in the post-intervention survey, compared to the pre-intervention survey[27].

Table 15, Proportion of ATSP pilot participants with a long-term health condition (pre- and post-intervention survey)

Health condition	Pre-intervention (n=38) Frequency	Pre-intervention (n=38) Valid %	Post-intervention (n=38) Frequency	Post-intervention (n=38) Valid %
Have a long-term physical or mental health condition	29	76.3	27	71.1
Do not have a long-term physical or mental health condition	8	21.1	9	23.7
Prefer not to say	1	2.6	2	5.3

[27] This decrease explains the slightly different *n* present for pre- and post-intervention in Table 15.

Clients who have a long-term health condition were asked whether their condition(s) or illness(es) reduce their ability to carry out day-to-day activities (Table 16). A higher proportion of clients (48.1%) reported the most severe impact (i.e., 'a lot') in the post-intervention survey, compared to the pre-intervention survey (41.4%), although this difference is not statistically significant (Wilcoxon signed-rank test).

Table 16, Impact of long-term health condition on ATSP pilot participants' ability to carry out day-to-day activities (pre- and post-intervention survey)

	Pre-intervention (n=29)		Post-intervention (n=27)	
Impact of health condition	Frequency	Valid %	Frequency	Valid %
Yes, a lot	12	41.4	13	48.1
Yes, a little	13	44.8	10	37.0
Not at all	3	10.3	4	14.8
Prefer not to say	1	3.4	0	0.0

Clients were asked about their health in general. Figure 12 shows mixed findings, with some clients reporting better health and others reporting worse health in the post-intervention survey, compared to the pre-intervention survey. There was no statistically significant difference in the pre- and post-intervention results (Wilcoxon signed-rank test).

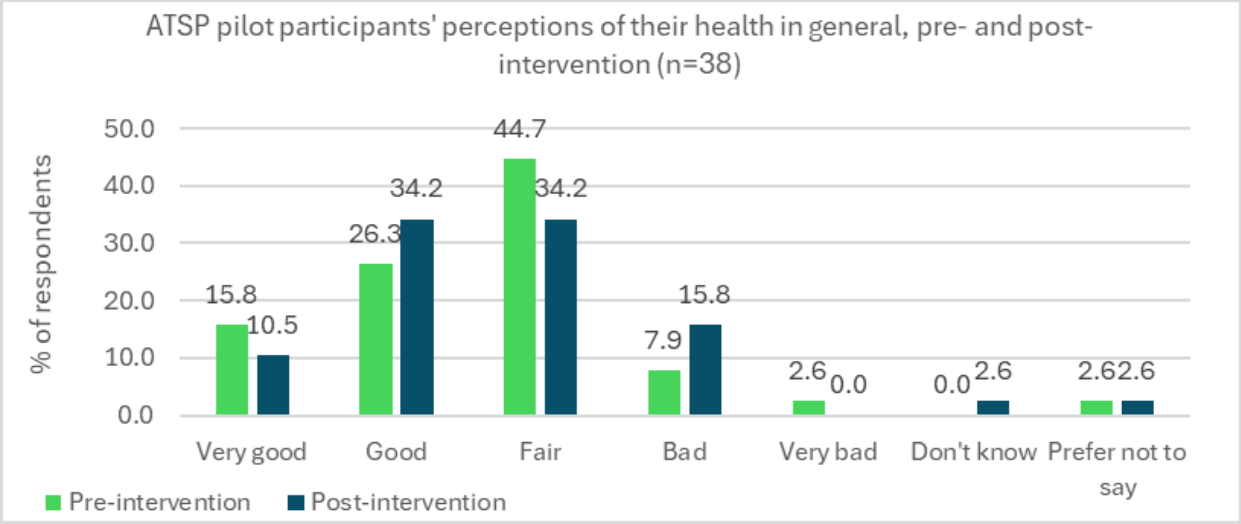


Figure 12, ATSP pilot participants' perceptions of their health in general (pre- and post-intervention survey)

Figure 13 shows no statistically significant difference in the clients' current levels of pain in the post-intervention survey, compared to the pre-intervention survey (Wilcoxon signed-rank test). Just over one third of clients reported not feeling any pain at all in the pre- and post-intervention surveys.

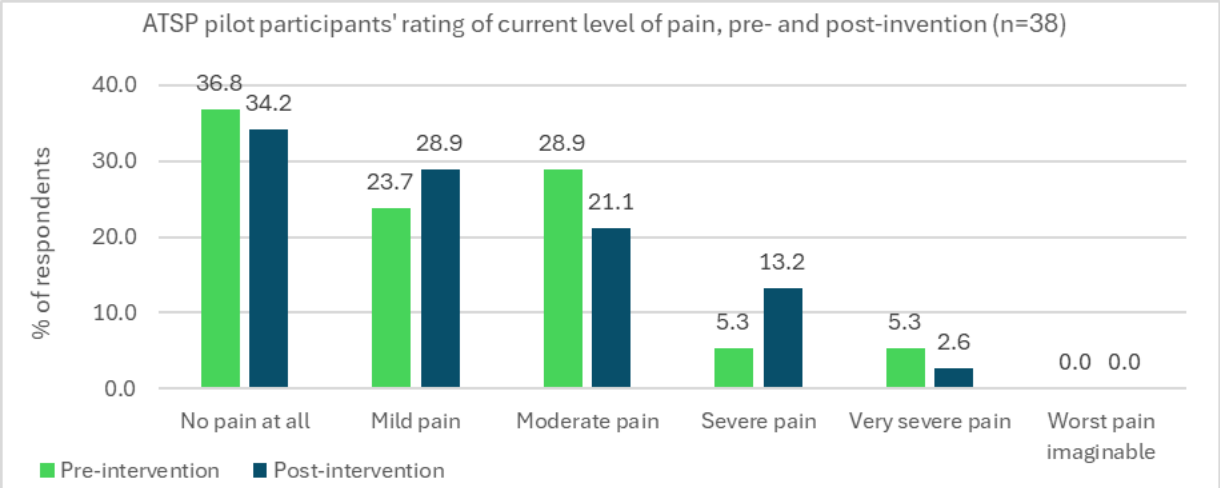


Figure 13, ATSP pilot participants' rating of their current level of pain (pre- and post-intervention survey)

Clients who reported experiencing pain[28] were asked about the cause(s). Table 17 shows an increase in the proportion of clients with 'long-term health condition' as the cause of pain over the intervention period, but a decrease in the proportion of clients with 'physical disability' as the cause of pain. The sample sizes for the causes of pain were too small to conduct meaningful statistical analysis.

[28] The number of clients who reported experiencing pain in the pre-intervention survey was 24, but the number who reported experiencing pain in the post-intervention survey was 25. This is why the *n* differs slightly in different in Table 17.

Table 17, Cause(s) of pain that the ATSP pilot participants are currently experiencing (pre- and post-intervention survey)

	Pre-intervention (n=24)		Post-intervention (n=25)	
Cause of pain*	Frequency	Valid %	Frequency	Valid %
A short-term illness	3	12.5	1	4.0
A recent physical injury	2	8.3	0	0.0
A long-term health condition	14	58.3	19	76.0
Physical disability	6	25.0	2	8.0
Ageing related pain	5	20.8	5	20.0
Occupational related pain	2	8.3	2	8.0
Other	3	12.5	2	8.0

* Participants could select multiple causes of pain

Clients were asked about their current energy levels. Figure 14 shows a decrease in the difficulty clients experienced with their energy levels in the post-intervention survey, compared to the pre-intervention survey, but this difference was not statistically significant (Wilcoxon signed-rank test). Approximately one in five clients reported 'significant' or 'severe' difficulty with their energy levels in the pre- and post-intervention surveys.

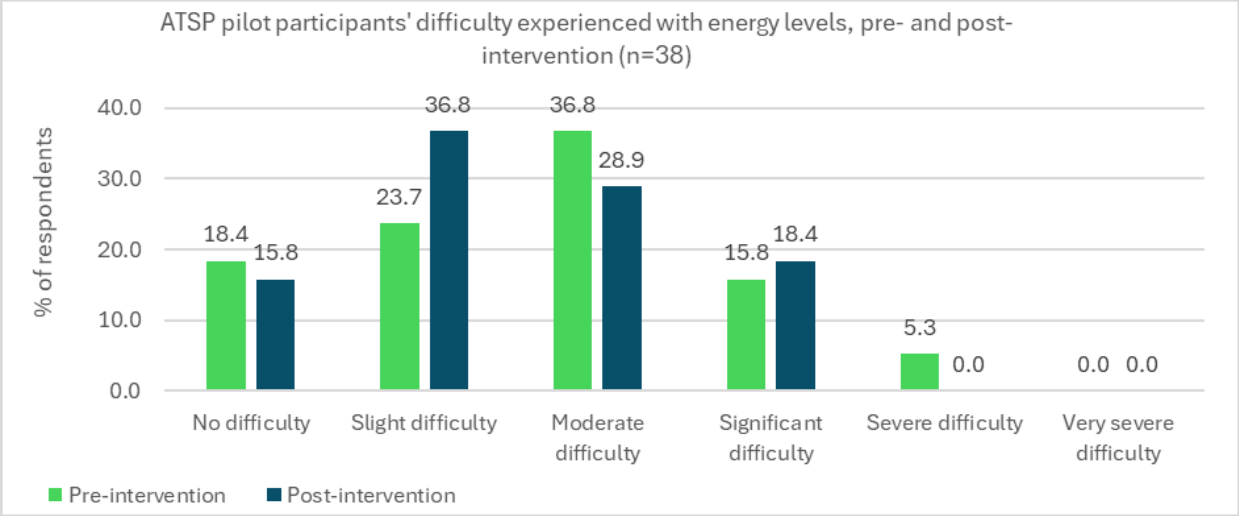


Figure 14, ATSP pilot participants' level of difficulty they experience with their energy levels (pre- and post-intervention survey)

Figure 15 shows clients reported talking to or visiting a GP less frequently in the post-intervention survey, compared to the pre-intervention survey, although the difference is not

statistically significant (Wilcoxon signed-rank test). The proportion who spoke to or visited their GP very frequently (i.e., more than ten times in the past 12 months) decreased from 26.3% to 18.4% over the intervention period.

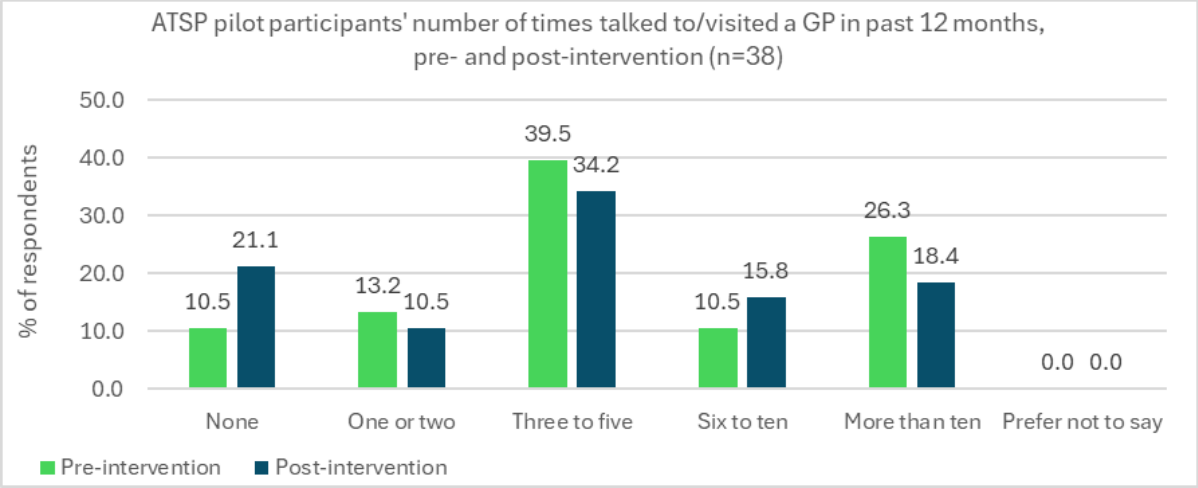


Figure 15, Number of times ATSP pilot participants have talked to or visited their GP/family doctor in the past 12 months about their own health (pre- and post-intervention survey)

Similarly, Figure 16 shows clients reported visiting hospital for their own health less frequently in the post-intervention survey, compared to the pre-intervention survey, although the difference is not statistically significant (Wilcoxon signed-rank test). The proportion who visited hospital very frequently (i.e., six times or more times in the past 12 months) decreased from 10.5% to 2.6% over the intervention period.

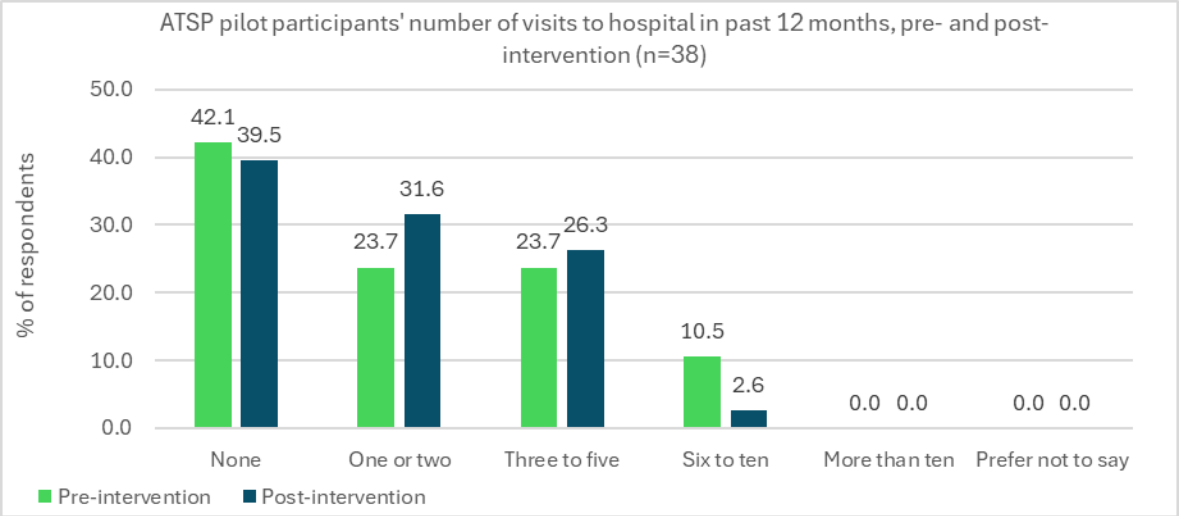


Figure 16, ATSP pilot participants' number of visits to hospital in the past 12 months about their own health (pre- and post-intervention survey)

6.1.5 Wellbeing and mental health

The survey included six metrics which relate to mental health and wellbeing, whereby participants were asked to indicate their current levels of wellbeing or peer support on a scale from 0 – 10. Figure 17 shows the clients reported statistically significantly higher levels of overall life satisfaction in the post-intervention survey, relative to the pre-intervention survey[29]. In addition, clients reported statistically significantly higher levels of feeling that the things they do in life are worthwhile in the post-intervention survey, relative to the pre-intervention survey[30]. There were no statistically significant differences over the intervention period for clients' level of happiness, level of anxiety, peer support for using active modes, or people they can depend on to help them (Paired samples t-tests).

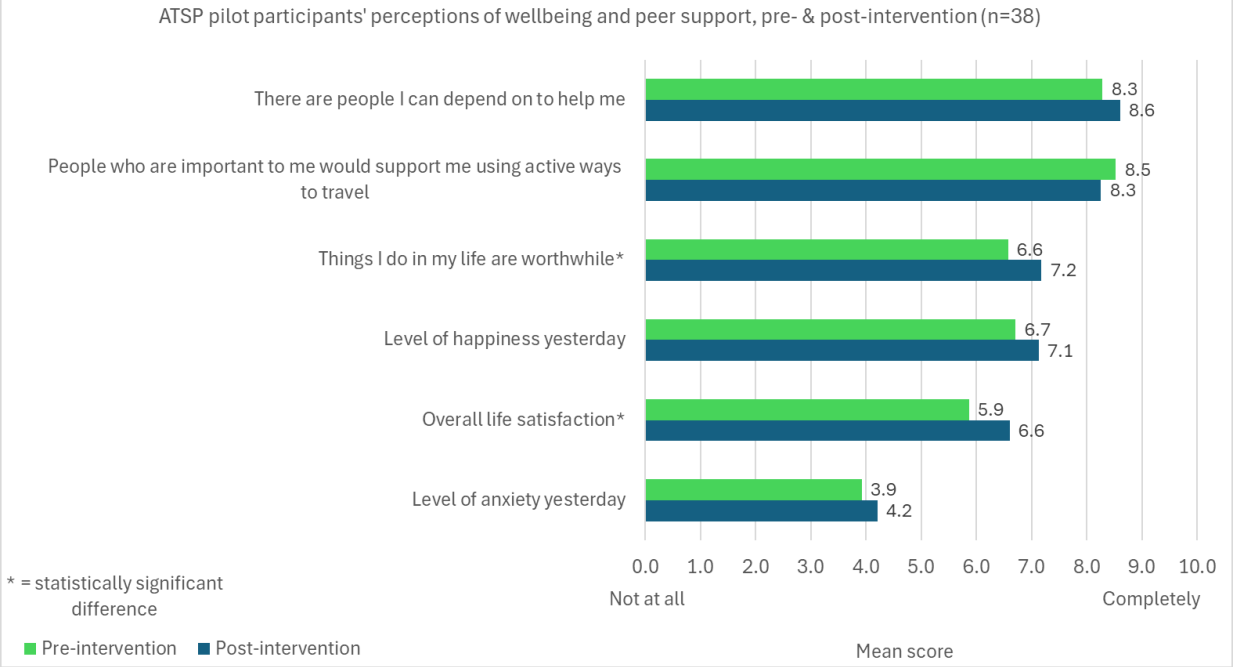


Figure 17, ATSP pilot participants' perceptions of wellbeing and peer support (pre- and post-intervention survey)

[29] A Paired samples t-test revealed higher levels of overall life satisfaction in the post-intervention survey (6.61 ± 2.27), compared to the pre-intervention survey (5.87 ± 2.55), a statistically significant difference of 0.74 (95% CI, 0.09 to 1.38), $t(37) = 2.307$, $p = .027$

[30] A Paired samples t-test revealed higher levels of feeling that the things clients do in life are worthwhile in the post-intervention survey (7.18 ± 2.35), compared to the pre-intervention survey (6.58 ± 2.84), a statistically significant difference of 0.60 (95% CI, 0.02 to 1.19), $t(37) = 2.097$, $p = .043$

6.2 Clients' evaluation of the pilot (post-intervention survey; quantitative and qualitative)

The post-intervention survey (see Appendix 6.8.2 for the survey protocol) included seven quantitative and four qualitative evaluation questions and the findings are presented here.

6.2.1 Clients' feedback on the effectiveness of the pilot

Clients were asked to rate their level of agreement that the support they received from the active travel activity provider(s) helped them to reach their active travel goals. Figure 18 shows most clients 'strongly agree' (55.3%) or 'agree' (23.7%) that activity provider support helped them to reach their goals.

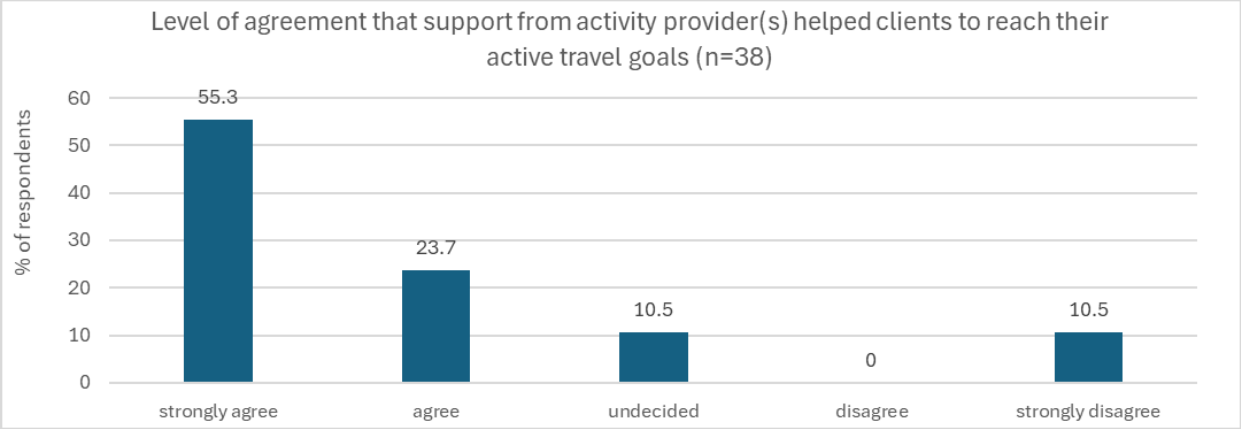


Figure 18, ATSP pilot participants' level of agreement that activity provider support helped them to reach their active travel goals (post-intervention survey)

Clients were then presented with four aspects of activity provider support and asked which they found most helpful for reaching their active travel goals (participants could select multiple aspects). Figure 19 shows 'encouragement' was the most frequently selected (81.6% of clients), followed by 'learning active travel routes' (52.6%).

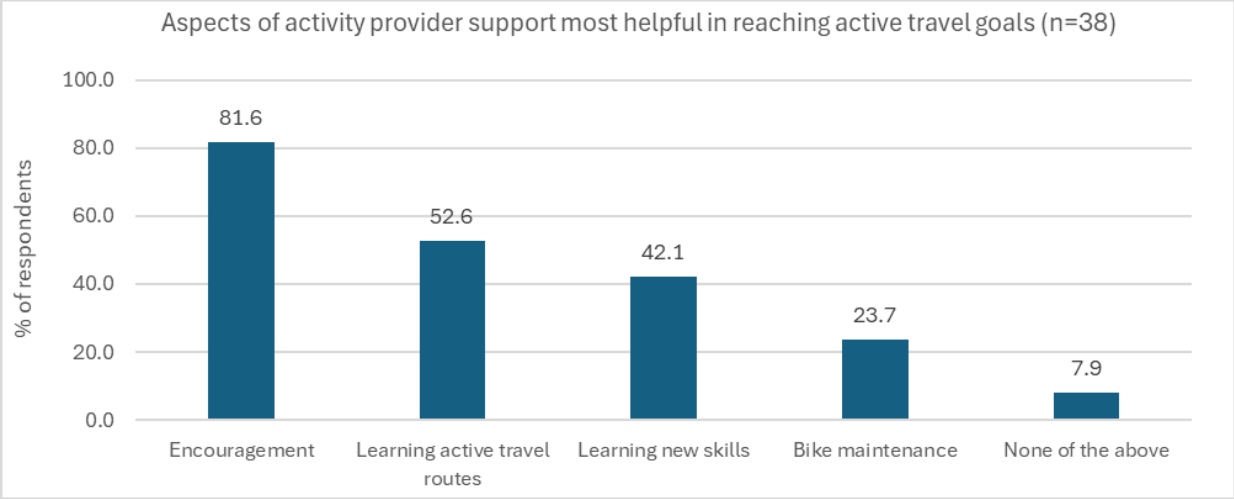


Figure 19, Aspects of activity provider support most helpful for clients to reach their active travel goals (post-intervention survey)

Participants were asked if they could suggest any ways in which the pilot could be improved (Table 18). Overall, clients provided positive feedback about their experience of taking part and the importance of Health Improvement Practitioner one-to-one support. Specific suggestions for improving the pilot include better communication from activity providers and catering for different ability levels.

Table 18, Clients' feedback on the ATSP pilot and the activity providers (post-intervention survey)

Theme	Example quote	Prevalence
Positive feedback on their experience	"Really good, nice, helpful, non-judgmental providers."	17
Feel supported by HIP or active travel provider	"HIP role helpful in providing encouragement to make behavioural and health changes. Think what doing great, definitely encouraged me."	8
Provide more one-to-one support	"Cycling project was good but would have preferred continuous one to one at the project due to mental health issues."	3
Better communication from active travel providers	"Communication to confirm group was on would be helpful."	3
No recommendations for improving the pilot	"No, I can't think of any as I have been so happy with the help I have received."	3

Theme	Example quote	Prevalence
Cater for different ability levels	"The need for different ability groups to be catered for."	2
Increase number of providers or schedule more active travel activities	"Variety of days as I am not always available on Fridays."	2
Negative feedback on their experience	"I felt I didn't get enough feedback / communication when I asked for things, or things were mentioned but not acted on…"	2
Increase bike donation schemes	"Own bike prone to punctures…would consider option at looking at replacing bike through bike donations scheme (via ATSP Provider CLR) to remove current barrier."	1

6.2.2 Active travel journey purposes and behaviour change

Of the 38 participants who completed the post-intervention survey, 31 reported using active travel in the past month. These 31 clients were presented with six typical journeys and asked which of these journeys they had used active travel for (clients could select multiple journey purposes). Figure 20 shows 'leisure or exercise' (87.1% of clients) and 'going to the shops, doctors, library, cinema etc.' (80.6%) were the most common journey purposes.

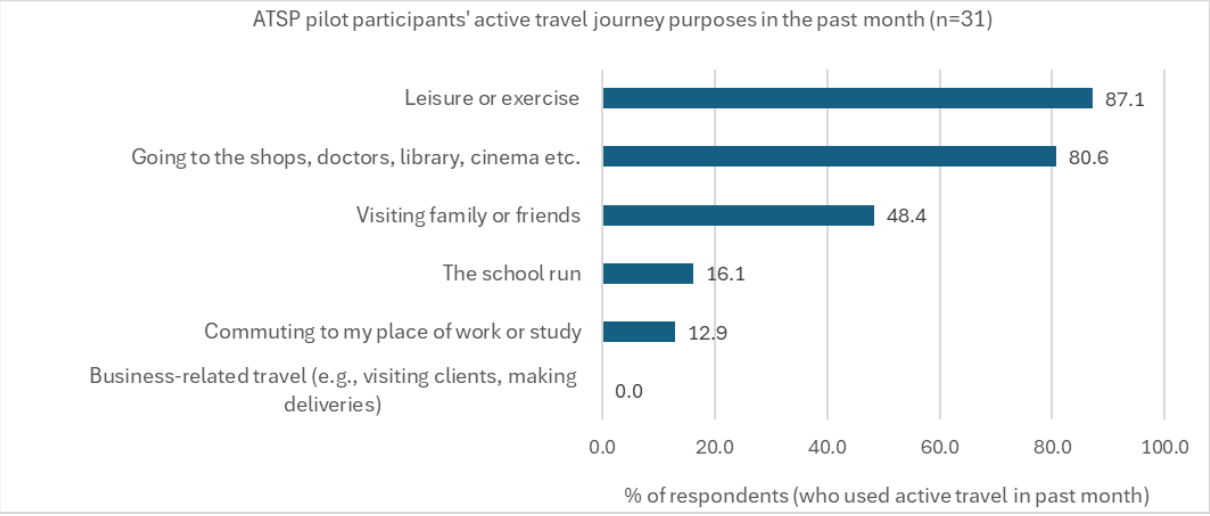


Figure 20, ATSP pilot participants' active travel journey purposes in the past month (post-intervention survey)

Clients who had used active travel in the past month were asked about the extent to which they had noticed a change in their use of active travel for different journey purposes. This question explored whether there was a higher uptake of active travel for a particular type of journey. Figure 20, above, shows most clients use active travel for leisure or exercise and Figure 21, below, shows one in five participants (25.8%) 'significantly increased' their use of active travel for this purpose (i.e., the darkest green bar). The grey bars in Figure 21 indicate where clients have not noticed a change in the use of active travel; for example, one in five clients (19.4%) have not noticed a change in their use of active travel for going to the shops. Although only four clients use active travel for commuting, two of these clients noticed a significant increase in their use of active travel for this purpose.

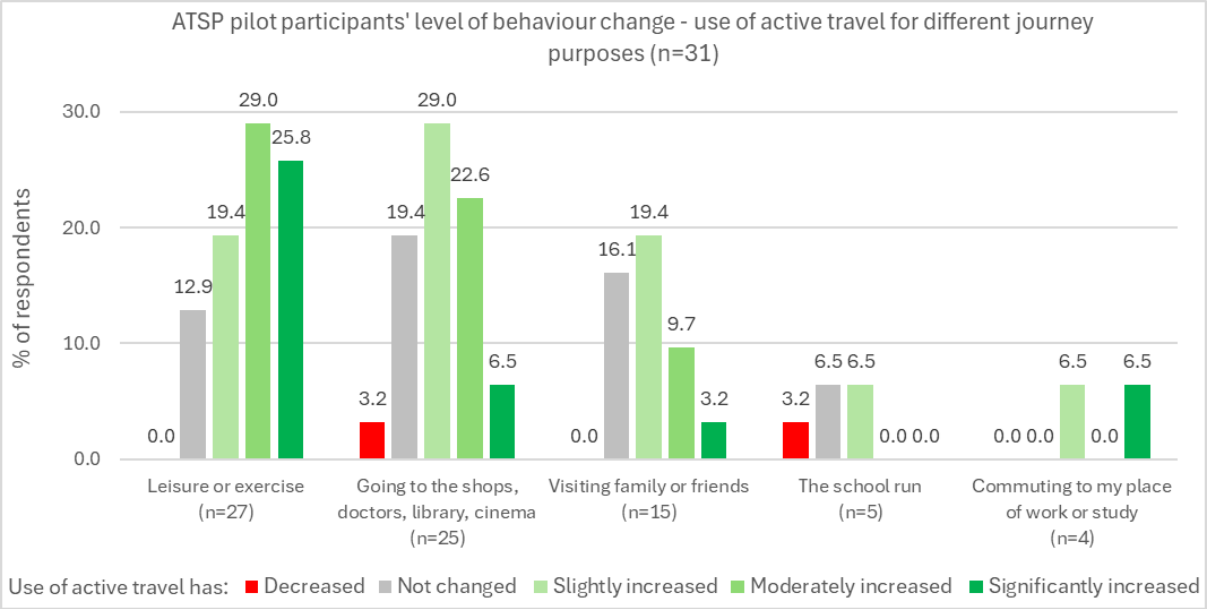


Figure 21, ATSP pilot participants' level of behaviour change in using active travel for different journey purposes (post-intervention survey)

Clients were not specifically asked about combining active travel with other modes of travel, but this emerged as a theme in the qualitative feedback (Table 19).

Table 19, Clients combine active travel with public transport (post-intervention survey)

Theme	Example quote	Prevalence
Access active travel activities using public transport	"Also involved with Southwest coast path Bodmin Connector walk - which uses a bus and walk model to the coast - would not have used buses without this."	6

6.2.3 Perceived benefits of active travel

The evaluation explored clients' views on the benefits of active travel. Clients were presented with five potential benefits and asked whether taking part in the pilot provided any of these benefits (clients could select multiple benefits). Figure 22 shows 'spending more time outside' (86.8%) and 'more opportunities for social interaction' (86.8%) were the most prominent benefits. The pilot also provided some practical benefits, such as accessing local services (50.0%) and saving money (42.1%).

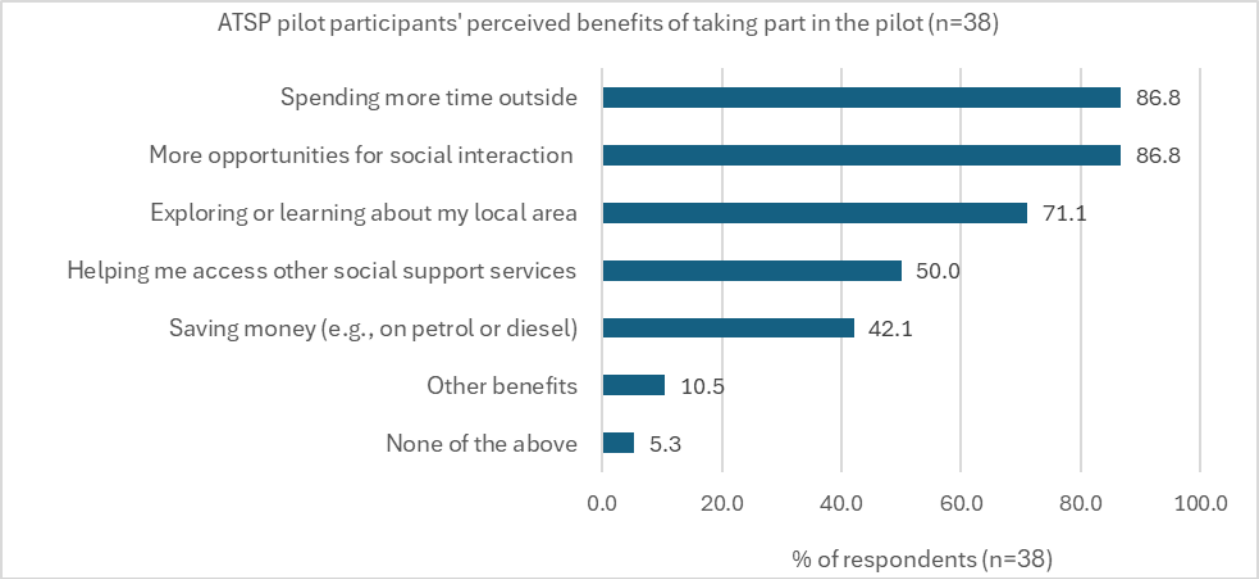


Figure 22, ATSP pilot participants' perceived benefits of taking part in the pilot (post-intervention survey)

Clients were asked two open feedback questions about the pilot, which elicited a number of perceived benefits (Table 20). Several clients described improvements in their physical health, increased opportunity to use active travel, and increased/more regular physical activity.

Table 20, Clients' perceived benefits from taking part in the ATSP pilot (post-intervention survey)

Theme	Example quote	Prevalence
Physical health benefits	"Really helped me back into getting into fitness and other physical activities, increased energy and motivation, more get up and go."	7
Increased opportunity to use active travel	"Engaged him in cycling for first time in his life. Made him go beyond comfort zone and try something new."	7

Theme	Example quote	Prevalence
Increased level of physical activity	"Since borrowing an e-bike from The Cornwall Bicycle Project, my knee injury has healed, and general fitness improved so now I use my own bike to cycle for fitness."	6
Mental health benefits	"So important this pilot continues - due to health and wellbeing benefit - 'Best thing [I've] ever done."	5
Increased capability to use active travel	"I want to thank you for this amazing opportunity, it has been life changing . I love going out on my bike. I still get nervous, but I now go out on my own. That was unheard of before."	4
Increased motivation to use active travel	"Being part of the group has help to encourage me."	4
Increased social interaction	"Socialising with a wider spectrum of people…"	2

6.2.4 Perceived barriers to active travel

The evaluation also explored possible barriers to active travel. Clients were presented with five potential barriers and asked to indicate to what extent taking part in the pilot helped them to overcome these barriers. Figure 23 shows the pilot was most effective in addressing clients' 'low fitness levels' and 'low confidence to use active travel'. Figure 23 also suggests the pilot was less effective at overcoming 'low cycling ability', but this likely reflects the perception among some clients that cycling is not at all feasible for them (Appendix 6.1.2). The qualitative findings indicate that clients who chose to engage in activities to improve their cycling ability found this training very helpful (Appendices 6.2.3 & 6.5.1).

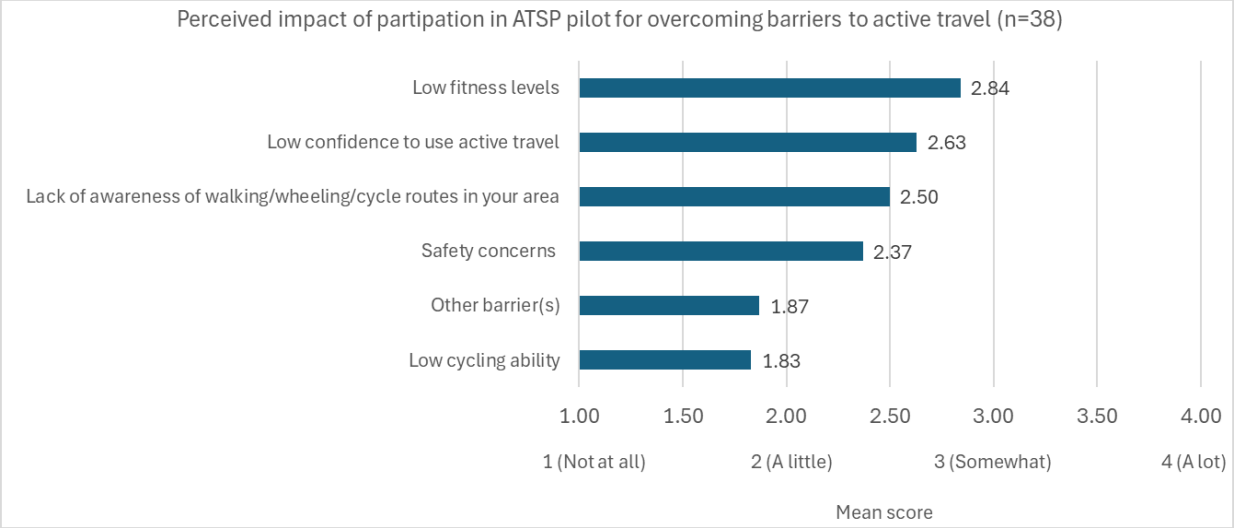


Figure 23, ATSP pilot participants' views on the impact of the pilot in overcoming barriers to active travel (post-intervention survey)

The majority of clients (60.5%) reported that they had experienced other barriers, in addition to the ones presented in Figure 23. Participants were asked to describe these barrier(s) and how it affects them. Table 21 provides a summary of their responses; the most important barriers were physical health conditions, day to day commitments or caring responsibilities, and road safety concerns.

Table 21, Barriers to active travel experienced by clients (post-intervention survey)

Theme	Example quote	Prevalence
Physical health condition or low fitness levels	"…a variety of other physical health conditions which limit mobility."	8
Day to day commitments or caring responsibilities	"Caring responsibility and partner's health due to mobility issues - wheelchair user - restricts time to engage in active travel."	8
Road safety concerns/attitude of other road users	"Would like to see a change in attitude towards cycle by other roads users."	6
Mental health condition	"I have mental health problems as I have a learning disability, but I have plenty of support around me."	5
Lack of confidence or motivation	"Engagement with CLR bike provider disrupted due to a dip in mental health - prior to this point was cycling 2-3 days a week and had ride on e-bike provision. Currently needing to regain confidence via 1:1 support."	5
Lack of/poorly maintained active travel infrastructure	"Roads around where I live - their condition, lack of footpaths, lack of cycle paths…"	4
Lack of/unreliable bus services constraints active travel	"Lack of bus service in local area."	4
Difficulty accessing active travel activities/rurality	"Access to starting point of groups."	3
Steep hills in Cornwall	"Unevenness of terrain, hills…"	2
Inclement weather	"Cold weather impact on son & own health, so default to car during these periods."	2

6.3 Uptake of active travel activities in the three pilot areas (post-intervention survey; quantitative)

This section is a summary of which active travel activities the clients who completed the post-intervention survey took part in (see Appendix 6.8.2 for the survey protocol). Some clients took part in several activities. Of the 38 clients, 52.6 % live in the Bodmin area, 42.1% live in St Austell & the Clays, and 5.3% live in Penzance. Cornwall Life Recycle and British Cycling operate in all three pilot areas and GLL Leisure operate in Bodmin and St Austell. The remaining activity providers operate in only one pilot area.

Table 22, Uptake of Cornwall Life Recycle activities in the three pilot areas

	Frequency	% of clients
CLR Bike confidence/learn to ride	13	34.2
CLR Led ride	12	31.6
CLR Led ride & road safety (Bikeability)	3	7.9
CLR Bike maintenance	8	21.1
CLR Bike check	4	10.5
CLR Bike recycling ownership scheme	0	0.0
CLR Membership of the Cornwall Bicycle Project	5	13.2
None of the above	17	44.7

Table 23, Uptake of British Cycling activities in the three pilot areas

	Frequency	% of clients
BC Breeze	2	5.3
BC Limitless	0	0.0
BC guided rides	3	7.9
BC Sofa to Saddle	0	0.0
BC Confidence (Currently only available in Penzance)	0	0.0
None of the above	34	89.5

Bodmin

Table 24, Uptake of GLL Leisure activities in Bodmin

	Frequency (n=20)	% of Bodmin clients
GLL Wellbeing walks	8	40.0
GLL BEAT programme	0	0.0
None of the above	12	60.0

Table 25, Uptake of other active travel activities in Bodmin

	Frequency (n=20)	% of Bodmin clients
Active Cornwall (Wellbeing Walks)	1	5.0
IntoBodmin	0	0.0
National Trust (Landhydrock)	7	35.0
RideOnEBikes	1	5.0
Bosvena led walks	0	0.0
Curious School of the Wild	0	0.0
Eden	0	0.0
Bus Pass	4	20.0
None of the above	8	40.0

Penzance

Table 26, Uptake of active travel activities in Penzance

	Frequency (n=2)	% of Penzance clients
RideOnEBikes	0	0.0
Sustainable PNZ	0	0.0
Whole Again Communities (WAC)	1	50.0
Parkwood Leisure	0	0.0
Bus Pass	1	50.0
Beryl Bikes	0	0.0
None of the above	1	50.0

St Austell & the Clays

Table 27, Uptake of GLL Leisure activities in St Austell

	Frequency (n=16)	% of St Austell clients
GLL Wellbeing walks	1	6.3
GLL BEAT programme	2	12.5
None of the above	13	81.3

Table 28, Uptake of other active travel activities in St Austell

	Frequency (n=16)	% of St Austell clients
Active Cornwall Wellbeing Walks	3	18.8
Wild Wonder & Wisdom	3	18.8
RideOnEBikes	2	12.5
Mencap	0	0.0
Volunteer Cornwall Beautiful Day Out	0	0.0
Eden	2	12.5
Bus Pass	3	18.8
Beryl Bikes	0	0.0
None of the above	7	43.8

6.4 Clients' experiences and outcomes of the pilot (interviews; qualitative)

This appendix presents findings from the semi-structured interviews with clients. Of the 38 clients who completed the post-intervention survey, seven agreed to take part in an interview about their experience of the pilot. This qualitative data has been summarised in Tables 29 – 33 below, and includes the perceived benefits of active travel, the barriers and enablers, the outcomes of taking part in the pilot, and clients' feedback on the pilot model and delivery. The interview protocol can be found in Appendix 6.8.3.

Summary of interview participants' sociodemographic characteristics

The age range was 48 to 79, with a mean age of 64 years old. Six participants are female, and one is male. In terms of ethnicity, all participants stated they are White British. All have long-term health conditions and four have caring responsibilities. Two are employed, one is unemployed, and three are retired (the employment status was not recorded for one participant). Three participants do voluntary work. Income levels were recorded for three participants and can be described as low income.

Referral routes or initial awareness of the ATSP pilot

The interview participants' referral routes or initial awareness of the pilot varied:

- two participants were referred by their GP
- two became aware of the pilot through attending an ATSP pilot engagement event
- one found out through attending a pre-diabetes course
- one saw an advertisement on Facebook posted by one of the activity providers
- one became aware during a face-to-face conversation with an activity provider

Activities attended during the pilot and clients' uptake of active travel

During the pilot, four interview participants took part in walking/wheeling activities, two took part in cycling activities, and one took part in both walking/wheeling and cycling activities. Most participants (n=6) used active travel for going to the shops or accessing local services such as the doctors or hairdressers. Leisure or exercise was another important reason for using active modes (n=6). Two participants used active travel for meeting friends or family, one for going to the gym, and one for accessing nature. Active travel journey distances ranged from half a mile to seven miles.

6.4.1 Benefits of active travel and taking part in the ATSP pilot

The interviews explored clients' views on the benefits of active travel and their participation in the ATSP pilot. Table 29 shows a wide range of perceived benefits; all interview participants described experiencing physical and mental health benefits, increased levels of physical activity,

more social interaction, and increased capability, opportunity and motivation to use active modes.

Table 29, Clients' perceived benefits of active travel and taking part in the ATSP pilot (client interviews)

Theme	Example quote	Prevalence
Increased level of physical activity	"Obviously I wouldn't walk the distance that we do, when we go on our regular [dog] walks. I do more now, because I realise the benefits of it. So, I do take xxxx on a longer walk now."	7
Physical health benefits or increased fitness levels	"When I started walking, I couldn't walk from xxxx down to the xxxx without puffing. Now I could almost run it and that's the difference…I couldn't get up the hill, but I can now, I'm not puffing."	7
Mental health and wellbeing benefits	"It's not just the [physical] health benefits that you get from the walking, it's the social element and, as a result of that, the mental health element, because I suffer from depression…but I've found my whole life has got a lot better as a result of what I've been doing with the groups."	7
Increased social interaction	"It's a very lonely life when you live alone. Many of us have spoken about that. So to be able to do things like this and build up that social network, in a way that's actually doing you good as well as getting you out of the house, it's fantastic."	7
Increased opportunity to use active travel	"Then I got a call from (cycling provider's first name)….'OK, so would you like to come around to (cycle track)?' And I was like, oh, OK. (They) said, 'look, it's going to be fine, all you do is just…go around the track as many times as you like. Can you actually ride your bike?' I was like, yes, because otherwise if I didn't, they would have taught me how to ride."	7
Increased motivation to use active travel	"My goal initially was to get my blood sugar level down to a suitable [level], and I managed that, I did that. But then when I realised the other benefits that were coming out of it, it made me want to continue. You know, it was	7

Theme	Example quote	Prevalence
	no longer that, now it's 'I want to lose weight'. So going on the walk, it's helping that."	
Increased capability to use active travel	"My goal was to cycle to the shops rather than drive, because it's only round the corner and I'd always get in the car, and also a big thing was to cycle to (local nature reserve) rather than driving. I didn't think in a million years that I would ever, ever get the confidence to do that, especially on my own."	6
Increased access to nature	"…joining this group, has just opened so many doors in regard to getting out into nature….I feel like I'm achieving something at the end of the week now because I'm getting out there and I am being active."	3
Individual financial benefits	"It doesn't cost anything to walk. It's the one thing you can do that doesn't cost money."	2
Reduced demand on the health system	"If people are more active, then potentially they're not going to have as many long-term [health] conditions…but long term, I think it would benefit the national health [system] and the environment."	2
Environmental benefits	"When I joined it, I didn't think about transport and reducing my…the fumes, the miles in the car….it's going to have a massive impact on everything, you know, on the environment because you're not using…the emissions."	1

6.4.2 Barriers to active travel experienced by clients

Clients were asked about the barriers they face in using active travel in Cornwall (Table 30). The most prominent barriers were road safety concerns and requiring a car to access active travel infrastructure, day to day responsibilities and a lack of time, the steep hills in Cornwall, and their health condition or low fitness levels.

Table 30, Barriers to using active travel experienced by clients (client interviews)

Theme	Example quote	Prevalence
Car is required to access active travel routes/paths	"That is one reason why I use the car, is to go somewhere to walk."	7

Theme	Example quote	Prevalence
Road safety concerns/attitude of other road users	“If it was (local town), I would have to drive because it's too far and again the roads are too dangerous to get on the bike.”	5
Caring or life responsibilities	“(Walking provider’s first name) has done quite a few around here, but unfortunately I haven't been able to go to all of them because of work commitments.”	5
Steep hills in Cornwall	“Oh gosh, I wouldn't do it here because of the hills.”	4
Physical health condition or low fitness levels	“I felt terrible because they (previous cycle group) were so fit, and they'd get right to the top of hill. But by the time I got there, they were like ‘right, and we go off.’ They never let me get my breath, so it put me off.”	3
Lack of confidence or motivation	“I thought I'd lost all confidence in everything. Not just maybe cycling, but everything.”	3
Car dependency or motor-normativity	“I would love to see less cars on the roads, but the reality is that people find it more convenient. You know, if you've only got two buses an hour, it's easy to get into a car and go somewhere.”	3
Lack of active travel infrastructure	“In terms of getting to places where you can just go for a walk, I find that difficult because of the lack of footpaths on a lot of the roads. If there could be footpaths or, like, the old routes across fields.”	2
Narrow pavements	“I mean the pavements here in xxxx are very narrow…some pavements…are wider than others…it is dangerous, you know, for crowds of people.”	2
Inclement weather	“At this moment because it's too wet and too cold….really cold weather really effects my xxxx. “	2
Lack of active travel equipment	“I can't quite afford one yet, but eventually I can see an electric bike being a good thing to have.”	2
Lack of shower facilities at work	“There’s no shower there, so I would be really, really hot and sweaty by the time I got there.”	1
Stigma of cycling	“There's a lot of stigma with cyclists. Yeah, I mean, you know…you're in lycra.”	1

Theme	Example quote	Prevalence
Personal safety concerns	"I wouldn't be happy to walk on a night on my own. Even teatime when it's dark, but I think that's just because coming from a very busy city that the crime, you know, is very high."	1
Cycle paths are not separated from walking paths	"It's hard to find somewhere these days to go walking, so I have to take him [dog] where I can go to walk and not have to worry, I've got to keep looking behind and I've got to be very vigilant that there's no bikes around."	1
Traffic rules do not reflect Cornish context	"They now want push bikes to ride two or three abreast and we're in Cornwall. Yeah, you can do that in London where the traffic's only doing 12 mile an hour. But in Cornwall it's, you know, 40-50 mile an hour."	1

6.4.3 Practical enablers of active travel

Support and encouragement from the activity providers and the Health Improvement Practitioners, as well as social interaction as a key motivator, emerged as important enablers of active travel during the pilot (Tables 29 & 33). However, clients also described some practical enablers such as help fixing their bicycle, information provision about local routes, and appropriate footwear to engage in active travel (Table 31).

Table 31, Practical enablers of active travel (client interviews)

Theme	Example quote	Prevalence
Support fixing their bike	"I've got an old mountain bike that I acquired for free, but the crank, I couldn't get it sorted. (Provider's first name) had it sorted for me."	1
Information about active travel routes	"She gives us the information [so] that we know what type of walk it is. And you know, if we are meeting up...somewhere I haven't been, she'll supply a map."	1
Appropriate active travel footwear	"There's a possibility that you can get some help towards walking boots...so that would be a great help because it's one of those things, especially with my foot problem."	1

Theme	Example quote	Prevalence
Availability of active travel infrastructure	"They've actually built cycle paths. So, I'm just hoping that the cycle paths go straight to (town name) so that in the future I can actually bike to the gym. Or bike to meet the walking group instead of having to get in the car."	1
E-bike assisted power for steep hills or speed	"I had an electric bike, I was like, 'oh well, if a car was behind me, I think it doesn't matter, I've got enough room for me. I've got enough power to keep going.'"	1
Support to access active travel routes	"I mean the ideal answer with things like that would be a sort of minibus to pick people up and then took them somewhere where they could walk, you know."	1
Digital communication facilitates engagement in active travel	"A few occasions she can't because she's been away for…family commitments. But you know, because she set up this WhatsApp group and she encourages us to, you know, meet up if we can."	1

6.4.4 Outcomes of the pilot for clients

The interviews explored clients' views on the outcomes of the pilot in terms of their uptake of active travel, their perceptions of using active modes, and whether active travel supported them to access to opportunities in their local communities (Table 32).

Table 32, Perceived outcomes of the pilot on clients' travel behaviours, perceptions of active travel, and accessing local opportunities (client interviews)

Theme	Example quote	Prevalence
Mode shift from car to active travel	"After this call I'm walking down the high street, which is a fair walk. I would normally get in the car. It's like you change, don't you? 'Well, could we drive? Can we walk? Let's walk and then we can do that in that area.'"	6
Increased awareness of active travel infrastructure	"There's been some, like, literally on my doorstep and I thought I would never have gone, like (nature reserve) when we went on our bike ride."	6
More positive perception of active travel	"It has [changed how I view active travel], yeah, 'Why would I, I've got a perfectly good car out there, [why]…cycle to the shop? I can just get in that and then	5

Theme	Example quote	Prevalence
	go to the gym and do a spin class.' But that's ridiculous…you could do it in the fresh air."	
Taking part in the pilot has connected client to other community activities	"…some of the people involved in the [walking] group…they go to the (long-term health condition) meetings….I started to go to those and of course I've picked up information regarding (long-term health condition) and how to try and control it."	3
Has followed (or is considering) a progression pathway	"I went and met this new group on their cycle [activity]…(walking provider's first name) was there and it was like a taster of cycling, so I joined that [walking] group that day."	3
Have recommended the pilot to others	"The road I live in, I'm probably the oldest person here, and you know they're all younger families, but I make sure I tell people [about the pilot]. Especially because I know it goes under this particular one under the St Austell Health care."	3
Active travel interacting with public transport	"…with the coastal walks, we do tend to catch a bus and that's fine."	2
Responsibilities encourage physical activity	"Except to go walking, more than anything, is to go to areas where I can walk and take my dog."	2
Increased access to employment opportunities	"I don't work, but funnily enough through walking, I'm now going to look for a part time job…So that's given me the confidence to [look for work]… and also that's a structure that I find very useful for when I'm wanting to go back to work, because you have to structure your life more."	1
Increased access to volunteering opportunities	"I have been asked for xxxx walks. The only reason I haven't, well one was a confidence thing. Now I think I've nailed it, I could easily do it…if I have availability on those walks, I will 100% volunteer."	1

Theme	Example quote	Prevalence
Have received support from their family to use active travel	"I wish I had a bike and my (family) surprised me on Christmas Day with a bike and all this stuff, helmet and everything."	1

6.4.5 Feedback on the pilot model or delivery

Finally, clients were asked for their feedback on the activities and the support they received (Table 33). Overall, clients were very positive about their experiences, describing how this support helped them to reach their active travel goals and how the activities were tailored to meet their individual needs.

Table 33, Clients' feedback on the ATSP pilot model and delivery (client interviews)

Theme	Example quote	Prevalence
Positive feedback on their experience of the pilot	"Well, it's been amazing for me. It's been really helpful. It's great to know things like that are out there as well. And so yeah, I can't fault it at all. And yeah, really, really, really helpful. Physically, mentally, socially, everything."	7
Clients feel supported by their activity provider(s)	"Absolutely brilliant, you know 100%. She is such a personable person. She's full of energy, and so she's very helpful and inclusive. And, you know, she asks you 'have you got any walks yourself that you would like to do?'"	7
Clients feel supported by their Health Improvement Practitioner	"She rings every month or so, every four to six weeks. She rings and sometimes we see her on our (provider walk)… that shows a relationship she has with people. She has a way of bringing out what they don't even know they need, and that's a gift."	5
Hopes active travel provision will continue after the pilot ends	"If the powers that be run more of these sort of things then it's always there, not only for myself but for other people…and in more areas as well. But obviously [in] my area."	5
Provision was adapted based on clients' individual needs	"There's different levels of ability and health, you know. They can say 'who would like to do, you know, maybe we've got a short walk, maybe a medium walk or maybe a long walk?' And then, you know, we can sort of be all	4

Theme	Example quote	Prevalence
	together in those groups and then gradually break away."	
More comms needed about activity providers	"If they're not on Facebook or they don't have a phone, how will they find out about these groups, you know, unless they visit the GP practice then maybe they can signpost them or if there was a leaflet drop for some of the rural villages, you know, for people to just get leaflets through the door about the active travel."	3
Outside activities support those with social anxiety	"They're not walking into a room with a load of people they don't know, because you're in an outside space, it doesn't look like a lot of people."	1

6.5 ATSP pilot delivery team and activity providers' evaluation (qualitative survey)

This appendix is a summary of the qualitative feedback provided by those involved in the delivery of the ATSP pilot. There were three groups:

1. community-based active travel providers who offered a range of one-to-one or group activities with clients (see Appendix 6.7.1 for an overview of the providers and their activities, or the ATSP pilot delivery report for in-depth case studies of their work with clients)
2. Social Prescribers and Health Improvement Practitioners who provided one-to-one support to clients during the pilot
3. members of Council Council's Wellbeing and Public Health team who were responsible for designing and delivering the pilot

These pilot delivery partners were asked to complete a short qualitative survey (see Appendices 6.8.4 to 6.8.6 for the survey protocols).

Description of the respondent sample (n=14)

The respondents included seven active travel providers, two Social Prescribers, two Health Improvement Practitioners, one Diabetes Care Co-ordinator, the ATSP pilot Project Manager and one member of the ATSP pilot steering group.

6.5.1 Outcomes of the pilot for clients

The activity providers and the ATSP delivery team were asked to reflect on the activities and community support they provided, and consider which client outcomes present in Table 34 had been successfully achieved and which have been less successful (Table 35).

Table 34, Pilot target groups and intended outcomes

The target groups of the ATSP pilot:	Intended outcomes:
– Adults seeking to improve their mental health and wellbeing – Adults with poor physical health (including long-term health conditions) – Disabled people (adults) – Unemployed adults – Adults aged 50+	– Increased physical activity – Improved physical health – Improved wellbeing/mental health – Reduced psychological barriers to using active travel – Reduced inequalities in access and mobility – Fewer motorised vehicles and trips

Table 35, Outcomes of the ATSP pilot for the clients (delivery team/service provider surveys)

Theme	Example quote	Prevalence
Provision can be tailored to clients' individual needs	"The clients get more specific interventions to their needs. We had a lot of vulnerable clients who [are] 'hard to reach' and therefore, we could tailor the support they received to what they really needed."	6
Improved physical health	"Feedback from participants has been increased mobility and strength…"	5
Reduced inequalities in access and mobility	"…reduced inequalities by removing cost to access the activities - access to bike donation scheme and free bike MOT, for example."	5
Mode shift/ increased active travel	"Secondary outcome of improved health has been an increase in participants taking short active travel journeys mainly walking within their local area. One lady stated she 'now thinks twice before using the car'."	4
Increased confidence to use active travel	"…for others it has meant they have been able to access more activities as they have built up a confidence to walk to various locations in Bodmin."	4
Improved wellbeing and mental health	"We wanted to encourage physical activity to help manage our patients' diabetes, which will improve their overall physical health and have found that this has also improved their mental and emotional wellbeing."	4
Increased physical activity	"Adults with poor physical health increased physical activity which has improved physical health and reduced psychological barriers."	4
Increased social interaction	"…the peer group have become friends, support each other and encourage further activities outside of this organised group."	3
Client outcomes were achieved (non-specific)	"It was highly beneficial for at least 2 of my clients, to the point of radically improving their life."	3
Reduced psychological barriers	"We have worked towards reducing psychological barriers to using active travel by increasing individuals' confidence using regular commuter routes, e.g. Penzance	3

Theme	Example quote	Prevalence
	station, Bissoe/Truro park and ride, Goss Moor/Indian Queens."	
Clients feel supported	"The benefits to the clients are that they probably wouldn't have started it without Social Prescribing Link Worker encouragement."	3
Range of providers enabled a progression pathway	"Having 17 providers through the fund also meant that there was adequate appropriate support available, we could really get the right intervention or multiple interventions for the clients."	2
Established new active travel habits	"Hopefully by engaging in some of the provision new habits and routine have been established which will carry on past the duration of the pilot."	2
Active travel map is a publicly available resource	"The map…is designed to be an aid to social prescribers in this area, but also to anyone else working or living in the area."	1
Individual financial savings	"Feedback from participants…cost saving such as car fuel savings etc. has also been mentioned."	1
Financial savings for the health and care system	"Due to an ageing population, it's great that the Council are investing in the communities and trying to offer the people a way of helping themselves [to] stay healthy and ultimately stay out of hospital and be self-reliant."	1

Table 36, Outcomes of the ATSP pilot for increasing Capability, Opportunity and Motivation to use active travel[31] (delivery team/service provider surveys)

Theme	Example quote	Prevalence
Increased capability to use active travel	"Having one-to-one sessions and sofa to saddle bike sessions really helped these clients as they could build up confidence and ability to then progress to an e-bike loan."	6

[31] Table 36 does not show responses to a specific survey question. It is interpretation of the delivery team/service provider survey responses using the COM-B theoretical model.

Theme	Example quote	Prevalence
Increased opportunity to use active travel	"They have given people a positive experience of walking a path, they know new routes and have enabled people to understand that walking is possible, reducing some of the barriers to using active travel."	6
Increased motivation to use active travel	"Some participant[s] seem to be self-motivated due to the benefits they have personal[ly] experienced (improved health, increased stamina, improved social network etc..)"	5

6.5.2 Barriers to uptake of active travel

The activity providers and ATSP delivery team were asked to identify clients' main constraints to using active travel and to make suggestions for how to overcome these barriers (Table 37).

Table 37, Barriers to active travel experienced by ATSP pilot clients (delivery team/service provider surveys)

Theme	Example quote	Prevalence
Psychological barriers	"For some older clients it was psychological barriers, some hadn't ever ridden a bike before and didn't have the confidence."	5
Cost of travel or clients' low income	"For a lot of my clients it's cost. The ones that have found the e-bike loans really helpful, but aren't fit enough to ride a manual bike, would really benefit from the e-bike loan scheme…"	4
Lack of access to public transport or own vehicle	"Connecting our activities to public transport and finding off-road walks was difficult."	4
Physical (in)ability or old age	"People with long-term health conditions were more difficult to engage with as they described limitations to their physicality and energy levels."	3
Steep hills or long distances	"West Penwith is a rural area, [the] main town of Penzance is quite steep in places."	3
Day to day commitments or responsibilities	"Caring responsibility/lack of bike storage within accommodation were a barrier."	2

Theme	Example quote	Prevalence
Inclement weather	"…when it rained or was cold and damp, numbers would dwindle."	2
Road safety concerns	"…safety concerns which was frequently cited - road traffic and lack of designated cycling/walking route."	2
E-bikes help overcome physical health barriers	"Not having an electric bike can be a huge barrier to continuing any learning taught for many people."	2

6.5.3 Challenges in delivering the pilot

The activity providers and ATSP delivery team were asked to identify the main challenges they experienced in the delivery of the pilot (Table 38).

Table 38, Challenges experienced in the delivery of the pilot (delivery team/service provider surveys)

Theme	Example quote	Prevalence
Clients with complex needs require more time and support	"Time - some individuals across these demographics require 1-2-1 support and more time to support them, build confidence and social connections."	6
Lack of understanding among some referral partners of active travel, modal shift, & the associated benefits	"Lack of understanding of modal shift. Default was to consider being physically active (mainly for leisure) rather than the consideration of access to employment, key services and benefits of inter-modal transport from a social and activity perspective."	2
Engagement with Active Travel England	"…delay in the confirmation of the evaluation framework. Quarterly reporting was often clunky and non-standard..."	1
Negative feedback on pilot aims and	The main point I would say is that the project aims and target participants don't make any sense to me. Those worse off tend to walk or cycle more anyway…Those with long-term chronic conditions, particularly COPD, frailty	1

Theme	Example quote	Prevalence
selection of target groups	etc. don't tend to go out too much anyway. Suggestions they start walking or cycling is not person centred or really understand the barriers they face."	
Challenge in designing user-friendly active travel maps	"We had a total of three consultation sessions in the area covered by the map and found that after each one there were more questions than answers! The challenge has been to define an area (as people wanted to stretch it to cover larger areas) and limit content to keep the design simple."	1
Too many activity providers for a limited number of clients	"The main challenges we found were the crossover of demographic areas with other providers. We feel it would be best if providers were allocated a geographical area which they could focus upon and achieve larger and more regular user groups."	1

The activity providers were asked if they had to adapt their delivery to meet the needs of clients, and how easy or otherwise they found this process (Table 39).

Table 39, Examples of activity providers' adapting their delivery during the pilot (delivery team/service provider surveys)

Theme	Example quote	Prevalence
Adapting their delivery was straight-forward and beneficial	"We felt like the acceptance of feedback and the ability to change our project following participant feedback was incredible. Both, the members of the group and us as provider felt very heard and listened to."	6
Adapting their delivery to meet the needs of specific clients	"We have a mixture of abilities attending our walks, sometimes we have included another instructor to aid in different routes for other participants or have included short cuts for certain people."	5
Adapting their delivery due to clients' difficulty accessing the activity	"We initially had to collect people in our van to help them access the cycling sessions, as they didn't have a car and weren't yet confident enough to cycle to the venue on their own."	2

6.5.4 Improving the referral process and the pilot design

The activity providers and ATSP delivery team were asked to provide feedback on the referral process and suggest ways for how it could be improved to identify and reach more people in the target groups, in particular those who are currently less engaged in active travel (Table 40).

Table 40, Delivery partners' feedback on the referral process (delivery team/service provider surveys)

Theme	Example quote	Prevalence
Expanding the referral routes reached more clients, including those less likely to engage	"At first, we were only taking referrals from social providers which proved to not be working. We weren't getting many and a lot of the initial referrals we received were not suitable…we changed the referral process so that we could receive a much larger number of referrals from suitable routes."	8
Better initial engagement with Social Prescribers and GP surgeries would have improved referral process	"More information sent to Social Prescribing Link Workers and explain more about the process. The information I received as a Social Prescribing Link Worker in the first instance didn't really make it clear at first."	6
More comms would increase participation	"More advertising through engagement events – i.e., summer festivals and social media…"	2
Postcode criteria hindered referrals	"The postcode criteria prevented us from working with some participants."	2
Referral in Cornwall is challenging	"I think the referral process was the best it could be for the area."	1
Referral process worked well	"The referral process worked really well through the Health Improvement Practitioners and Social Prescribers. Through the ATSP project we have connected with further organisations that refer into us."	1

The activity providers and ATSP delivery team were asked to if had any feedback on the design and delivery of the pilot, or the intervention model which combines one-to-one Health Improvement Practitioner support with community-based active travel service provision (Table 41).

Table 41, Key learnings and suggestions for improving the pilot design (delivery team/service provider surveys)

Theme	Example quote	Prevalence
Some clients require one-to-one support to reach their active travel goals	"The one-to-one approach is highly successful. I felt it had a greater chance of success with my particular clients than a group approach."	6
Pilot was too short to influence communities of practice among social prescribers	"Over time, as they have seen our work and how its benefited people, other social prescribers have become engaged. But with it being only a 2-year pilot, it wasn't long enough to get that critical mass among the network."	2
Cornwall ATSP Fund was effective in enabling a wide range of activity provision	"The community chest or grant allowed grass root providers to have a simple bidding process, to gain funding to mobilise quickly and expand existing provision which was a benefit to supporting and reaching our cohorts."	2
Building on existing delivery capacity reaches more clients	"Some of our providers reached more than others and that is because some providers were more 'embedded' in the local communities than others."	2
Health Improvement Practitioner role ensured providers were supported and also accountable	"By having the Health Improvement Practitioner role help to ensure some accountability back from the providers. The role of the Health Improvement Practitioner I believe in the early stage help[ed] to make ATSP providers [feel] supported."	2
Better integration of active travel with public transport is needed	"I would like to see other parts of the transport system considering active travel and the inter-modal opportunities aligning, e.g. bikes / trains / buses and making it easier for mobility aides, prams / bikes to be compatible with modes of public transport."	2

Theme	Example quote	Prevalence
Pilot design enabled alignment of clients' needs and providers' activities	"We have been able to develop the 'demand side' as well as the 'supply side' (by which I mean, we have supported clients to become ready to engage in activities, as well as develop activities that they want to engage with)."	2
Plan active travel routes to access local community services	"It's really helped us to know the walk infrastructure better and connected us with village halls and other community centres as public facilities are not readily available along the routes and this can also be a barrier."	2
Not all clients want Health Improvement Practitioner support	"Not all participants want/need the support of the Health Improvement Practitioner - some just need signposting opportunities and the provision available."	1
Health Improvement Practitioner role ensured robust data collection	"Health Improvement Practitioner role undertook all monitoring and survey data collection which made it feel contained and robust."	1
Stronger theoretical foundation may have targeted interventions or activities towards intended pilot outcomes	"A lot of focus was on…physical activity for leisure. We could have maximised the COM-B model and considered intervention type, general focus tended to be on awareness and education. On reflection I think the programme could have been front loaded with more behavioural insight."	1
Greater emphasis on the co-benefits of active travel is required	"There was little connection with co-benefits around air quality, congestion, perceptions of safety that exist around modal shift. Motor-normativity across society places the car / motorised transport at the heart of everything and this project could not address all of those cultural issues."	1
Caution against over-reliance on digital engagement with clients	"Increasingly, social prescribers do not seem to offer personalised support or individual guidance but navigate to apps and online courses, and there's very little personal referral. It can take time for people to	1

Theme	Example quote	Prevalence
	find an opportunity and trust a service, so they are looking for a longer term and consistent offer."	

6.5.5 Suggestions for ensuring the legacy of the pilot

The activity providers and ATSP delivery team were asked to make suggestions for maximising the legacy of the pilot or for supporting clients to continue using active travel after the activity or support finishes (Table 42).

Table 42, Suggestions for ensuring the legacy of the pilot (delivery team/service provider surveys)

Theme	Example quote	Prevalence
Positive feedback (non-specific)	"Probably one of the best projects our organisation has been lucky to be part of."	9
Continue to provide funding for activity providers	"Continuation of limited funding in order for regular groups to continue, this would allow the clients to feel confident and supported."	8
Continue to support coordination and knowledge sharing between activity providers	"The whole programme has been an excellent example of bringing different providers together. I have a far better idea of which groups are able to provide what support in the Clays area specifically and across Cornwall more generally, and have been able to use this information to arrange (for example) bike maintenance sessions at GP surgeries."	6
Continue to provide bikes and equipment to clients	"Continue to offer access to bikes and gear for those unable to afford their own - either through donation, loan schemes, or repair support."	6
Identify 'harder to reach' groups and adapt delivery to their needs	"Embed provision within underserved communities: Work closely with groups like refugees, people with disabilities, and those in rural areas — bringing services to them via mobile workshops or local hubs."	5
Improve active travel infrastructure	"Walk[ing] infrastructure including path surfaces and roads with no pavement."	5

Theme	Example quote	Prevalence
Ensure long-term referral partnerships	"Establish long-term referral partnerships: with social prescribers, housing teams, youth services, and community workers - to ensure the most in-need people continue to benefit."	3
Ensure better coordination across Council departments	"Cornwall Council - infrastructure to support active travel within planning and transport."	2
Support clients to stay connected after pilot ends	"We encouraged all participants to join our community groups on Spond and WhatsApp, creating a supportive network that helps people stay connected after the initial activity ends."	2
Connect/ integrate the active travel maps for different areas	"It would be helpful to more formally connect this map up with a number of maps covering neighbouring areas. We have made contact with organisations such as Eden Project and Natural England, who have similar maps covering areas nearby, and there are also maps of the Clay Trails, and linking these maps would be helpful for residents."	2

6.6 Differences between clients and the control group in their travel attitudes, behaviours and health (pre-intervention survey; quantitative)

This appendix presents the findings of the pre-intervention survey that was conducted with ATSP pilot clients (n=67) and a control group (n=300) (see Appendix 6.8.1 for the survey protocol). Descriptive statistics of the two groups are presented. Between-group analysis was used to explore differences in the two groups' travel behaviours, their attitudes towards active travel, their health and wellbeing, and their sociodemographic characteristics. The statistical tests used were Independent-samples t-test, Welch t-test, Mann-Whitney U test, and Fisher's exact test.

6.6.1 Sociodemographic characteristics

This section presents the sociodemographic characteristics of the clients and the control group. Table 43 shows the postcode area where the clients live. Participation in the evaluation study was higher in Bodmin (40.3%) and St Austell (40.3%) than in Penzance (19.4%), reflecting the higher number of referrals in those areas. Only 40 of the control group participants live in Bodmin, St Austell or Penzance[32]. Previous research has shown that people across Cornwall experience similar challenges in using active modes, such as a lack of active travel infrastructure, road safety concerns, steep hills and long distances[33]. The control group participants who live in the three case areas are therefore considered likely to have broadly similar travel behaviours and experiences of active travel to those who live in other locations in Cornwall.

Table 43, Postcode area (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Postcode area	Frequency	Valid %	Frequency	Valid %
Bodmin (PL30, PL31)	27	40.3	15	5.0
Penzance (TR18)	13	19.4	3	1.0
St Austell & the China Clays Area (PL25, PL26)	27	40.3	22	7.3

[32] Ideally, the control group would be matched with the clients on postcodes areas for direct comparability. However, only two market research companies were able to provide a Cornwall sample matched to these specific postcode areas. These companies are significantly more expensive and beyond the budget of this evaluation study.

[33] See previous CAST reports on engaging Cornwall residents in low-carbon behaviours, including active travel: Wilson, M., and Whitmarsh, L. (2023). Cornwall Council behaviour change and engagement programme – survey of residents.

Wilson, M., and Whitmarsh, L. (2024). CAST-the-centre-for-climate-change-and-social-transformations-Cornwall-Council-report-Behaviour-change-interventions-to-encourage-uptake-of-e-bike-shared-mobility-in-Cornwall.pdf

Other area in Cornwall	N/A	N/A	260	86.7

Table 44 shows most (89.5%) clients live in a rural area (countryside, village or small town) and this reflects the three case areas of the pilot. Most control group participants (72.7%) also live in a rural area.

Table 44, Location of home (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Rural/urban descriptor	Frequency	Valid %	Frequency	Valid %
Countryside or small village	22	32.8	98	32.7
Large village or small town	38	56.7	120	40.0
Suburbs of large town or city	3	4.5	60	20.0
Centre of large town or city	4	6.0	22	7.3

Table 45 shows a high proportion of clients are in the older age categories, likely reflecting the eligibility criteria of the pilot. However, the pilot reached people from younger age groups because one in three (31.3%) participants are aged 44 or younger. The clients are statistically significantly older than the control group[34]. The distribution of the control group is slightly skewed towards the younger age categories.

Table 45, Age category (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Age category	Frequency	Valid %	Frequency	Valid %
18 – 24	3	4.5	40	13.3
25 – 34	10	14.9	84	28.0
35 – 44	8	11.9	72	24.0
45 – 54	15	22.4	46	15.3
55 – 64	14	20.9	37	12.3
65+	17	25.4	20	6.7
Prefer not to say	0	0	1	0.3

[34] Mann-Whitney U test revealed the clients are statistically significantly older (mean rank = 243.03) than the control group participants (mean rank = 170.16), U = 6028, z = -5.194, p = .001. The median for ATSP clients = 45 – 54, whereas the median for the control group = 35 – 44.

Almost two thirds (65.7%) of clients are female, which is statistically significantly higher than the control group[35] (Table 46).

Table 46, Gender (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Gender	Frequency	Valid %	Frequency	Valid %
Male	22	32.8	159	53.0
Female	44	65.7	139	46.3
Non-binary	1	1.5	1	0.3
Prefer not to say	0	0.0	1	0.3

There was no difference between clients and the control group in terms of their sexual orientation (Fisher's exact test; Table 47).

Table 47, Sexual orientation (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Sexual orientation	Frequency	Valid %	Frequency	Valid %
Straight or Heterosexual	59	89.4	272	90.7
Gay or Lesbian	1	1.5	8	2.7
Bisexual	0	0.0	17	5.7
Other sexual orientation	0	0.0	2	0.7
Prefer not to say	6	9.1	1	0.3

Table 48 shows most clients (97.0%) and control group participants (89.7%) stated their ethnicity as white. The cell count was too low for most response categories to carry out a Chi-square test or Fisher's exact test, but the two groups' reported ethnicity is very similar.

[35] A larger proportion of ATSP clients (65.7%) are female, compared to the control group (46.3%). A Fisher's exact test revealed this difference in proportions is statistically significant, $p = .004$ (The cell counts for 'non-binary' and 'prefer not to say' responses were insufficient to conduct a Chi-square test of homogeneity).

Table 48, Ethnicity (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Ethnicity descriptor	Frequency	Valid %	Frequency	Valid %
White (English / Welsh / Scottish / Northern Irish / Cornish / British; Irish; Gypsy or Irish traveller)	64	95.5	264	88.0
Any other White background (please specify)	1	1.5	5	1.7
Mixed / Multiple ethnic groups (White and Black Caribbean; White and Black African; White and Asian)	2	3.0	10	3.3
Any other Mixed / Multiple ethnic background (please specify)	0	0.0	2	0.7
Asian / Asian British (Indian; Pakistani; Bangladeshi; Chinese)	0	0.0	10	3.3
Any other Asian background (please specify)	0	0.0	1	0.3
Black / African / Caribbean / Black British (African; Caribbean)	0	0.0	7	2.3
Any other Black / African / Caribbean background (please specify)	0	0.0	1	0.3
Other ethnic group (Arab)	0	0.0	0	0.0
Any other ethnic group (please specify)	0	0.0	0	0.0
Prefer not to say	0	0.0	0	0.0

Table 49 shows approximately one third of clients (34.3%) and control group participants (37.7%) have children under the age of 18 living at home. There was no statistically significant difference between the two groups (Fisher's exact test).

Table 49, Household composition (pre-intervention survey)

Household composition	ATSP clients (n=67)		Control group (n=300)	
	Frequency	Valid %	Frequency	Valid %
Have children living at home	23	34.3	113	37.7
No children living at home	44	65.7	184	61.3
Prefer not to say	0	0.0	3	1.0

In terms of education level, the most common response for clients was 'GCSE or O-level' followed by 'vocational qualification', whereas the most common response the control group was 'undergraduate degree' followed by 'A-level' (Table 50). A smaller proportion of ATSP clients (13.5%) have an undergraduate or postgraduate degree than control group participants (50.0%)[36]

Table 50, Education (pre-intervention survey)

Highest level of education achieved so far	ATSP clients (n=67)		Control group (n=300)	
	Frequency	Valid %	Frequency	Valid %
No formal qualifications	5	7.5	4	1.3
GCSE or O-level	17	25.4	54	18.0
A-level	11	16.4	70	23.3
Undergraduate degree (e.g. Bachelor's)	6	9.0	88	29.3
Postgraduate degree (e.g. Master's, PhD)	3	4.5	62	20.7
Vocational qualification	13	19.4	20	6.7
Other	9	13.4	0	0.0
Prefer not to say	3	4.5	2	0.7

[36] A smaller proportion of ATSP clients (13.5%) have an undergraduate or postgraduate degree, compared to the control group (50.0%). A Fisher's exact test revealed this difference in proportions is statistically significant, $p = .001$ (More than 20% of the expected cell counts in Table 50 are less than five and this invalidates conducting a Chi-square test of homogeneity).

Table 51 shows the survey participants' employment status; a smaller proportion of ATSP clients are in part- or full-time employment than control group participants[37].

Table 51, Employment status (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Current employment status	Frequency	Valid %	Frequency	Valid %
Full-time student	3	4.5	15	5.0
Full time paid employment	6	9.0	176	58.7
Part time paid employment	7	10.4	39	13.0
Full time self-employment	2	3.0	12	4.0
Part time self-employment	3	4.5	9	3.0
Unemployed	11	16.4	9	3.0
Retired	14	20.9	23	7.7
Looking after the home or family	2	3.0	7	2.3
Temporarily sick or disabled	3	4.5	0	0.0
Long term sickness or disability	10	14.9	9	3.0
Other	6	9.0	0	0.0
Prefer not to say	0	0.0	1	0.3

For household combined income, Table 52 shows the clients tend to earn less than the control group[38]. The median income category for the clients was £13,000 - £18,999, whereas the median for the control group was £32,000 - £47,999. One in three (36.4%) clients preferred not to answer the question about their income.

[37] A smaller proportion of ATSP clients (26.9%) are in employment (full or part-time, including self-employed), compared to the control group (78.7%). A Fisher's exact test revealed this difference in proportions is statistically significant, $p = .001$ (More than 20% of the expected cell counts in Table 51 are less than five and this invalidates conducting a Chi-square test of homogeneity).

[38] A Mann-Whitney U test revealed the clients' combined household income (mean rank = 73.36) is statistically significantly less than the control group participants' (mean rank = 182.09), $U = 10170.0$, $z = 6.866$, $p = .001$. The median for ATSP clients = £13,000 - £18,999, whereas the median for the control group = £32,000 - £47,999 (with the 'prefer not to say' response removed from the ordinal scale).

Table 52, Household combined income (per year, before tax deductions) (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Household income category	Frequency	Valid %	Frequency	Valid %
Less than £6,000	2	3.0	7	2.3
£6,000 - £12,999	11	16.7	14	4.7
£13,000 - £18,999	11	16.7	12	4.0
£19,000 - £25,999	8	12.1	30	10.0
£26,000 - £31,999	3	4.5	34	11.3
£32,000 - £47,999	5	7.6	66	22.0
£48,000 - £63,999	1	1.5	66	22.0
£64,000 - £95,999	1	1.5	42	14.0
More than £96,000	0	0.0	23	7.7
Prefer not to say	24	36.4	6	2.0

Most respondents own a car or van (in their household; Table 53), although car ownership is notably lower among the clients (74.6%) than the control group (95.0%)[39].

Table 53, Household car ownership (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Household car ownership	Frequency	Valid %	Frequency	Valid %
Household owns a car or van	50	74.6	285	95.0
Household does not own a car or van	17	25.4	15	5.0

[39] A smaller proportion of the ATSP clients (74.6%) owns a car or van, compared to the control group (95.0%). A Fisher's exact test revealed this difference in proportions is statistically significant, $p = .001$

6.6.2 Travel behaviours

The survey explored the participants' current travel behaviours for the following modes: walking/wheeling, cycling, private car, taxi, and public transport.

Walking/wheeling

Approximately one in ten clients (11.9%) and control group participants (11.7%) reported they have not done a continuous walk/wheel that lasted at least ten minutes in the past four weeks[40]. Those who had walked or wheeled in the past four weeks were asked how often they walk/wheel (Figure 24). Over half (54.2%) of clients walk/wheel five or more days per week, which is more frequently than the control group[41].

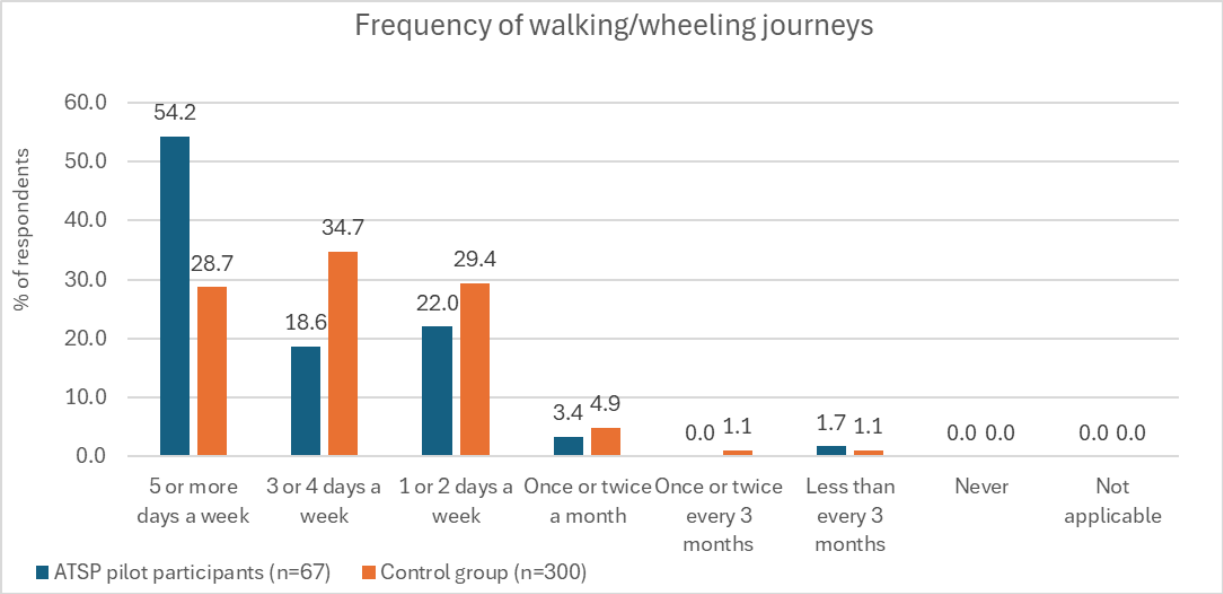


Figure 24, Frequency of walking/wheeling journeys (pre-intervention survey)

Cycling

Participants were asked how often they use a bicycle; Figure 25 shows 13.5% of clients cycle on a weekly basis. However, over three quarters (77.6%) of clients never use a bicycle, which

[40] There was no statistically significant difference in the proportions of two groups that had walked/wheeled in the past 4 weeks (Fisher's exact test).

[41] A Mann-Whitney U test revealed ATSP clients walk/wheel more frequently (mean rank = 131.99) than the control group participants (mean rank = 169.29), U = 9617.5, z = 2.902, p = 0.004. The median response for ATSP clients = 5 or more days a week, whereas the median response for the control group = 3 or 4 days a week.

corresponds with the high proportion (56.7%) that do not own a bike (Table 54). The clients travel less frequently by bicycle, compared to the control group[42].

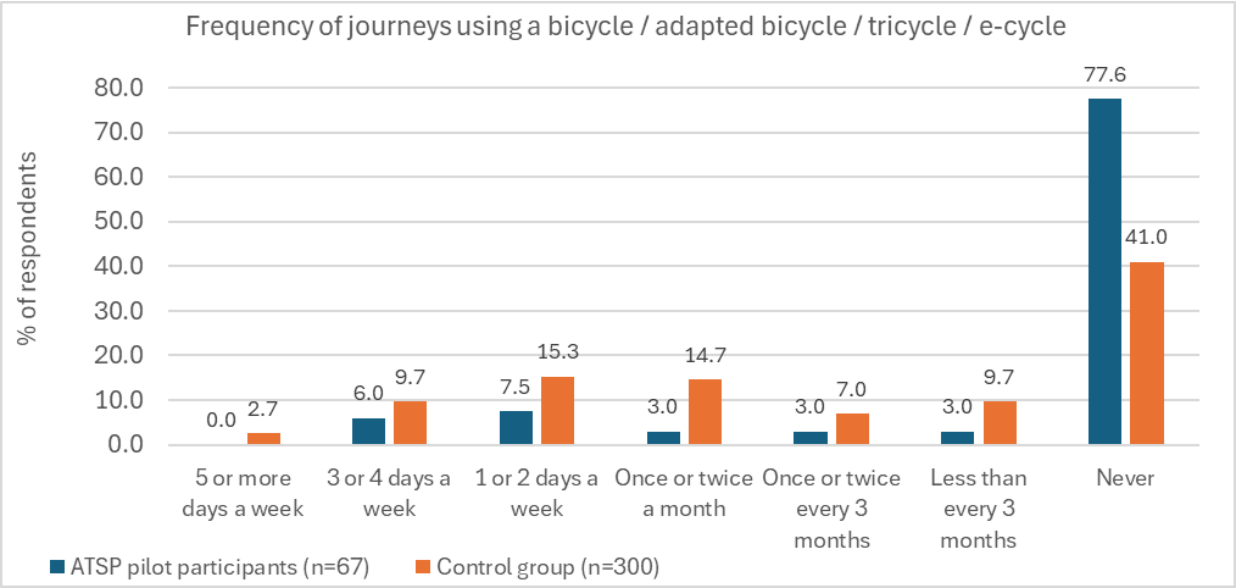


Figure 25, Frequency of journeys using a bicycle / adapted bicycle / tricycle / e-cycle (pre-intervention survey)

Table 54 shows the participants' bike ownership. The proportion of clients that own an e-bike (11.9%) is comparable with the control group (13.3%), but the proportion that own a conventional or adapted bike (20.9%) is statistically significantly lower than the control group (43.3.%)[43]. Bike ownership among the control group is comparable with a previous study of Cornwall residents[44].

[42] A Mann-Whitney U test revealed ATSP clients cycle less frequently (mean rank = 237.01) than the control group participants (mean rank = 172.16), U = 6498.0, z = -4.808, p = 0.001. The median response for ATSP clients = never, whereas the median response for the control group = less than every 3 months.

[43] A smaller proportion of the ATSP clients (20.9%) owns a conventional or adapted bike, compared to the control group (43.3%). A Fisher's exact test revealed this difference in proportions is statistically significant, p = .001

[44] In the previous study, 45.0% of residents own a conventional bike and 15.9% own an e-bike. See: Wilson, M., and Whitmarsh, L. (2024). CAST-the-centre-for-climate-change-and-social-transformations-Cornwall-Council-report-Behaviour-change-interventions-to-encourage-uptake-of-e-bike-shared-mobility-in-Cornwall.pdf

Table 54, Bicycle ownership (pre-intervention survey)

Bike ownership category*	ATSP clients (n=67) Frequency	%	Control group (n=300) Frequency	%
I own a conventional bike or an adapted bike	14	20.9	130	43.3
I own an e-bike (i.e. an electric bike)	8	11.9	40	13.3
I own a bike but it is in disrepair	5	7.5	47	15.7
I do not own a bike	38	56.7	103	34.3
Not applicable	4	6.0	5	1.7

* participants could select multiple options

Travel by car

Most respondents own a car or van (in their household), although car ownership is notably lower among the clients (74.6%) than the control group (95.0%)[45]. Figure 26 shows 43.3% of clients use their car five or more days per week. There was no statistically significant difference in the frequency of car journeys between clients and the control group (Mann-Whitney U test).

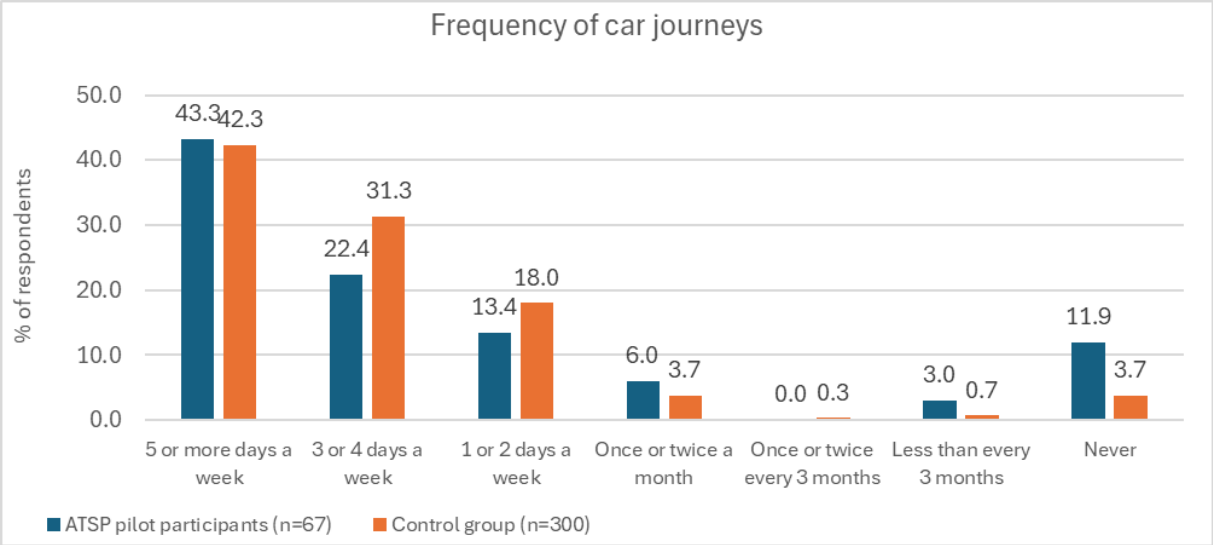


Figure 26, Frequency of car journeys (pre-intervention survey)

[45] A smaller proportion of the ATSP clients (74.6%) owns a car or van, compared to the control group (95.0%). A Fisher's exact test revealed this difference in proportions is statistically significant, $p = .001$

Private car is the dominant mode of transport in Cornwall[46] and so two further questions were included to compare car travel with active modes. The first aimed to validate the results for journey frequency presented in Figures 24, 25 and 26; the participants were asked *how many journeys* they made last week by car, bike, or walking/wheeling (as opposed to *how many days* per week they travel using these three modes). Figure 27 shows the clients made fewer trips by car and active modes, compared to the control group[47]. Thus, the clients and the control group travel the same number of days each week by car, but clients may make only one journey per day, whereas the control group participants make multiple trips on any given day.

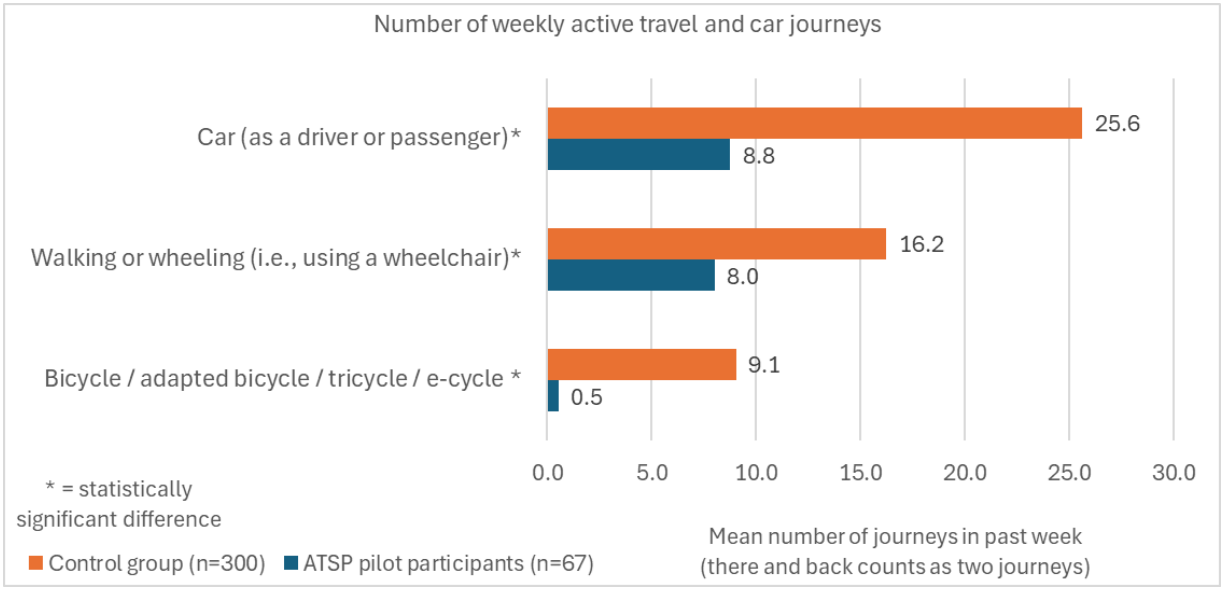


Figure 27, Number of weekly active travel and car journeys (pre-intervention survey)

The distances travelled by active modes and car were also explored. Figure 28 shows the clients travel shorter distances by bike than the control group[48], but there were no statistically significant differences between the two groups for the distances they travel by car or walking/wheeling (Independent samples t-tests).

[46] See: Wilson, M., and Whitmarsh, L. (2023). Cornwall Council behaviour change and engagement programme – survey of residents

[47] Welch t-tests revealed:

— ATSP clients make fewer weekly trips by car (as a driver or passenger) (8.75 ± 9.28), compared to the control group (25.61 ± 25.43), a statistically significant difference of 16.87 (95% CI, 13.22 to 20.52), $t(291) = 9.092$, $p = .001$

— ATSP clients make fewer weekly walking/wheeling trips (8.01 ± 8.79), compared to the control group (16.24 ± 17.76), a statistically significant difference of 8.23 (95% CI, 5.30 to 11.15), $t(203) = 5.538$, $p = .001$

— ATSP clients make fewer weekly cycling trips (.54 ± 1.62), compared to the control group (9.05 ± 16.11), a statistically significant difference of 8.51 (95% CI, 6.64 to 10.38), $t(323) = 8.954$, $p = .001$

[48] A Welch t-test revealed ATSP clients travel shorter distances by bike (2.03 ± 5.73), compared to the control group (9.52 ± 12.13), a statistically significant difference of 7.49 (95% CI, 5.53 to 9.46), $t(207) = 7.513$, $p = .001$

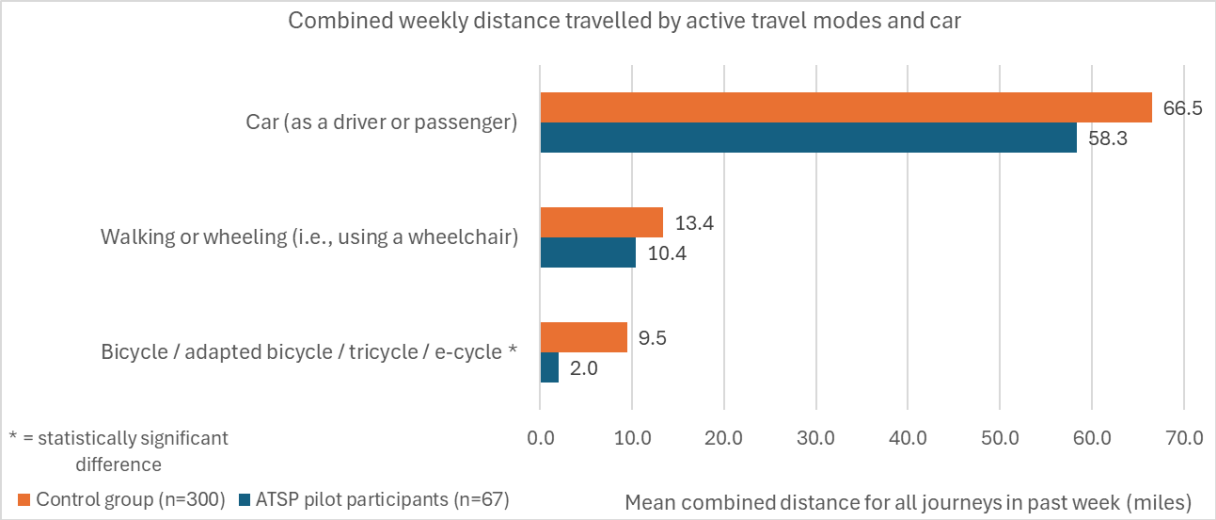


Figure 28, Combined distance travelled by active modes and car, per week (pre-intervention survey)

Travel by public transport

Table 55 shows clients travel less frequently by bus or coach, compared to the control group[49]. One in six (16.5%) clients use a bus on weekly basis, compared to one in three (36.1%) control group participants.

Table 55, Frequency of bus or coach journeys (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Frequency category	Frequency	Valid %	Frequency	Valid %
5 or more days a week	3	4.5	8	2.7
3 or 4 days a week	2	3.0	29	9.7
1 or 2 days a week	6	9.0	71	23.7
Once or twice a month	12	17.9	60	20.0
Once or twice every 3 months	5	7.5	30	10.0
Less than every 3 months	16	23.9	54	18.0
Never	23	34.3	48	16.0

[49] A Mann-Whitney U test revealed ATSP clients travel less frequently by bus or coach (mean rank = 228.19) than the control group participants (mean rank = 174.13), U = 7089.0, z = -3.834, p = 0.001. The median response for ATSP clients = less than every 3 months, whereas the median response for the control group = once or twice a month.

Similarly, Table 56 shows the clients travel less frequently by train or tram, compared to the control group[50]. Only 3.0% of clients use trains on a weekly basis.

Table 56, Frequency of train or tram journeys (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Frequency category	Frequency	Valid %	Frequency	Valid %
5 or more days a week	0	0.0	4	1.3
3 or 4 days a week	0	0.0	13	4.3
1 or 2 days a week	2	3.0	65	21.7
Once or twice a month	4	6.0	75	25.0
Once or twice every 3 months	8	11.9	39	13.0
Less than every 3 months	25	37.3	61	20.3
Never	28	41.8	43	14.3

Travel by taxi

Table 57 shows the clients travel less frequently by taxi, compared to the control group[51]. Two thirds (67.2%) of clients never use a taxi.

Table 57, Frequency of taxi or private hire rental journeys (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Frequency category	Frequency	Valid %	Frequency	Valid %
5 or more days a week	1	1.5	6	2.0
3 or 4 days a week	2	3.0	22	7.3
1 or 2 days a week	0	0.0	59	19.7
Once or twice a month	6	9.0	65	21.7
Once or twice every 3 months	3	4.5	35	11.7
Less than every 3 months	10	14.9	62	20.7
Never	45	67.2	51	17.0

[50] A Mann-Whitney U test revealed ATSP clients travel less frequently by train or tram (mean rank = 264.59) than the control group participants (mean rank = 166.00), U = 4650.5, z = -7.013, p = 0.001. The median response for ATSP clients = less than every 3 months, whereas the median response for the control group = once or twice a month.
[51] A Mann-Whitney U test revealed ATSP clients travel less frequently by taxi or private hire rental (mean rank = 269.75) than the control group participants (mean rank = 164.85), U = 4305.0, z = -7.461, p = 0.001. The median response for ATSP clients = never, whereas the median response for the control group = once or twice a month.

6.6.3 Perceptions of active travel

This section presents the clients' attitudes towards active travel as a form of transport, their awareness of active travel routes in their local area, and their confidence and safety perception when using active modes.

Walking/wheeling

Table 58 shows one in four (25.4%) clients know 'a great deal' about walking/wheeling routes in their local area, although one in three (35.8%) know 'just a little'. Awareness of local walking/wheeling routes was similar for the control group participants (Mann-Whitney U test).

Table 58, Participants' awareness of walking/wheeling routes in their local area (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Level of awareness	Frequency	Valid %	Frequency	Valid %
A great deal	17	25.4	80	26.7
A fair amount	20	29.9	128	42.7
Just a little	24	35.8	63	21.0
Heard of them, know nothing about them	3	4.5	13	4.3
Never heard of them	2	3.0	12	4.0
Don't know	1	1.5	0	0.0
Not applicable	0	0.0	4	1.3

Table 59 shows most clients are either 'very confident' (34.3%) or 'fairly confident' (37.3%) when walking/wheeling in their local area. There was no statistically significant difference between the clients and the control group in their level of confidence (Mann-Whitney U test).

Table 59, Participants' confidence when walking/wheeling (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Level of confidence	Frequency	Valid %	Frequency	Valid %
Very confident	23	34.3	106	35.3
Fairly confident	25	37.3	146	48.7
Not very confident	13	19.4	29	9.7
Not at all confident	4	6.0	9	3.0
Don't know	0	0.0	4	1.3
Not applicable	2	3.0	6	2.0

One area where the clients and the control group differ is their perception of safety when walking/wheeling[52]. Figure 29 shows 22.4% of clients feel 'very safe' when walking or wheeling, compared to 32.7% of the control group.

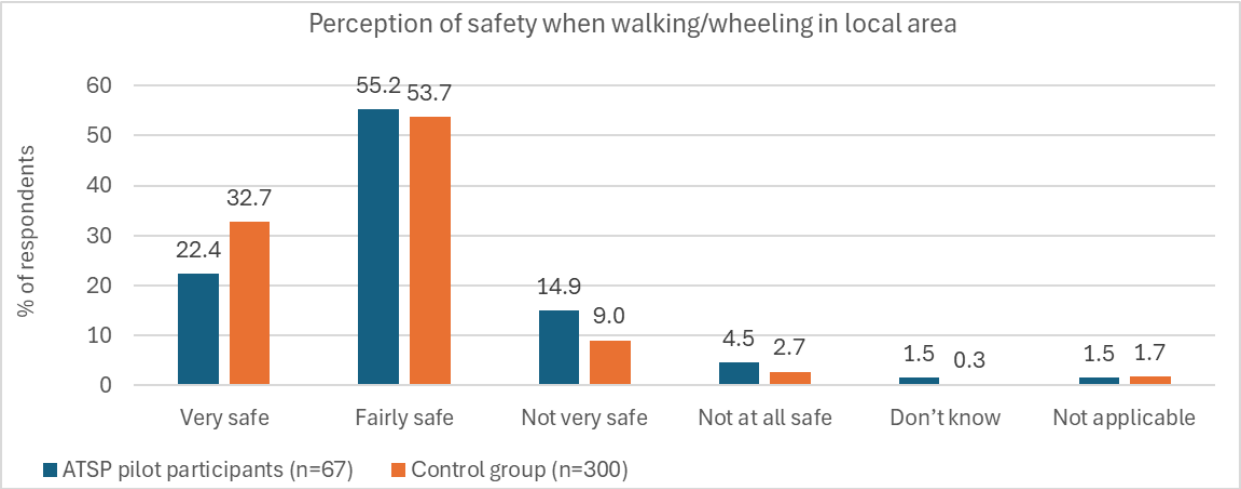


Figure 29, Participants' perception of safety when walking/wheeling in their local area (pre-intervention survey)

Table 60 shows most clients are either 'very favourable' (46.3%) or 'fairly favourable' (32.8%) towards walking/wheeling as a form of transport. There was no statistically significant difference between clients and the control group in terms of their attitude towards walking/wheeling (Mann-Whitney U test).

[52] A Mann-Whitney U test revealed ATSP clients feel less safe (mean rank = 201.22) than control group participants (mean rank = 175.31), when walking/wheeling in their local area, U = 8175, z = -2.037, p = 0.042. The median response for the ATSP clients and the control group = Fairly safe.

Table 60, Participants' attitude towards walking/wheeling as a form of transport (pre-intervention survey)

Attitude towards walking/wheeling	ATSP clients (n=67)		Control group (n=300)	
	Frequency	Valid %	Frequency	Valid %
Very favourable	31	46.3	83	27.7
Fairly favourable	22	32.8	145	48.3
Neither favourable nor unfavourable	3	4.5	43	14.3
Fairly unfavourable	6	9.0	18	6.0
Very unfavourable	5	7.5	8	2.7
Don't know	0	0.0	1	0.3
Not applicable	0	0.0	2	0.7

Cycling

Figure 30 shows one in ten (10.4%) clients are 'very able' to cycle on the highway, but 20.9% are 'not very able' and a further 13.4% are 'not at all able'. Overall, the clients reported a lower level of cycling ability than the control group[53].

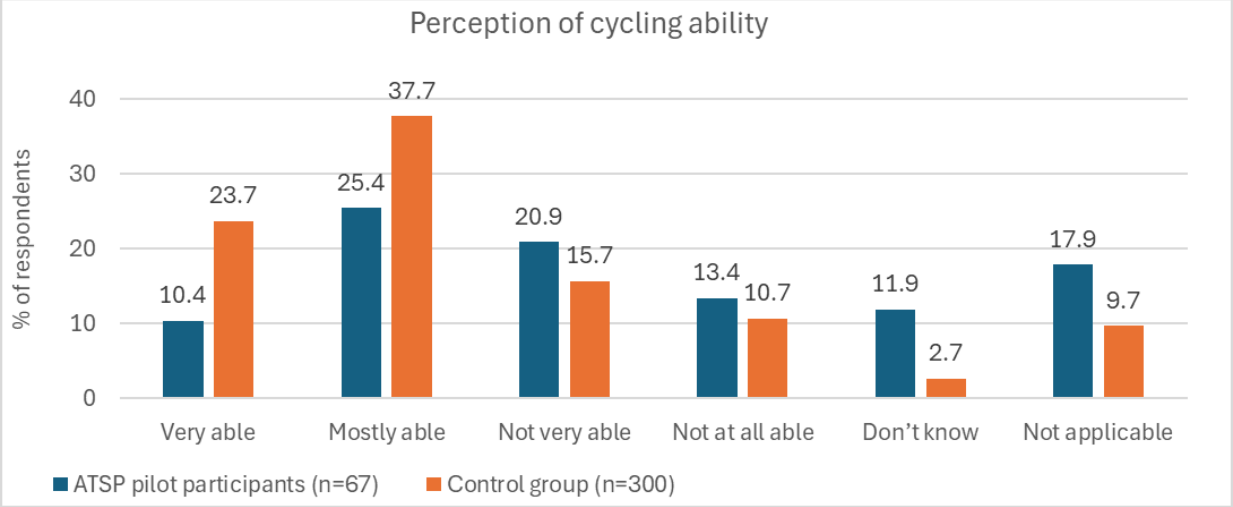


Figure 30, Participants' perceptions of their cycling ability (pre-intervention survey)

[53] A Mann-Whitney U test revealed ATSP clients reported a lower level of cycling ability (mean rank = 184.51) than the control group participants (mean rank = 150.32), U = 4817.0, z = -2.539, p = 0.011. The median response for ATSP clients = Not very able, whereas the median response for the control group = Mostly able (with 'don't know' and 'not applicable' responses removed from the ordinal scale).

Table 61 shows the clients reported a much lower awareness of cycling infrastructure (e.g., cycle lanes, cycle routes, cycle storage, cycle hire, adapted cycling, e-cycling) in their local area, compared to their awareness of walking/wheeling routes (Table 58). There was no statistically significant difference between clients and the control group for awareness of cycling infrastructure (Mann-Whitney U test).

Table 61, Awareness of cycling infrastructure in their local area (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Level of awareness	Frequency	Valid %	Frequency	Valid %
A great deal	3	4.5	32	10.7
A fair amount	17	25.4	98	32.7
Just a little	23	34.3	100	33.3
Heard of them, know nothing about them	11	16.4	39	13.0
Never heard of them	4	6.0	12	4.0
Don't know	2	3.0	5	1.7
Not applicable	7	10.4	14	4.7

Figure 31 shows a high proportion of clients feel 'not very confident' (14.9%) or 'not at all confident' (23.9%) when cycling on roads in their local area. Overall, the clients feel less confident than the control group participants when cycling[54].

[54] A Mann-Whitney U test revealed ATSP clients reported a lower level of confidence when cycling on roads in their local area (mean rank = 189.28) than the control group participants (mean rank = 144.01), $U = 3858$, $z = -3.361$, $p = 0.001$. The median response for ATSP clients = Not very confident, whereas the median response for the control group = Fairly confident (with 'don't know' and 'not applicable' responses removed from the ordinal scale)

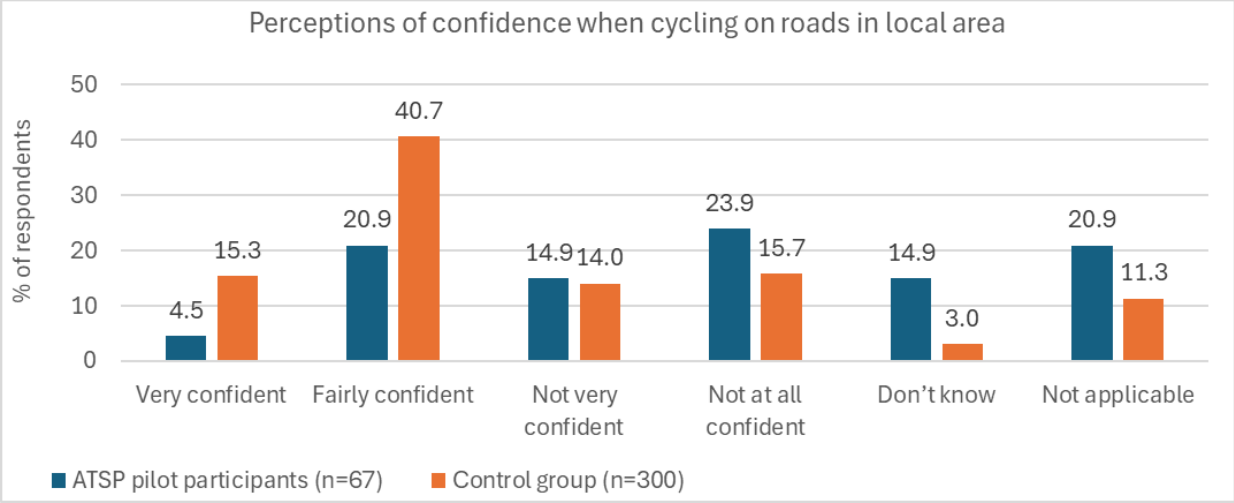


Figure 31, Participants' perceptions of confidence when cycling on roads in local area (pre-intervention survey)

Figure 32 shows most clients do not feel safe when cycling/e-cycling on roads in their local area. The proportion of clients that feel 'very safe' (1.5%) or 'fairly safe' (14.9%) is statistically significantly lower than the control group[55].

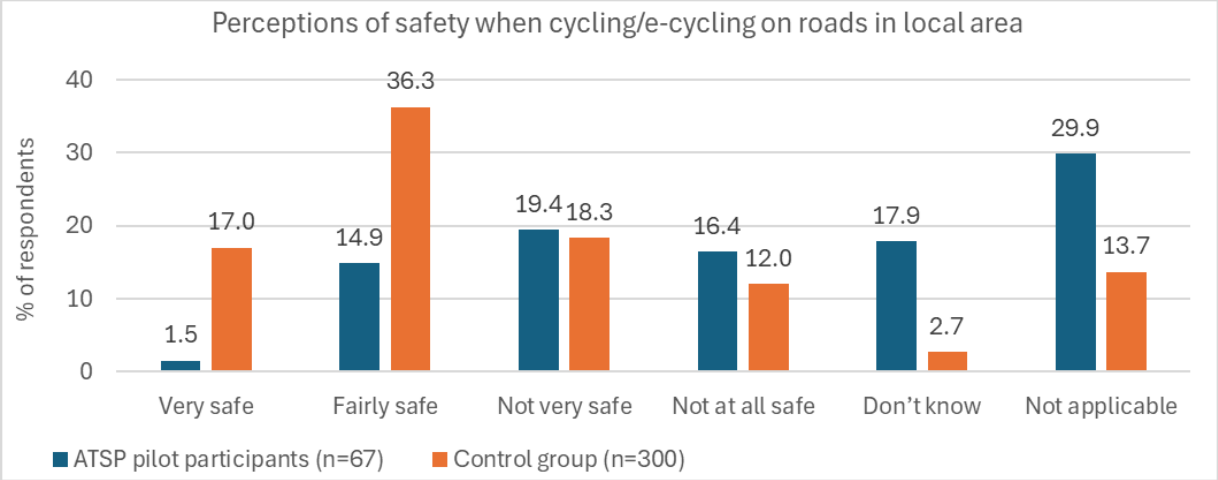


Figure 32, Participants' perceptions of safety when cycling/e-cycling on roads in their local area (pre-intervention survey)

[55] A Mann-Whitney U test revealed ATSP clients feel less safe (mean rank = 191.74) than control group participants (mean rank = 136.77), when cycling/e-cycling on roads in their local area, $U = 2704.0$, $z = -3.874$, $p = 0.001$. The median response for the ATSP clients = Not very safe, whereas the median response for the control group = Fairly safe (with 'don't know' and 'not applicable' responses removed from the ordinal scale).

Despite their lower levels of cycling confidence and ability, the majority of clients have a favourable attitude towards cycling as a form of transport (Table 62). There was no statistically significant difference between the clients and the control group (Mann-Whitney U test).

Table 62, Participants' attitude towards cycling as a form of transport (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Attitude towards cycling	Frequency	Valid %	Frequency	Valid %
Very favourable	18	26.9	57	19.0
Fairly favourable	23	34.3	104	34.7
Neither favourable nor unfavourable	3	4.5	57	19.0
Fairly unfavourable	8	11.9	36	12.0
Very unfavourable	7	10.4	26	8.7
Don't know	3	4.5	2	0.7
Not applicable	5	7.5	18	6.0

6.6.4 Physical activity

Participants were asked which physical activities or sports they have done in the last four weeks. Table 63 shows swimming, cycling and aerobics were the most common activities for the clients, whereas gym, running or exercises were the most common activities for the control group.

Table 63, Physical activities or sports the participants have done in the last four weeks (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Activity or sport	Frequency	%	Frequency	%
Swimming	17	25.4	85	28.3
Cycling	11	16.4	76	25.3
Workout at a gym / Exercise bike / Weight training	4	6.0	100	33.3
Aerobics / Keep fit / Gymnastics / Dance for fitness	9	13.4	41	13.7
Running / Jogging	2	3.0	91	30.3
Football / Rugby	0	0.0	67	22.3
Badminton / Tennis / Squash	0	0.0	41	13.7
Exercises (e.g., press-ups, sit-ups)	3	4.5	106	35.3
Other activity	12	18.0	15	4.7
I have not done any of these activities	27	40.3	56	18.7

Participants were then asked how frequently they had undertaken these physical activities or sports; Table 64 shows clients typically do these activities between 1 – 4 times a week. The control group also tend to do these activities between 1 – 4 times a week. Clients go running and do aerobics less frequently than the control group.

Table 64, Median frequency of physical activities or sports the participants have done in the last four weeks (pre-intervention survey)

Activity or sport	ATSP clients (n=67) Median response	Control group (n=300) Median response
Swimming	1 or 2 days a week	1 or 2 days a week
Cycling	1 or 2 days a week	1 or 2 days a week
Workout at a gym / Exercise bike / Weight training	3 or 4 days a week	3 or 4 days a week
Aerobics / Keep fit / Gymnastics / Dance for fitness	Once or twice a month	1 or 2 days a week
Running / Jogging	3 or 4 days a week	1 or 2 days a week
Football / Rugby	-	1 or 2 days a week
Badminton / Tennis / Squash	-	1 or 2 days a week
Exercises (e.g. press-ups, sit-ups)	3 or 4 days a week	3 or 4 days a week
Other activity	1 or 2 days a week	1 or 2 days a week

6.6.5 Physical health

The survey included eight questions which explored the participants' physical health. Relative to the control group, the clients reported worse health in all but one of these indicators. Given two of the pilot eligibility criteria focus on health, this is not surprising, but such differences provide a strong justification for trialling approaches to address health inequalities, such as ATSP.

Table 65 shows most (74.6%) clients have a long-term health condition lasting, or expected to last, 12 months or more. This is statistically significantly higher than the control group (29.0%)[56].

[56] A larger proportion of the ATSP clients (74.6%) have a long-term health condition, compared to the control group (29.0%). A Fisher's exact test revealed this difference in proportions is statistically significant, $p = .001$ (The cell counts for 'prefer not to say' responses was insufficient to conduct a Chi-square test of homogeneity).

Table 65, Proportion of participants with a long-term health condition (pre-intervention survey)

	ATSP clients (n=67)		Control group (n=300)	
Health condition	Frequency	Valid %	Frequency	Valid %
Have a long-term physical or mental health condition	50	74.6	87	29.0
Do not have a long-term physical or mental health condition	13	19.4	209	69.7
Prefer not to say	4	6.0	4	1.3

Those who have a long-term health condition were then asked whether their condition(s) or illness(es) reduce their ability to carry out day-to-day activities (Table 66). A sizeable proportion (40.0%) of clients reported the most severe impact (i.e., 'a lot'). There was no statistically significant difference between the clients and the control group in terms of the impact of their health condition (Mann-Whitney U test).

Table 66, Impact of long-term health condition on participants' ability to carry out day-to-day activities (pre-intervention survey)

	ATSP clients (n=50)		Control group (n=87)	
Impact of health condition	Frequency	Valid %	Frequency	Valid %
Yes, a lot	20	40.0	26	29.9
Yes, a little	25	50.0	46	52.9
Not at all	4	8.0	15	17.2
Prefer not to say	1	2.0	0	0.0

All survey participants were asked about their health in general. Figure 33 shows almost half (49.3%) of the clients consider their health to be 'fair', but 13.5% consider their health to be 'bad' or 'very bad'. Overall, the clients' perception of their health was worse than the perception of health among the control group participants[57].

[57] A Mann-Whitney U test revealed ATSP clients' perception of their health in general (mean rank = 220.47) was statistically significantly worse than the control group participants (mean rank = 174.25), U = 7249.5, z = -3.429, p = 0.001. The median response for the ATSP clients = Fair, whereas the median response for the control group = Good.

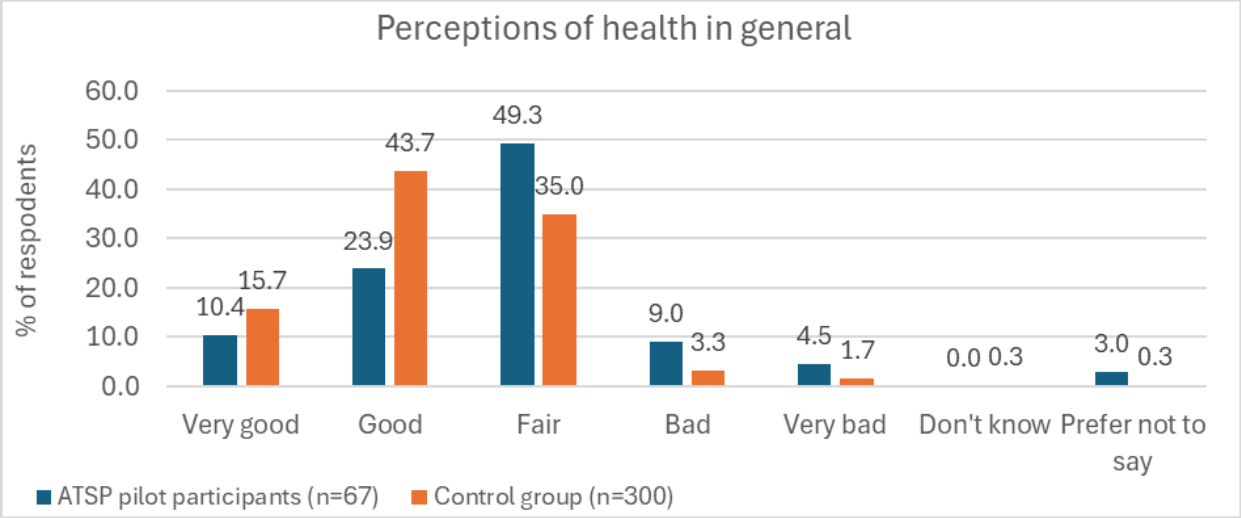


Figure 33, Participants' perceptions of their health in general (pre-intervention survey)

Figure 34 shows the clients reported higher current levels of pain, compared to the control group participants[58]. Approximately one third (31.3%) of clients do not currently feel any pain at all, compared to 45.3% of the control group.

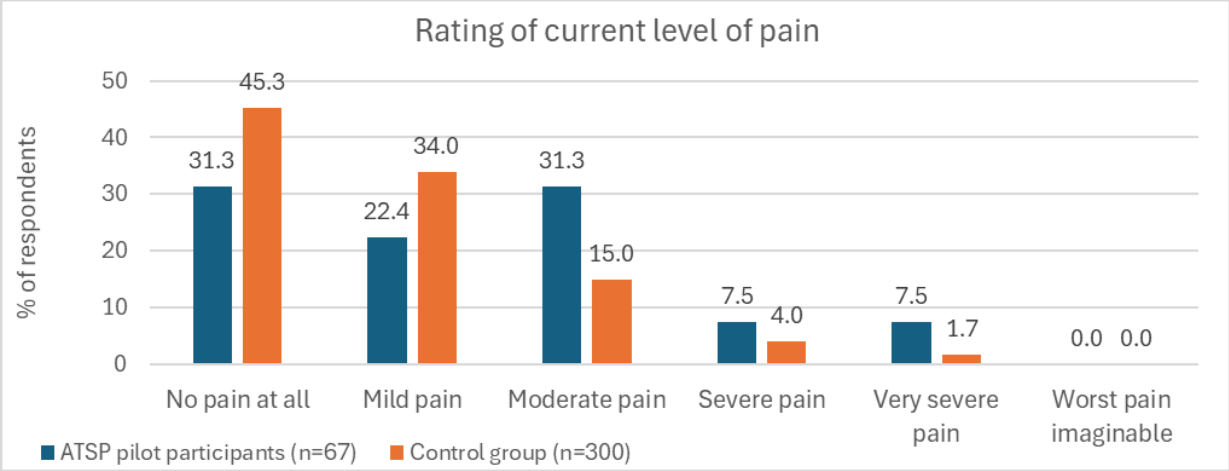


Figure 34, Participants' rating of their current level of pain (pre-intervention survey)

Participants who reported experiencing pain were asked about the cause(s). Table 67 shows a long-term health condition or a physical disability are the most common causes of pain among the clients, and the proportions currently experiencing these types of pain are higher than the

[58] A Mann-Whitney U test revealed ATSP clients reported higher levels of pain (mean rank = 222.60) than the control group participants (mean rank = 175.38), U = 7464.0, z = -3.504, p = 0.001. The median response for the ATSP clients and the control group = Mild pain.

control group[59]. There were no statistically significant differences between the two groups for pain related to a short-term illness, age, a recent injury, or their occupation (Fisher's exact tests).

Table 67, Cause(s) of pain that the participants are currently experiencing (pre-intervention survey)

	ATSP clients (n=46)		Control group (n=164)	
Cause of pain*	Frequency	Valid %	Frequency	Valid %
A short-term illness	5	7.5	13	4.3
A recent physical injury	4	6.0	44	14.7
A long-term health condition	24	35.8	52	17.3
Physical disability	12	17.9	21	7.0
Ageing related pain	11	16.4	42	14.0
Occupational related pain	7	10.4	16	5.3
Other	8	11.9	6	2.0

* Participants could select multiple causes

All survey participants were asked about their current energy levels. Figure 35 shows one in four (25.4%) clients experience 'significant', 'severe' or 'very severe' difficulty with their energy levels. Clients experience more difficulty with their energy levels than control group participants[60].

[59] Fisher's exact tests revealed:

— Of the participants who reported experiencing pain, a greater proportion of the ATSP clients (35.8%) experience this pain due to a long term health condition, compared to the control group (17.3%). A Fisher's exact test revealed this difference in proportions is statistically significant, $p = .001$

— Of the participants who reported experiencing pain, a greater proportion of the ATSP clients (17.9%) experience this pain due to a physical disability, compared to the control group (7.0%). A Fisher's exact test revealed this difference in proportions is statistically significant, $p = .008$

[60] A Mann-Whitney U test revealed ATSP clients' experience more difficulty with their energy levels (mean rank = 233.63) than the control group participants (mean rank = 172.92), $U = 6725.0$, $z = -4.424$, $p = 0.001$. The median response for the ATSP clients = Moderate difficulty, whereas the median response for the control group = Slight difficulty.

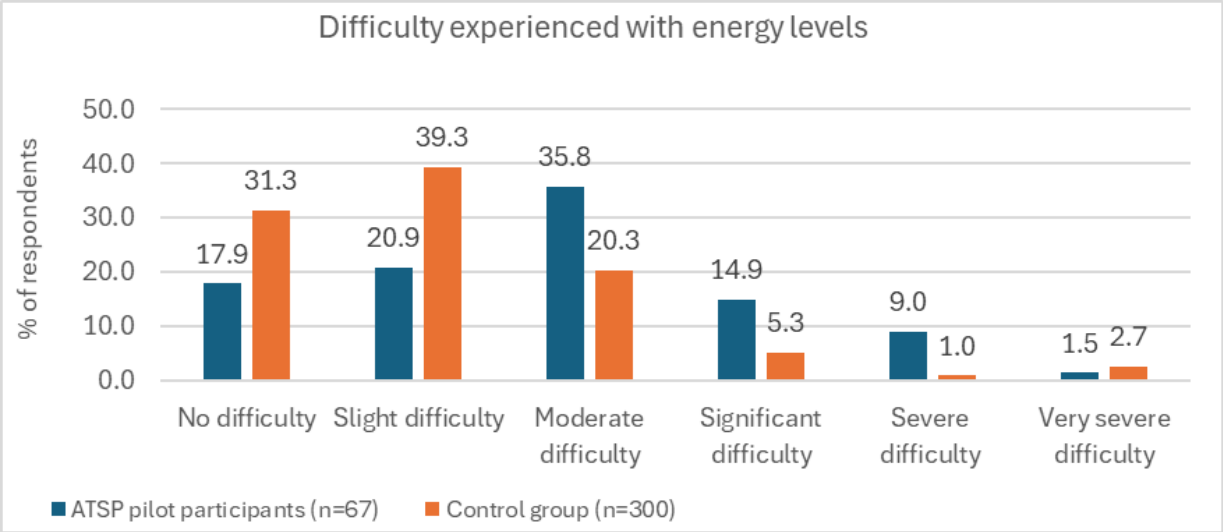


Figure 35, Participants' level of difficulty they experience with their energy levels (pre-intervention survey)

Figure 36 shows clients visit their GP more frequently than control group participants[61]. One in four (26.9%) clients visited their GP more than ten times in the past 12 months.

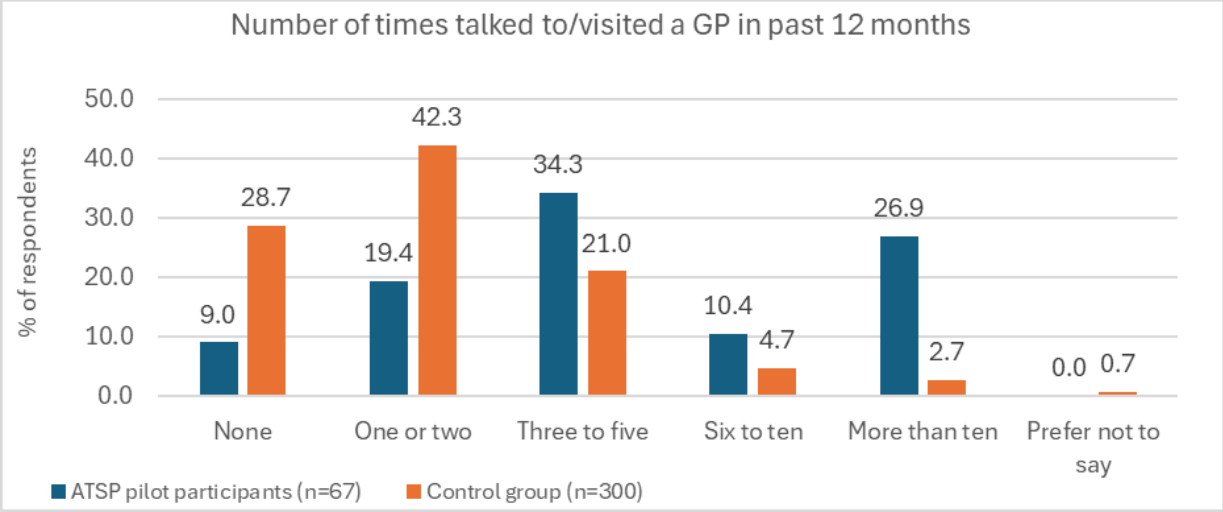


Figure 36, Number of times participants have talked to or visited their GP/family doctor in the past 12 months, about their own health (pre-intervention survey)

[61] A Mann-Whitney U test revealed ATSP clients visited/talked to a GP about their own health in the past 12 months (mean rank = 259.34) more frequently than the control group participants (mean rank = 167.17), U = 5002.0, z = -6.720, p = 0.001. The median response for the ATSP clients = Three to five, whereas the median response for the control group = One or two.

Similarly, Figure 37 shows clients visit hospital for their own health more frequently than control group participants[62]. One in ten (10.5%) clients visited hospital six times or more in the past 12 months.

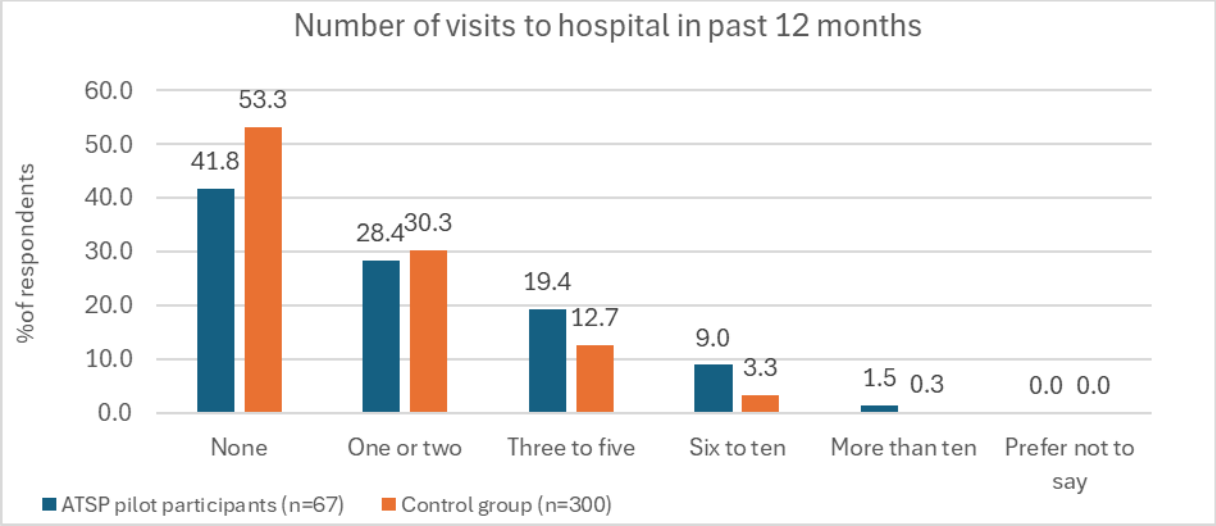


Figure 37, Number of visits to hospital in the past 12 months, about their own health (pre-intervention survey)

6.6.6 Wellbeing and mental health

The survey included six metrics which relate to wellbeing and mental health, whereby participants were asked to indicate their current levels of wellbeing or peer support on a scale from 0 – 10. Notably, the clients reported a high level of peer support for using active modes (the top bar in Figure 38), suggesting the positive views of family members or friends may be one mechanism for reinforcing new active travel behaviours adopted during the pilot. Relative to the control group, the clients reported higher levels of peer support, but lower levels of life satisfaction (Independent samples t-tests)[63]. There were no statistically significant differences in

[62] A Mann-Whitney U test revealed ATSP clients visited hospital about their own health in the past 12 months (mean rank = 208.90) more frequently than the control group participants (mean rank = 178.44), U = 8382, z = -2.324, p = 0.020. The median response for the ATSP clients = One or two, whereas the median response for the control group = None.

[63] Independent samples t-tests revealed:

— ATSP clients report higher levels of agreement that people who are important to them would support them using active ways to travel (8.16 ± 2.19), compared to the control group (6.67 ± 2.26), a statistically significant difference of 1.49 (95% CI, .90 to 2.09), t(365) = 4.939, p = .001

— ATSP clients report higher levels of agreement that there are people they can depend on if they need help (8.03 ± 2.60), compared to the control group (7.15 ± 2.29), a statistically significant difference of .88 (95% CI, .26 to 1.50), t(365) = 2.775, p = .006

— ATSP clients report lower levels of life satisfaction (5.46 ± 2.27), compared to the control group (6.33 ± 2.29), a statistically significant difference of .87 (95% CI, .26 to 1.47), t(365) = 2.811, p = .005

the participants' level of happiness, level of anxiety, or feeling that the things they do in life are worthwhile.

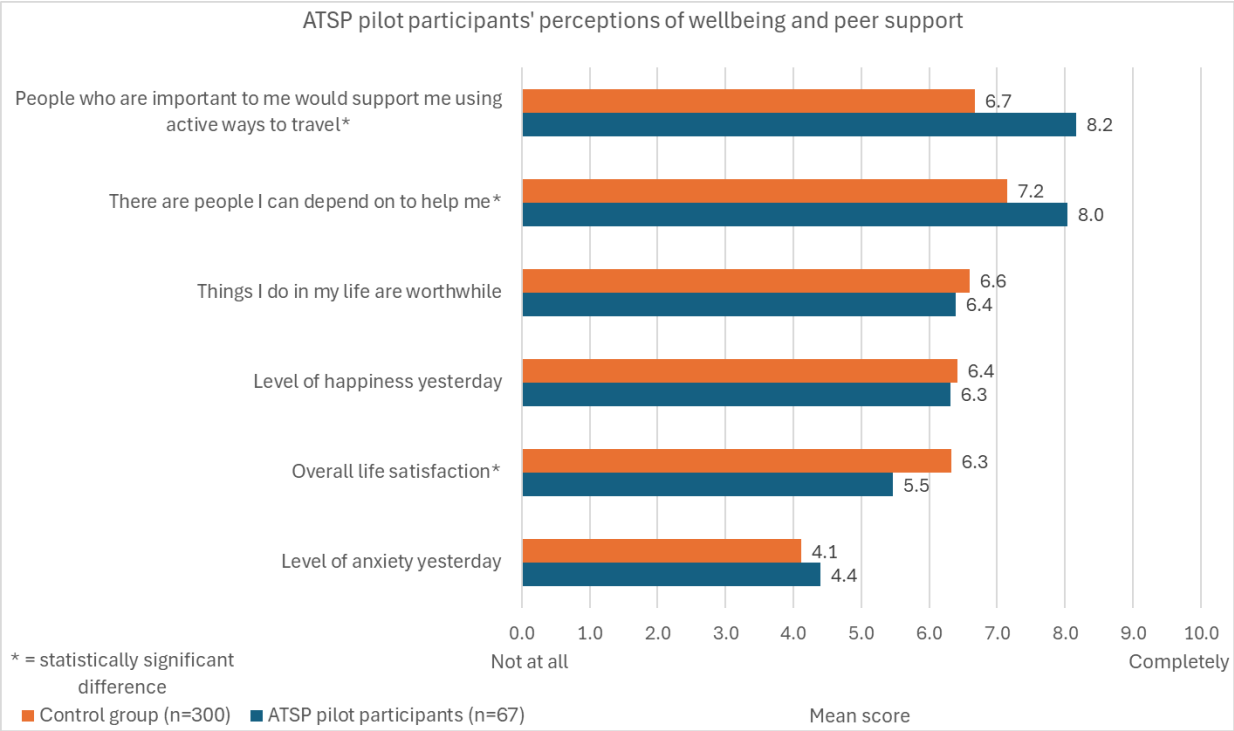
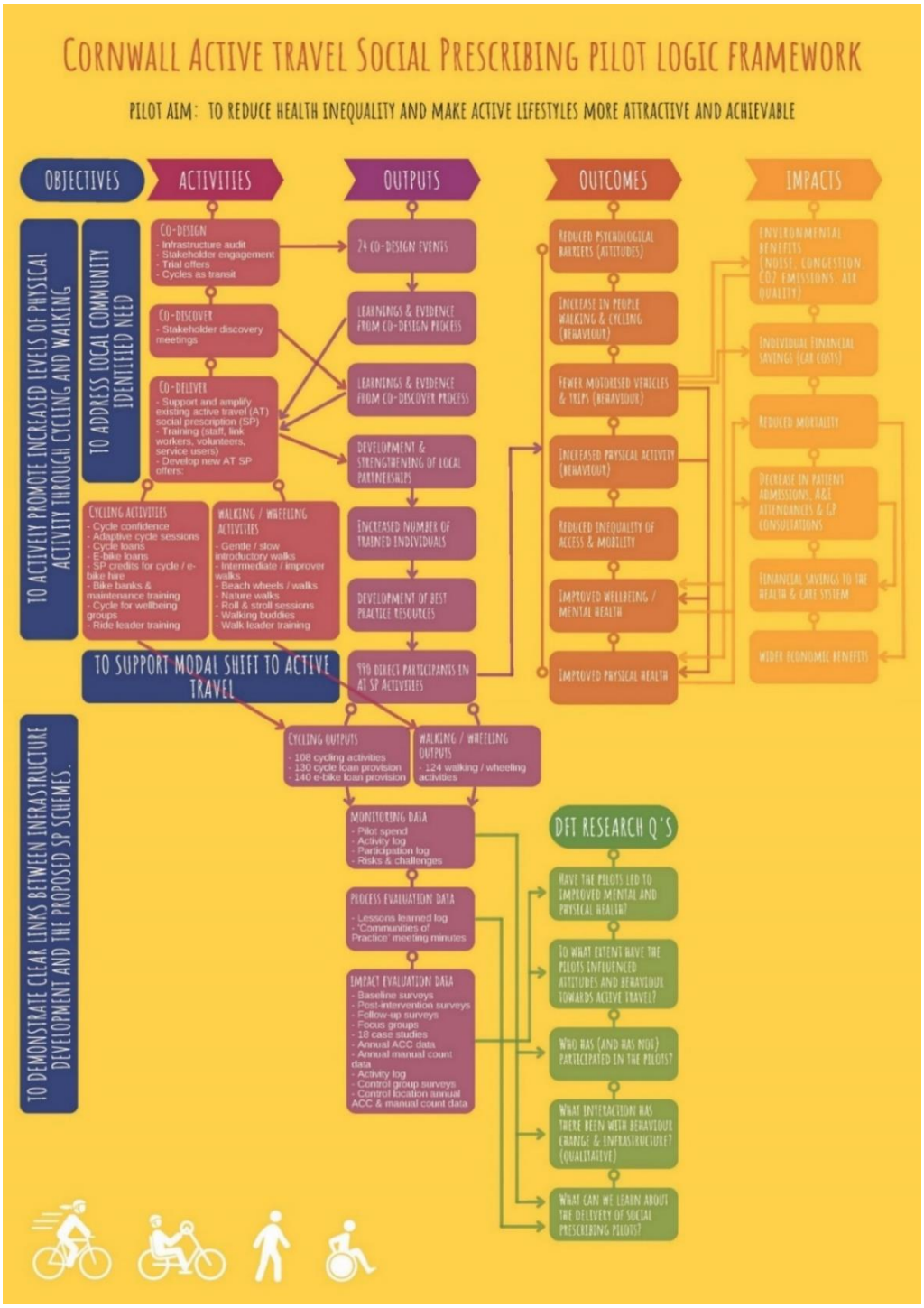


Figure 38, Perceptions of wellbeing and peer support (pre-intervention survey)

6.7 ATSP pilot scope documents and referral routes

This appendix presents the logic framework, a description of the activity providers and the referral routes, the literature review, and the intervention functions using the COM-B model.

6.7.1 Cornwall ATSP pilot logic framework



6.7.2 Description of the active travel projects supported by the ATSP Fund

Prior to the pilot launch in January 2024, the Health Improvement Practitioners conducted asset mapping to understand the current provision of active travel services and infrastructure in the three locations. They contacted activity providers to encourage applications for the ATSP Fund, and connected with local social prescribers and link workers. Thus, the Health Improvement Practitioners played a key role in shaping the pilot by engaging the delivery partners and supporting clients.

In April 2024, grants were awarded to the activity providers through the ATSP Fund; 23 applications were received and 17 were accepted. The funding panel approved applications that demonstrated a clear understanding of the clients' needs, could address locally identified barriers to active travel, and would help the pilot achieve its outputs and outcomes. A total of £371,000 was awarded, and a further £85,400 was leveraged into the pilot from Sports England and in-kind contributions from the activity providers . Tables 68 – 70 present an overview of the activity providers and the activities they offered to clients. See the ATSP pilot delivery report for in-depth case studies of these providers and their work with clients.

Table 68, Cycling-related activities supported by the ATSP Fund

Service provider and area	Description of active travel activity
Cornwall Life Recycle - The Active Cycle (Diwrosa) Connection: "Activating Journeys, Transforming Paths: Learn, Connect, Cycle, Change." Penzance, St Austell & The China Clay Area, Bodmin.	Cornwall Life Recycle provides cycling provision in conjunction with The Bicycle Project. They help people plan routes, run bike confidence sessions and adaptive cycling sessions. They can help you learn to ride and maintain a bike. They provide bike check/basic service to help get your bike on the road.
Ride On E-Bikes - Flexible Term E-Bike and Equipment Loans, and Confidence Training to Facilitate Active Travel. Penzance, St Austell & The China Clay Area, Bodmin.	Ride On E-Bikes has 12 electric bikes to loan to people on flexible terms (from 1 week up to 3 months). They also provide confidence-building sessions to use the bikes. Each bike is fully equipped with bags, baskets, tools, safety equipment, tracking, and a lock. There is a fee of £1/day for an e-bike loan.
British Cycling - Sofa to Saddle Cornwall - Empowering Communities though British Cycling Participation Programmes.	British Cycling supports people to learn to ride a bike. They run a ride leadership programme (training new ride leaders). You can take part in Sofa to Saddle sessions, adaptive cycling and guided rides.

Service provider and area	Description of active travel activity
Penzance, St Austell & The China Clay Area, Bodmin.	
GLL Leisure - B.E.A.T. Project (Better Engagement In Active Travelling). St Austell & The China Clay Area, Bodmin.	GLL Leisure at Bodmin Leisure Centre and St Austell Leisure Centre are running engagement sessions. You can learn more about active travelling and take part in a led ride with Cornwall Life Recycle.
The National Trust/ Bosvena Health - Walks and Cycle Rides at Lanhydrock to Encourage Walking and Cycling for Active Travel. Bodmin.	The National Trust will provide walking and cycling provision around Lanhydrock. They are working closely with the diabetic service and Bosvena Health (GP surgery).

Table 69, Walking/wheeling-related activities supported by the ATSP Fund

Service provider and area	Description of active travel activity
Active Cornwall - Wellbeing Walks Cornwall (to support Active Travel). Penzance, St Austell & The China Clay Area and Bodmin.	Active Cornwall provide free walk leader training with the Ramblers Association. You can learn to become a walk leader.
Wild Wonder and Wisdom - Wellbeing Walk/Talks. St Austell.	Wild Wonder and Wisdom is leading weekly walks that link local transport with leisure facilities and outside spaces. They provide help to buy waterproofs and footwear if required. There is the opportunity to try beginner cycle session through Cornwall Life Recycle and The Bicycle Project.
Into Bodmin - Walking Bus Initiative for Bodmin Community Wellbeing. Bodmin.	Into Bodmin will lead walks from eight outlying neighbourhoods into Bodmin.
Whole Again Communities - Treneere Walk, Penzance.	Whole Again Communities are supporting people in Treneere in Penzance to walk for travel as opposed to taking a taxi or the car. People can take part in one of two 12-week programmes of walking to destinations that people would usually take a car or taxi to.
Walx – Walking sessions Penzance.	Parkwood Leisure in Penzance will run a series of walking sessions using WALX.

Service provider and area	Description of active travel activity
Bosvena Health - Bosvena Health Project to Establish Walk for Wellbeing Groups and Training for Walk Leaders. Bodmin.	Bosvena Health (GP surgery) are leading socially prescribed walks in Bodmin. They will also train walk leaders.
The Eden Project - Routes to Nature Connection. Increasing Awareness about 'Active Travel' to Activities at the Eden Project. St Austell.	The Eden Project is using the local infrastructure (cycle ways and footpaths) to support people to access Eden in an active travel way. They are creating a map of the walking and cycling routes into Eden. They are running a series of events (such as walking buses) and installing signage and benches.
Sustainable PNZ - An Interactive Walking Map of Penzance Supported by Community Workshops & Events. Penzance.	Sustainable PNZ is creating an accessible walking map of the Penzance area. They will co-design the map with the community, run group walks, train volunteers and create an interactive online version of the map.

Table 70, Other active travel-related activities supported by the ATSP Fund

Service provider and area	Description of active travel activity
Mencap - Our Active Community Travel Fund. Supporting People with a Learning Disability to Lead Active Lifestyles. St Austell & The China Clay Area.	Mencap support people with learning disabilities. In this project they will understand the barriers people face when travelling actively. They will create an Active Travel Fund to support people with learning difficulties to access activities in an active travel way.
Volunteer Cornwall - 'Beautiful Day Out' Map to Promote Active Travel in Nature Between Roche and St. Dennis. St Austell & The China Clay Area.	Volunteer Cornwall will create a 'Beautiful Day Out' map. This will promote the ways in which people can travel actively between Roche and St. Dennis.
Curious School of the Wild - Waymaking. Bodmin.	Curious School of the Wild are supporting people to take part in journeys using public transport.
St Petrocs - Unlocking Cornwall: Project to Encourage Public	St Petrocs is supporting people living in supported housing to use public transport. They build up the

Service provider and area	Description of active travel activity
Transport for People Experiencing Homelessness. Penzance, St Austell & The China Clay Area, Bodmin.	confidence of clients to use trains, buses and Beryl Bikes/cycle hires.

6.7.3 ATSP pilot referral routes

Referral model

Referrals from GPs and social prescribers were initially low and it became evident early in the pilot that referrals would not meet the pilot logic framework targets in terms of the number of clients taking part in active travel activities. To address this, the ATSP pilot delivery team made two changes to the referral process, while retaining the eligibility criteria:

1. Referral routes were extended to include Allied Health Professionals, internal referrals from Healthy Cornwall (the health programme delivery branch of Cornwall Council), and employment workers.
2. Activity providers could also recruit clients and refer them to the local Health Improvement Practitioner for one-to-one support. This is called 'reverse social prescribing'.

In line with recent guidance from the Social Prescribing Network[64], these partners can be considered part of a wider social prescribing 'ecosystem'. Expanding the number of referral routes increased the potential for reaching more clients and may be particularly important for supporting clients in areas where social prescribing networks are less developed. 'Reverse social prescribing' is a term used by the research team at Sheffield Hallam University[65] to describe how the Health Improvement Practitioners could receive referrals from the activity providers, in addition to the Health Improvement Practitioners referring clients to the providers. These activity providers are embedded in their local communities and so could identify individuals who they feel they would benefit from one-to-one support from a Health Improvement Practitioner. The Health Improvement Practitioner ultimately decided if the client was eligible for the support programme, but this change increased the reach of the pilot and ensured more clients benefitted from the Health Improvement Practitioner intervention.

Number of referrals to the Health Improvement Practitioners

The Health Improvement Practitioner intervention was trialled by Cornwall Council and so there was no stipulated target from Active Travel England for the number of referrals[66]. The total

[64] The Social Prescribing Network is a UK-based hub which provides an independent, holistic, objective, grassroots voice to drive innovations and best practice of social prescribing in the UK and internationally. See: https://www.socialprescribingnetwork.com/

[65] Researchers at Sheffield Hallam University conducted the national evaluation of the ATSP pilots, on behalf of Active Travel England.

[66] The number of referrals to the Health Improvement Practitioners differs from the number of people supported by the activity providers to engage in active travel activities. Activity providers could directly recruit people within their local communities and so the overall number of people supported to engage in active travel (n≤1992) is much larger than the number of Health Improvement Practitioner referrals (n=105).

number of clients referred to the Health Improvement Practitioners was 105; 29 were referred by a social prescriber or link worker, 48 by Allied Health Professionals, 27 by Healthy Cornwall, and one by an employment worker. Eight referrals were assessed to be inappropriate for the pilot. In terms of the three case areas, 43 clients were referred in Bodmin, 37 in St Austell and the China Clay Area, and 25 in Penzance. Figure 39 shows the referral routes for the clients taking part in the evaluation study.

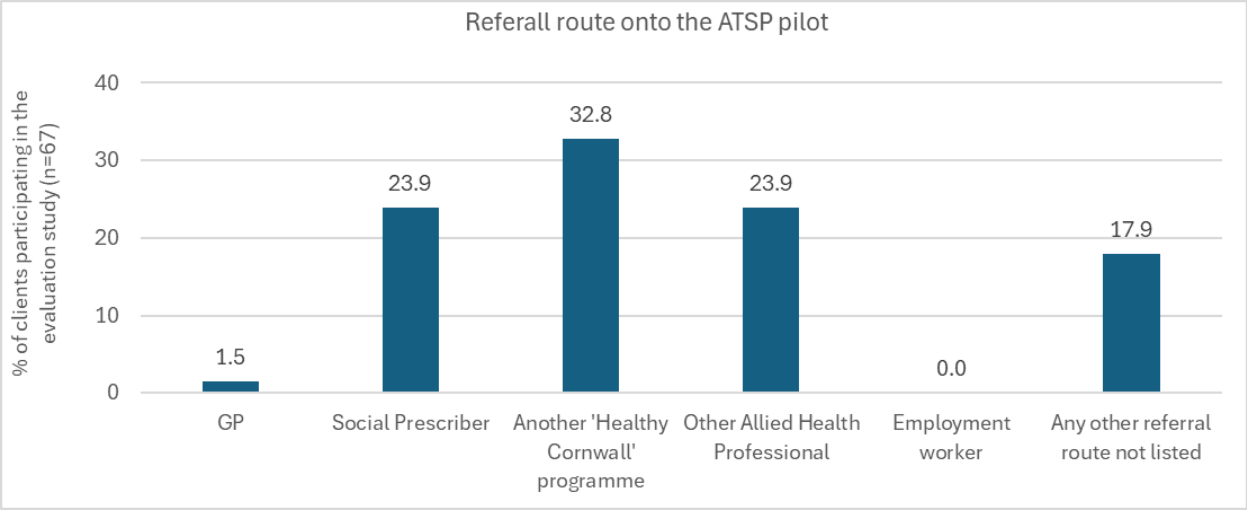


Figure 39, Referral routes onto the ATSP pilot - evaluation study participants (pre-intervention survey)

Table 71 provides further detail on three of the referral routes presented in Figure 39; these are the additional routes following the initial low referrals from a GP or social prescriber.

Table 71, Referral routes onto the ATSP pilot – evaluation study participants (pre-intervention survey)

Referral routes	Frequency	Valid %
Another 'Healthy Cornwall' programme		
Swim and weigh	6	9.0
Active travel	5	6.5
St Austell	2	3.0
Ali Badcock smoking cessation and weaning programs	1	1.5
Cornwall Bike project	1	1.5
Cycle maintenance at Claytwac	1	1.5
Anonymised, ClayTawc, St Dennis	1	1.5
Drop at Chy Trevail	1	1.5

Referral routes	Frequency	Valid %
HIP ATSP	1	1.5
Interest via Diabetic group	1	1.5
Trelya	1	1.5
Wellbeing and Public Health	1	1.5
Health Cornwall total:	22	32
Other Allied Health Professional		
Diabetic service	5	7.5
HIP	3	4.5
OT support worker	2	3.0
Cornwall Life Recycle	1	1.5
Gul project	1	1.5
Mental Health Wellbeing practitioner	1	1.5
Mental health worker GP practice	1	1.5
Support Worker at MIND	1	1.5
Tutor	1	1.5
Allied Health Professional total:	16	24
Any other referral route not listed above		
Self-referral from Diabetic group	2	3.0
ATSP Funded project	1	1.5
ATSP HIP	1	1.5
ATSP HIP via mother engagement	1	1.5
Diabetic event Bodmin Dragon centre - 11/7/24 self-referral route	1	1.5
Employer liaison with Healthy Cornwall, *(HIP 2 - anonymised)*	1	1.5
HIP ATSP via diabetic event	1	1.5
My partner	1	1.5
Programme facilitator	1	1.5
Anonymised from Ride On E-bikes	1	1.5
Walks facilitator	1	1.5
Other referral route total:	12	18

6.7.4 Literature review

A literature review informed the approach and design of the Cornwall ATSP intervention by considering the barriers and enablers of active travel, as well as important factors which can influence behaviour change such as capability or motivation. Previous research has tended to focus on cycling, as opposed to walking and wheeling. A recent systematic review found the main barriers to cycling were infrastructure- and safety-related, particularly a concern about sharing the road with vehicles[67]. Further research identified the important role of motivation and social support for cycling[68], which in some cases can moderate the impact of barriers such as inclement weather or a lack of infrastructure[69].

Two well-established behaviour change frameworks are the COM-B model[70] and the Theoretical Domains Framework[71]. The COM-B model understands human behaviour to be influenced by physical and psychological *capability*, physical and social *opportunity*, and automatic (emotional) and reflective (rationale) *motivation* (Figure 1). The Theoretical Domains Framework identifies key mechanisms that drive behaviour change, such as enablement, incentivisation and modelling. The COM-B model has been used to understand the effectiveness of active travel interventions. One study considered the effects of allocating more street space for active modes and found *opportunity* and *motivation* factors were reflected in the barriers (accessibility and integration of the schemes, controversy) as well as the enablers (new routes, perceived health or sustainability benefits)[72]. Another study examined the propensity of UK school children and their

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[67] Pearson, L., Berkovic, D., Reeder, S., Gabbe, B., and Beck, B. (2023). Adults' self-reported barriers and enablers to riding a bike for transport: a systematic review. *Transport Review, 43*(3), 356-384. https://doi.org/10.1080/01441647.2022.2113570

[68] Benson, J., and Scriven, A. (2012). Psychological, social and environmental barriers to cycling to school. *International Journal of Health Promotion and Education, 50*(1), 34-44. https://doi.org/10.1080/14635240.2012.661956
Also see: Ross, A., and Wilson, K. (2021). The power of the neighborhood: Perceived normative behaviors moderate individual predictors of walking and biking to school. *Journal of Transport & Health, 22*(1). https://doi.org/10.1016/j.jth.2021.101236

[69] Bjørnarå, H., B., Westergren, T., Fegran, L., te Velde, S., J., Fyhri, A., Deforche, B., Andersen, L., B., Berntsen, S., and Bere, E. (2020). Cumbersome but desirable - Breaking the code of everyday cycling. *PLoS One,15*(9): e0239127. https://doi.org/10.1371/journal.pone.0239127
Also see: Fitch, D., T., Rhemtulla, M., and Handy, S., L. (2019). The relation of the road environment and bicycling attitudes to usual travel mode to school in teenagers. *Transportation Research Part A: Policy and Practice, 123*(1), 35-53. https://doi.org/10.1016/j.tra.2018.06.013

[70] Michie, S., van Stralen, M., M., and West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implement Science, 6*(42). https://doi.org/10.1186/1748-5908-6-42

[71] Michie, S., Johnston, M., Abraham, C., Lawton, R., Parker, D., Walker, A., et al. (2005). Making psychological theory useful for implementing evidence based practice: a consensus approach. *Qual Saf Health Care,*14(1): 26–33.

[72] Lunetto, M., Castro, O., Gericke, C., and Hale, J. (2023). Barriers and enablers to local active travel during COVID-19: A case study of Streetspace interventions in two London boroughs. *Wellcome Open Research, 8*(177). https://doi.org/10.12688/wellcomeopenres.19164.1

parents to cycle and similarly found *motivation* and *opportunity* to be key determinants of behaviour[73].

Although these studies provide useful insights into which dimensions of the COM-B model most influence active travel behaviour, it is important to acknowledge the specific target groups and the rural context of the Cornwall ATSP pilot. The physical and psychological *capabilities* of the clients may be as important as their *motivation* or *opportunity* to engage in active travel.

[73] Bishop, D. T., Batley, B., Waheed, H., Dkaidek, T., S., Atanasova, G., and Broadbent, D., P. (2024). Barriers and enablers for cycling: A COM-B survey study of UK schoolchildren and their parents. *Journal of Transport & Health, 35*. https://doi.org/10.1016/j.jth.2024.101765

6.7.5 COM-B dimensions and intervention functions of active travel activities

Table 72 is a categorisation of the pilot activity functions, according to the COM-B model and the Theoretical Domains Framework.

Table 72, Categorisation of the ATSP pilot activity functions, according to the COM-B model

Project name	COM-B dimension[74]	Function 1 (see key below)	Function 2 (see key below)
Cornwall Life Recycle - The Active Cycle (Diwrosa) Connection	Motivation	Training	
Ride on E-Bikes	Opportunity	Incentives	Training
Sofa to Saddle	Opportunity	Education	Environmental restructuring
Active Cornwall (support to AT)	Capability	Environmental restructuring	Environmental restructuring
St Petrocs	Capability	Environmental restructuring	Training
Wellbeing walks/Talk	Capability	Environmental restructuring	
Interactive walking Map PNZ	Capability	Environmental restructuring	Training
Into Bodmin Walking Bus	Capability	Environmental restructuring	
BEAT	Opportunity	Education	
Mencap - access to AT	Capability	Environmental restructuring	
Treneere Walk - PNZ	Opportunity	Education	Environmental restructuring
Lanhydrock walking and cycling	Opportunity	Education	Environmental restructuring
Beautiful Day Out	Opportunity	Education	
Bosvena Health	Capability	Environmental restructuring	Modelling

[74] Michie, S., van Stralen, M. and West, R., 2011. The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science* 2011, 6(42), http://www.implementationscience.com/content/6/1/42

Waymaking Bodmin	Opportunity	Persuasion	
Eden Nature Connects	Opportunity	Education	Environmental restructuring

Theoretical Domains Framework[75] – key:

Function label	Function objective
Education	Increasing knowledge or understanding
Persuasion	Using communication to induce positive or negative feelings or stimulate action
Incentives	Creating an expectation of reward
Coercion	Creating an expectation of punishment or cost
Training	Imparting skills
Restriction	Using rules to reduce the opportunity to engage in the target behaviour (or to increase the target behaviour by reducing the opportunity to engage in competing behaviours)
Environmental restructuring	Changing the physical or social context where the behaviour occurs
Modelling	Providing an example for people to aspire to or imitate
Enablement	Increasing means/reducing barriers to increase capability (beyond education and training) or opportunity (beyond environmental restructuring)

[75] Michie, S., Johnston, M., Abraham, C., Lawton, R., Parker, D., Walker, A., et al. (2005). Making psychological theory useful for implementing evidence based practice: a consensus approach. *Qual Saf Health Care,*14(1): 26–33.

6.8 Data collection protocols

This appendix is the data collection protocols that were used for the evaluation study.

6.8.1 Pre-intervention survey protocol – ATSP pilot clients and the control group

Overview of survey structure

Block number	Block theme
1	Participant Information Sheet ; Consent Form ; Referral route
2	Travel behaviour
3	Active travel
4	Physical activity
5	Health status
6	Wellbeing
7	Sociodemographics
8	Debrief and interview opt-in

Note:

Questions in black text are duplicated from the Active Travel England IPSOS guidance document

Questions in red text are new questions we have added

Blue text [in box brackets] indicates display logic or validation requirements (i.e. how the survey functions)

Cornwall Council's Active Travel Social Prescribing pilot - Survey 1

Block 1 - PIS ; Consent form ; Referral route

Participant information sheet

Information for participants

What is this study about?

We are researchers at the University of Bath working with Cornwall Council to evaluate the Council's Active Travel Social Prescribing pilot (ATSP pilot). This evaluation is to understand how successful the ATSP pilot is for encouraging active ways to travel (i.e. walking, cycling, or wheeling) and for improving the health of people taking part in the pilot.

What does it involve?

The evaluation study will involve two surveys. Each survey will take about 15 minutes and will be conducted by phone or an online video call with your Health Improvement Practitioner. We will ask you to:

1. Complete the first survey before you start the support programme with your Health Improvement Practitioner.
2. Complete the second survey in 6 months' time, after you have finished the support programme with your Health Improvement Practitioner.

You will be asked questions about your travel behaviour, your health and wellbeing, your physical activity, and what you think about active ways to travel.

At the end of the first survey, we will ask whether you would be interested in participating in a one-to-one interview about your experience of the ATSP pilot (at a later date).

Who can take part?

Anyone (aged 18+) who is taking part in Cornwall Council's ATSP pilot.

What are the benefits and risks of taking part?

The information you provide will be very useful for the research team and Cornwall Council to understand the views of people taking part in the ATSP pilot. There is a minor risk of experiencing psychological discomfort when answering some questions about your wellbeing.

This research has been reviewed and approved by the University of Bath Biomedical Sciences Research Ethics Committee. The REC reference number is: 0996-1586

Do I have to take part?

Taking part in this evaluation study is entirely voluntary. You are free to withdraw at any time until you have completed the second survey. You can withdraw by telling your Health Improvement Practitioner that you wish to withdraw. You do not have to answer any questions that you do not want to. You can still take part in the ATSP pilot, even if you do not want to take part in the evaluation study.

We will ask for your name – this is to match your responses for the two surveys. Your name will be permanently deleted within 14 days of completing the second survey. Your data would then be anonymous and cannot be traced back to you, and so we would be unable to identify and remove your data. You can ask for your data to be removed from the study at any time prior to this by telling your Health Improvement Practitioner or by contacting the research team at the University of Bath (see contact details below).

What happens to all the information?

The Health Improvement Practitioner will enter your responses directly into the University of Bath online survey – the Health Improvement Practitioner will not keep any of your survey data. All the information you provide is confidential and will be stored on a secure drive at the University of Bath (password-protected). The University of Bath privacy notice can be found **here**. Any incomplete surveys (i.e. because you withdrew from the study) will be removed from the data and permanently deleted.

The research team at the University of Bath will anonymise your data, so you cannot be identified in any reports or data sets. They will share this anonymised data with the Wellbeing and Public Health team at Cornwall Council. They will also share this anonymised data with Active Travel England and researchers at Sheffield Hallam University (who are analysing the data for Active Travel England). This research is funded by Active Travel England.

What do I do if I have any questions?

Please contact the research team at the University of Bath for further information: Mark Wilson (mw2640@bath.ac.uk) or Lorraine Whitmarsh (lw2253@bath.ac.uk).

Or if you have any concerns about this study, please contact the University of Bath Research Governance and Compliance Team: (research-ethics@bath.ac.uk; University of Bath, Claverton Down, Bath, BA2 7AY). The REC reference number is: 0996-1586

Your Health Improvement Practitioner will send you a copy of this information sheet.

How can I take part?
Please click 'NEXT' below

Consent Form
Your Health Improvement Practitioner will read 10 statements to you. Please then indicate to your Health Improvement Practitioner that you have understood these statements before deciding whether you wish to take part:

1. I understand the nature and purpose of the procedures involved in this evaluation study. These have been communicated to me on the information sheet on the previous page. My Health Improvement Practitioner will send me a copy of the information sheet.

2. I understand that my participation in this study is entirely voluntary. I can withdraw from the study by telling the Health Improvement Practitioner that I wish to withdraw. Once I complete the second survey, my data will be anonymised and can no longer be withdrawn from the study. I can withdraw my data at any time before then by contacting my Health Improvement Practitioner or the research team (see contact details below).

3. I understand that I will be asked to provide my name – this is to match my responses for the two surveys. My name will be permanently deleted within 14 days of completing the second survey. My survey responses will be submitted directly to the researchers; my Health Improvement Practitioner will not store any of my responses.

4. I understand that I can still take part in the ATSP pilot, even if I do not want to take part in the evaluation study.

5. I understand that I do not have to answer any questions that I do not want to.

6. I understand that this study will be used by Cornwall Council to inform policy and service

delivery.

7. I understand that my anonymised data will be shared with Cornwall Council, Active Travel England, and researchers at Sheffield Hallam University. I will not be identifiable in any reports or data shared with these organisations.

8. I understand that the University of Bath may use the data collected for this project in a future research project but that the conditions on this form under which I have provided the data will still apply.

9. I understand that personal data will be processed in accordance with current UK data protection legislation. The University of Bath privacy notice can be found **here**.

10. I understand that I am free to discuss any concerns I may have with the research team: Mark Wilson (mw2640@bath.ac.uk) or Lorraine Whitmarsh (lw2253@bath.ac.uk).

If they are unable to resolve your concern or you wish to make a complaint, please contact the University of Bath Research Governance and Compliance Team (research-ethics@bath.ac.uk). The REC reference number is: 0996-1586

1.1) I understand these statements and I provide my verbal consent to take part in the evaluation study: [Response is compulsory]

- I **CONSENT** to take part in the study [Survey continues]
- I **DO NOT CONSENT** to take part in the study [Survey terminates]

_____

To move through the survey:

Click 'NEXT' to move onto the next question,
or click the 'UP' arrow to return to the previous question.

1.2) What is your first name and surname? [Response is compulsory]

_____

_____

1.3) What date were you referred to the Active Travel Social Prescribing pilot? [Response is compulsory]

Day ▪ Month ▪ Year ▪

_____

1.4) Who were you referred by? [Response is compulsory]

- My GP
- A social prescriber
- Another 'Healthy Cornwall' programme (Please indicate which Healthy Cornwall Programme: _____)
- Other Allied Health Professional (Please indicate which Allied Health Professional: _____)
- An employment worker (Please indicate which employment department: _____)
- Any other referral route not listed above (Please indicate which other referral route: _____)

_____

1.5) Who is your Health Improvement Practitioner? [Response is compulsory]

- HIP 1 *(anonymised)*
- HIP 2 *(anonymised)*
- HIP 3 *(anonymised)*
- Someone else (Please specify: _____)

_____

Block 2 - Travel behaviour

The following questions are about how you travel for everyday activities, like going to the shops, visiting friends, commuting to work etc.

_____

2.1) How frequently do you travel by **private car**?

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never

_____

2.2) How frequently do you travel by **taxi or private hire rental**?

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never

_____

2.3) How frequently do you travel by **bus / coach**?

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never

2.4) How frequently do you travel by **train / tram**?

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never

2.5) How frequently do you travel using a **bicycle / adapted bicycle / tricycle / e-cycle**?

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never

2.6) In total, how many journeys did you make **last week** using the following travel modes:

(i.e., the **total number of journeys** for the entire week, for each travel mode. Travelling there and back would count as two journeys)

- walking or wheeling (i.e., using a wheelchair)
- bicycle / adapted bicycle / tricycle / e-cycle
- car (as a driver or passenger)

2.7) In total, approximately how far did you travel **last week** using the following travel modes:

(i.e., the **combined distance** travelled for **ALL** of your journeys last week, for each travel mode. Please move the slider into the correct position)

- walking or wheeling (i.e., using a wheelchair)
- bicycle / adapted bicycle / tricycle / e-cycle
- car (as a driver or passenger)

2.8) Does your household **own** a car or van?

- Yes
- No

Block 3 - Active travel

The next few questions are about your views on active ways to travel (e.g. walking, cycling, or wheeling).

First, thinking about walking or wheeling (i.e., using a wheelchair)…

3.1) Before today, how much, if anything, would you say you knew about **walking / wheeling routes** in your local area?

- A great deal
- A fair amount
- Just a little
- Heard of them, know nothing about them
- Never heard of them
- Don't know
- Not applicable

3.2) In general, how **confident**, if at all, would you say you are when walking / wheeling in your local area?

- Very confident
- Fairly confident
- Not very confident
- Not at all confident
- Don't know
- Not applicable

_____

3.3) How **safe** do you feel walking / wheeling in your local area?

- Very safe
- Fairly safe
- Not very safe
- Not at all safe
- Don't know
- Not applicable

_____

3.4) To what extent is your **attitude** towards walking / wheeling, as a form of transport, **favourable or unfavourable**?

- Very favourable
- Fairly favourable
- Neither favourable nor unfavourable
- Fairly unfavourable
- Very unfavourable
- Don't know
- Not applicable

_____

Now thinking about cycling. This includes adapted cycling and e-cycling (i.e., using e-bikes), as well as conventional bicycles...

_____

3.5) What would you say your level of cycling / adapted cycling / e-cycling **ability** currently is (i.e. the ability to cycle on the highway)?

- Very able
- Mostly able
- Not very able
- Not at all able
- Don't know
- Not applicable

_____

3.6) Before today, how much, if anything, would you say you knew about **cycling infrastructure**, for example cycle lanes, cycle routes, cycle storage, cycle hire, adapted cycling, e-cycling, in your local area?

- A great deal
- A fair amount
- Just a little
- Heard of them, know nothing about them
- Never heard of them
- Don't know
- Not applicable

_____

3.7) In general, how **confident**, if at all, would you say you are when cycling / e-cycling on roads in your local area?

- Very confident
- Fairly confident
- Not very confident
- Not at all confident
- Don't know
- Not applicable

3.8) How **safe** do you feel cycling / e-cycling on roads in your local area?

- Very safe
- Fairly safe
- Not very safe
- Not at all safe
- Don't know
- Not applicable

3.9) To what extent is your **attitude** towards cycling / adapted cycling / tricycling / e-cycling, as a form of transport, **favourable or unfavourable**?

- Very favourable
- Fairly favourable
- Neither favourable nor unfavourable
- Fairly unfavourable
- Very unfavourable
- Don't know
- Not applicable

3.10) Please tell us about your current bicycle ownership.

Please select all that apply:

- I own a conventional bike or an adapted bike
- I own an e-bike (i.e. an electric bike)

- I own a bike but it is in disrepair
- I do not own a bike
- Not applicable

Block 4 - Physical activity

You're doing great! These questions are about exercise or physical activity that you do.

4.1) In the past four weeks, have you done a **continuous walk / wheel** that lasted at least **10 minutes**?

- Yes
- No

4.2) How **frequently** have you done a continuous walk / wheel that lasted at least 10 minutes?
[Display logic: Q4.2 presented if Q4.1 = Yes]

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never
- Not applicable

4.3) Which other **activities** have you done in the last four weeks?
Please select all that apply:

- Swimming
- Cycling
- Workout at a gym / Exercise bike / Weight training

- Aerobics / Keep fit / Gymnastics / Dance for fitness
- Running / Jogging
- Football / Rugby
- Badminton / Tennis / Squash
- Exercises (e.g. press-up, sit-ups)
- Other activity (Please specify which activity/activities: _____)
- I have not done any of these activities

4.4) How **frequently** have you undertaken these activities?

[Display logic: the activities presented in Q4.4 are routed from the options selected in Q4.3]

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never

Block 5 - Health status

The next few questions are about your health.

5.1) Do you have any **physical or mental health conditions or illnesses** lasting, or expected to last, 12 months or more?

- Yes
- No
- Prefer not to say

5.2) Does your condition or illness / do any of your conditions or illnesses **reduce your ability** to carry out day-to-day activities?

[Display logic: Q5.2 presented if Q5.1 = Yes]

- Yes, a lot
- Yes, a little
- Not at all
- Prefer not to say

5.3) How is your **health** in general?

- Very good
- Good
- Fair
- Bad
- Very bad
- Don't know
- Prefer not to say

5.4) Please rate your current level of **pain**:

- No pain at all
- Mild pain
- Moderate pain
- Severe pain
- Very severe pain
- Worst pain imaginable

5.5) What is / are the **cause(s)** of the pain you are currently experiencing?

Please select all that apply:

[Display logic: Q5.5 presented if Q5.4 does NOT EQUAL 'No pain at all']

- A short-term illness
- A recent physical injury
- A long-term health condition

- Physical disability
- Ageing related pain
- Occupational related pain
- Other_____

_____

5.6) Please rate your current **energy levels**:

- No difficulty with my energy levels
- Slight difficulty with my energy levels
- Moderate difficulty with my energy levels
- Significant difficulty with my energy levels
- Severe difficulty with my energy levels
- Very severe difficulty with my energy levels

_____

5.7) In the last 12 months, approximately how many times have you talked to or visited a **GP / family doctor** about your **own health**?

- None
- One or two
- Three to five
- Six to ten
- More than ten
- Prefer not to say

_____

5.8) In the last 12 months, approximately how many times have you visited **hospital** about your **own health**?

- None
- One or two
- Three to five
- Six to ten
- More than ten
- Prefer not to say

Block 6 - Wellbeing

You're almost finished! These questions are about your wellbeing.

6.1) Overall, how **satisfied** are you with your life nowadays?
On a scale from 0-10. Please move the slider into the correct position.

6.2) Overall, to what extent do you feel that the things you do in your life are **worthwhile**?
On a scale from 0-10. Please move the slider into the correct position.

6.3) Overall, how **happy** did you feel **yesterday**?
On a scale from 0-10. Please move the slider into the correct position.

6.4) Overall, how **anxious** did you feel **yesterday**?
On a scale from 0-10. Please move the slider into the correct position.

6.5) People who are important to me would support me using active ways to travel.

On a scale from 0-10, **please rate how much you agree with this statement** - by moving the slider into the correct position.

_____

6.6) There are people I can depend on to help me if I really need it.

On a scale from 0-10, **please rate how much you agree with this statement** - by moving the slider into the correct position.

_____

Block 7 - Sociodemographics

Finally, we would like to know a bit more about you.

7.1) What best describes the area where you live?

- Countryside or small village
- Large village or small town
- Suburbs of large town or city
- Centre of large town or city

_____

7.2) What is your partial postcode?

This is your postcode without the final two letters (e.g. PL31 2)

_____

7.3) Which age group do you fall into?

- 18 – 24
- 25 – 34
- 35 – 44
- 45 – 54
- 55 – 64
- 65+
- Prefer not to say

_____

7.4) Are you:

- Male
- Female
- Prefer to self-describe as (e.g. non-binary, gender-fluid, agender) (If you wish, please specify:_____)
- Prefer not to say

_____

7.5) Which of the following best describes your sexual orientation?

- Straight or Heterosexual
- Gay or Lesbian
- Bisexual
- Other sexual orientation (If you wish, please specify:_____)
- Prefer not to say

_____

7.6) How would you describe your ethnic group?

Choose one option that best describes your ethnic group or background:

- White (English / Welsh / Scottish / Northern Irish / Cornish / British; Irish; Gypsy or Irish traveller)
- Any other White background (please specify:_____)
- Mixed / Multiple ethnic groups (White and Black Caribbean; White and Black African; White and Asian)
- Any other Mixed / Multiple ethnic background (please specify:_____)
- Asian / Asian British (Indian; Pakistani; Bangladeshi; Chinese)
- Any other Asian background (please specify:_____)
- Black / African / Caribbean / Black British (African; Caribbean)
- Any other Black / African / Caribbean background (please specify:_____)
- Other ethnic group (Arab)
- Any other ethnic group (please specify:_____)
- Prefer not to say

_____

7.7) Do you have children (aged under 18) living at home?

We ask this question to understand whether family responsibilities may affect your travel choices.

- Yes
- No
- Prefer not to say

7.8) What is the highest level of education you have achieved so far?

- No formal qualifications
- GCSE or O-level
- A-level
- Undergraduate degree (e.g. Bachelor's)
- Postgraduate degree (e.g. Master's, PhD)
- Vocational qualification
- Other
- Prefer not to say

7.9) Please indicate your current employment status:

- Full-time student
- Full time paid employment
- Part time paid employment
- Full time self-employment
- Part time self-employment
- Unemployed
- Retired
- Looking after the home or family
- Temporarily sick or disabled
- Long term sickness or disability
- Other
- Prefer not to say

7.10) Please indicate the approximate **combined income** of your **household** (per year, before tax deductions):

- Less than £6,000
- £6,000 - £12,999
- £13,000 - £18,999
- £19,000 - £25,999
- £26,000 - £31,999
- £32,000 - £47,999
- £48,000 - £63,999
- £64,000 - £95,999
- More than £96,000
- Prefer not to say

_____

Block 8 - Debrief and interview opt-in

8.1) Do you have any comments about the survey, or anything to add about the topics you were asked about:

_____

Thank you for completing this survey!

We will ask you to complete another survey in 6 months' time. This follow up survey will measure whether taking part in the ATSP pilot has enabled you to change how you travel, or improve your health.

Please click 'NEXT'

_____

If answering any of the questions in this survey has caused you to experience distress, please be aware there are a number of support services available. This includes your GP, and two charities: **Mind** and **Samaritans.**

_____

8.2) Would you be interested in taking part in a one-to-one interview about your experience of the ATSP pilot at a later date? [Response is compulsory]

This interview will be with someone from the Council's ATSP team. Your participation is entirely optional.

- Yes
- No

Debrief

Further information

This study is a collaboration between Cornwall Council and researchers at the University of Bath. The aim of the study is to evaluate the Council's Active Travel Social Prescribing pilot (ATSP pilot). Your responses to the survey questions will be used to understand how successful the ATSP pilot is in encouraging active ways to travel (i.e. walking, cycling, or wheeling) and improving health.

This information will be used by the Wellbeing and Public Health team at Cornwall Council to improve their service. This research is funded by Active Travel England.

If you have any questions about the evaluation study, please contact the research team: Mark Wilson (mw2640@bath.ac.uk) or Lorraine Whitmarsh (lw2253@bath.ac.uk).

If you have concerns about your participation in this study or you wish to make a complaint, please contact the University of Bath Research Governance and Compliance Team (research-ethics@bath.ac.uk). The REC reference number is: 0996-1586

Privacy Notice: Your data will be used only for the purposes set out in the information sheet and consent form. Your consent is conditional upon the University complying with its duties and obligations under current UK data protection legislation. The University of Bath privacy notice can be found **here**.

Your Health Improvement Practitioner will send you a copy of the information sheet.

Please click **'DONE'** to submit your responses.

6.8.2 Post-intervention survey protocol – ATSP pilot clients

Overview of survey structure

Block number	Block theme
1	Participant Information Sheet ; Consent Form (repeated)
2	Travel behaviour
3	Active travel
4	Physical activity
5	Health status
6	Wellbeing
9	Activity participation
9A	Bodmin activities
9B	St Austell activities
9C	Penzance activities
10	Evaluation of ATSP
11	Impacts on travel behaviours
8	Debrief

Note:

Questions in black text are duplicated from the Active Travel England IPSOS guidance document

Questions in red text are new questions we added in Survey 1

Blue text [in box brackets] indicates display logic or validation requirements (i.e., how the survey functions)

Blocks 9 – 11 are new questions we added in Survey 2

Block 7 – Sociodemographic characteristic questions are not repeated in Survey 2

Cornwall Council's Active Travel Social Prescribing pilot - Survey 2

Block 1 - PIS ; Consent form
Participant information sheet

Information for participants

This information sheet is identical to the information sheet for Survey 1 - if you wish, please review this information again.

What is this study about?
We are researchers at the University of Bath working with Cornwall Council to evaluate the Council's Active Travel Social Prescribing pilot (ATSP pilot). This evaluation is to understand how successful the ATSP pilot is for encouraging active ways to travel (i.e. walking, cycling, or wheeling) and for improving the health of people taking part in the pilot.

What does it involve?
The evaluation study will involve two surveys. Each survey will take about 15 minutes and will be conducted by phone or an online video call with your Health Improvement Practitioner. We will ask you to:

1. Complete the first survey before you start the support programme with your Health Improvement Practitioner. **You have already completed Survey 1 - thank you!**
2. Complete the second survey in 6 months' time, after you have finished the support programme with your Health Improvement Practitioner. **This is Survey 2.**

You will be asked questions about your travel behaviour, your health and wellbeing, your physical activity, and what you think about active ways to travel.

Who can take part?
Anyone (aged 18+) who is taking part in Cornwall Council's ATSP pilot.

What are the benefits and risks of taking part?
The information you provide will be very useful for the research team and Cornwall Council to understand the views of people taking part in the ATSP pilot. There is a minor risk of experiencing psychological discomfort when answering some questions about your wellbeing.

This research has been reviewed and approved by the University of Bath Biomedical Sciences Research Ethics Committee. The REC reference number is: 0996-1586

Do I have to take part?

Taking part in this evaluation study is entirely voluntary. You are free to withdraw at any time until you have completed the second survey. You can withdraw by telling your Health Improvement Practitioner that you wish to withdraw. You do not have to answer any questions that you do not want to. You can still take part in the ATSP pilot, even if you do not want to take part in the evaluation study.

We will ask for your name – this is to match your responses for the two surveys. Your name will be permanently deleted within 14 days of completing the second survey. Your data would then be anonymous and cannot be traced back to you, and so we would be unable to identify and remove your data. You can ask for your data to be removed from the study at any time prior to this by telling your Health Improvement Practitioner or by contacting the research team at the University of Bath (see contact details below).

What happens to all the information?

The Health Improvement Practitioner will enter your responses directly into the University of Bath online survey – the Health Improvement Practitioner will not keep any of your survey data. All the information you provide is confidential and will be stored on a secure drive at the University of Bath (password-protected). The University of Bath privacy notice can be found **here**. Any incomplete surveys (i.e. because you withdrew from the study) will be removed from the data and permanently deleted.

The research team at the University of Bath will anonymise your data, so you cannot be identified in any reports or data sets. They will share this anonymised data with the Wellbeing and Public Health team at Cornwall Council. They will also share this anonymised data with Active Travel England and researchers at Sheffield Hallam University (who are analysing the data for Active Travel England). This research is funded by Active Travel England.

What do I do if I have any questions?

Please contact the research team at the University of Bath for further information: Mark Wilson (mw2640@bath.ac.uk) or Lorraine Whitmarsh (lw2253@bath.ac.uk).

Or if you have any concerns about this study, please contact the University of Bath Research Governance and Compliance Team: (research-ethics@bath.ac.uk; University of Bath, Claverton Down, Bath, BA2 7AY). The REC reference number is: 0996-1586

Your Health Improvement Practitioner will send you a copy of this information sheet.

How can I take part?
Please click 'NEXT' below

Consent Form
This consent form is identical to the one you completed for Survey 1. If you wish, please review these statements again before choosing whether to take part in Survey 2.

Your Health Improvement Practitioner will read 10 statements to you. Please then indicate to your Health Improvement Practitioner that you have understood these statements before deciding whether you wish to take part:

1. I understand the nature and purpose of the procedures involved in this evaluation study. These have been communicated to me on the information sheet on the previous page. My Health Improvement Practitioner will send me a copy of the information sheet.

2. I understand that my participation in this study is entirely voluntary. I can withdraw from the study by telling the Health Improvement Practitioner that I wish to withdraw. Once I complete the second survey, my data will be anonymised and can no longer be withdrawn from the study. I can withdraw my data at any time before then by contacting my Health Improvement Practitioner or the research team (see contact details below).

3. I understand that I will be asked to provide my name – this is to match my responses for the two surveys. My name will be permanently deleted within 14 days of completing the second survey. My survey responses will be submitted directly to the researchers; my Health Improvement Practitioner will not store any of my responses.

4. I understand that I can still take part in the ATSP pilot, even if I do not want to take part in the evaluation study.

5. I understand that I do not have to answer any questions that I do not want to.

6. I understand that this study will be used by Cornwall Council to inform policy and service delivery.

7. I understand that my anonymised data will be shared with Cornwall Council, Active Travel England, and researchers at Sheffield Hallam University. I will not be identifiable in any reports or data shared with these organisations.

8. I understand that the University of Bath may use the data collected for this project in a future research project but that the conditions on this form under which I have provided the data will still apply.

9. I understand that personal data will be processed in accordance with current UK data protection legislation. The University of Bath privacy notice can be found **here**.

10. I understand that I am free to discuss any concerns I may have with the research team: Mark Wilson (mw2640@bath.ac.uk) or Lorraine Whitmarsh (lw2253@bath.ac.uk).

If they are unable to resolve your concern or you wish to make a complaint, please contact the University of Bath Research Governance and Compliance Team (research-ethics@bath.ac.uk). The REC reference number is: 0996-1586

1.1) I understand these statements and I provide my verbal consent to take part in the evaluation study: [Response is compulsory]

- I **CONSENT** to take part in Survey 2 [Survey continues]
- I **DO NOT CONSENT** to take part in Survey 2 [Survey terminates]

To move through the survey:

Click 'NEXT' to move onto the next question,
or click the 'UP' arrow to return to the previous question.

For some questions, you may have to scroll down to see all of the response options.

Please note, some of the questions are similar to those you answered in Survey 1 - this is intentional!

_____

1.2 B) What is your first name and surname? [Response is compulsory]

_____

_____

1.5 B) Who is your Health Improvement Practitioner? [Response is compulsory]

- HIP 1 (anonymised)
- HIP 2 (anonymised)
- HIP 3 (anonymised)

_____

Block 2 - Travel behaviour

The following questions are about how you travel for everyday activities, like going to the shops, visiting friends, commuting to work etc.

_____

2.1 B) How frequently do you travel by **private car**?

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never

_____

2.2 B) How frequently do you travel by **taxi or private hire rental**?

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never

_____

2.3 B) How frequently do you travel by **bus / coach**?

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never

_____

2.4 B) How frequently do you travel by **train / tram**?

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never

_____

2.5 B) How frequently do you travel using a **bicycle / adapted bicycle / tricycle / e-cycle**?

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week

- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never

2.6 B) In total, how many journeys did you make **last week** using the following travel modes:

(i.e., the **total number of journeys** for the entire week, for each travel mode. Travelling there and back would count as **two** journeys)

- walking or wheeling (i.e., using a wheelchair)
- bicycle / adapted bicycle / tricycle / e-cycle
- car (as a driver or passenger)

2.7 B) In total, approximately how far did you travel **last week** using the following travel modes:

(i.e., the **combined distance** travelled for **ALL** of your journeys last week, for each travel mode. Please move the slider into the correct position)

- walking or wheeling (i.e., using a wheelchair) *Scale: 0 – 50+ miles*
- bicycle / adapted bicycle / tricycle / e-cycle *Scale: 0 – 50+ miles*

2.9 B) In total, approximately how far did you travel **last week** using the following travel modes:

(i.e., the **combined distance** travelled for **ALL** of your journeys last week. Please move the slider into the correct position)

- car (as a driver or passenger) *Scale: 0 – 150+ miles*

2.8 B) Does your household **own** a car or van?

- Yes
- No

Block 3 - Active travel

The next few questions are about your views on active ways to travel (e.g. walking, cycling, or wheeling).

First, thinking about walking or wheeling (i.e., using a wheelchair)…

3.1 B) Since taking part in the ATSP pilot, how much, if anything, would you say you know about **walking / wheeling routes** in your local area?

- A great deal
- A fair amount
- Just a little
- Heard of them, know nothing about them
- Never heard of them
- Don't know
- Not applicable

3.2 B) In general, how **confident**, if at all, would you say you are when walking / wheeling in your local area?

- Very confident
- Fairly confident
- Not very confident
- Not at all confident
- Don't know
- Not applicable

_____

3.3 B) How **safe** do you feel walking / wheeling in your local area?

- Very safe
- Fairly safe
- Not very safe
- Not at all safe
- Don't know
- Not applicable

_____

3.4 B) To what extent is your **attitude** towards walking / wheeling, as a form of transport, **favourable or unfavourable**?

- Very favourable
- Fairly favourable
- Neither favourable nor unfavourable
- Fairly unfavourable
- Very unfavourable
- Don't know
- Not applicable

_____

Now thinking about cycling. This includes adapted cycling and e-cycling (i.e., using e-bikes), as well as conventional bicycles...

_____

3.5 B) What would you say your level of cycling / adapted cycling / e-cycling **ability** currently is (i.e. the ability to cycle on the highway)?

- Very able
- Mostly able
- Not very able
- Not at all able
- Don't know
- Not applicable

3.6 B) Since taking part in the ATSP pilot, how much, if anything, would you say you know about **cycling infrastructure**, for example cycle lanes, cycle routes, cycle storage, cycle hire, adapted cycling, e-cycling, in your local area?

- A great deal
- A fair amount
- Just a little
- Heard of them, know nothing about them
- Never heard of them
- Don't know
- Not applicable

3.7 B) In general, how **confident**, if at all, would you say you are when cycling / e-cycling on roads in your local area?

- Very confident
- Fairly confident
- Not very confident
- Not at all confident
- Don't know
- Not applicable

3.8 B) How **safe** do you feel cycling / e-cycling on roads in your local area?

- Very safe
- Fairly safe
- Not very safe
- Not at all safe
- Don't know
- Not applicable

3.9 B) To what extent is your **attitude** towards cycling / adapted cycling / tricycling / e-cycling, as a form of transport, **favourable or unfavourable**?

- Very favourable
- Fairly favourable
- Neither favourable nor unfavourable
- Fairly unfavourable
- Very unfavourable
- Don't know
- Not applicable

3.10 B) Please tell us about your current bicycle ownership.

Please select all that apply:

- I own a conventional bike or an adapted bike
- I own an e-bike (i.e. an electric bike)
- I own a bike but it is in disrepair
- I do not own a bike
- Not applicable

Block 4 - Physical activity

You're doing great! These questions are about exercise or physical activity that you do.

4.1 B is a routing question [Response is compulsory]

4.1 B) In the past four weeks, have you done a **continuous walk / wheel** that lasted at least **10 minutes**?

- Yes > Q4.2 B
- No > Q4.2 B

4.2 B) How **frequently** have you done a continuous walk / wheel that lasted at least 10 minutes?
[Display logic: Q4.2 B presented if Q4.1 B = Yes]

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months
- Never
- Not applicable

_____

4.3 B) Which other **activities** have you done in the last four weeks?
Please select all that apply:

- Swimming
- Cycling
- Workout at a gym / Exercise bike / Weight training
- Aerobics / Keep fit / Gymnastics / Dance for fitness
- Running / Jogging
- Football / Rugby
- Badminton / Tennis / Squash
- Exercises (e.g. press-up, sit-ups)
- Other activity (Please specify which activity/activities: _____)
- I have not done any of these activities (exclusive option)

_____

4.4 B) How **frequently** have you undertaken these activities?
[Display logic: the activities presented in Q4.4 B are routed from the options selected in Q4.3 B]

- 5 or more days a week
- 3 or 4 days a week
- 1 or 2 days a week
- Once or twice a month
- Once or twice every 3 months
- Less than every 3 months

– Never

Block 5 - Health status

The next few questions are about your health.

5.1 B is a routing question [Response is compulsory]

5.1 B) Do you have any **physical or mental health conditions or illnesses** lasting, or expected to last, 12 months or more?

– Yes > Q5.2 B
– No > Q5.3 B
– Prefer not to say > Q5.3 B

5.2 B) Does your condition or illness / do any of your conditions or illnesses **reduce your ability** to carry out day-to-day activities?

[Display logic: Q5.2 B presented if Q5.1 B = Yes]

– Yes, a lot
– Yes, a little
– Not at all
– Prefer not to say

5.3 B) How is your **health** in general?

– Very good
– Good
– Fair
– Bad
– Very bad
– Don't know
– Prefer not to say

5.4 B is a routing question [Response is compulsory]

5.4 B) Please rate your current level of **pain**:

- No pain at all > Q5.6 B
- Mild pain > Q5.5 B
- Moderate pain > Q5.5 B
- Severe pain > Q5.5 B
- Very severe pain > Q5.5 B
- Worst pain imaginable > Q5.5 B

5.5 B) What is / are the **cause(s)** of the pain you are currently experiencing?

Please select all that apply:

[Display logic: Q5.5 B presented if Q5.4 B does NOT EQUAL 'No pain at all']

- A short-term illness
- A recent physical injury
- A long-term health condition
- Physical disability
- Ageing related pain
- Occupational related pain
- Other_____(If you wish, please specify the other cause of pain you are experiencing)
- Prefer not to say (exclusive option)

5.6 B) Please rate your current **energy levels**:

- No difficulty with my energy levels
- Slight difficulty with my energy levels
- Moderate difficulty with my energy levels
- Significant difficulty with my energy levels
- Severe difficulty with my energy levels
- Very severe difficulty with my energy levels

5.7 B) In the last 12 months, approximately how many times have you talked to or visited a **GP / family doctor** about your **own health**?

- None
- One or two
- Three to five
- Six to ten
- More than ten
- Prefer not to say

5.8 B) In the last 12 months, approximately how many times have you visited **hospital** about your **own health**?

- None
- One or two
- Three to five
- Six to ten
- More than ten
- Prefer not to say

Block 6 - Wellbeing

The following questions are about your wellbeing.

6.1 B) Overall, how **satisfied** are you with your life nowadays?
On a scale from 0-10. Please move the slider into the correct position.

6.2 B) Overall, to what extent do you feel that the things you do in your life are **worthwhile**?
On a scale from 0-10. Please move the slider into the correct position.

6.3 B) Overall, how **happy** did you feel **yesterday**?
On a scale from 0-10. Please move the slider into the correct position.

_____

6.4 B) Overall, how **anxious** did you feel **yesterday**?
On a scale from 0-10. Please move the slider into the correct position.

_____

6.5 B) People who are important to me would support me using active ways to travel.
On a scale from 0-10, **please rate how much you agree with this statement** - by moving the slider into the correct position.

_____

6.6 B) There are people I can depend on to help me if I really need it.
On a scale from 0-10, **please rate how much you agree with this statement** - by moving the slider into the correct position.

_____

Block 9 - Activity Participation
You're doing really well.

We'd like to know which activities you have participated in during the ATSP pilot.

_____

9.1) Which of the following **Cornwall Life Recycle** activities have you participated in?
(Available in all 3 Cornwall areas)
Please select all that apply

- CLR Bike confidence/learn to ride
- CLR Led ride
- CLR Led ride & road safety (Bikeability)
- CLR Bike maintenance
- CLR Bike check

- CLR Bike recycling ownership scheme
- CLR Membership of the Cornwall Bicycle Project
- None of the above (exclusive option)

9.2) Which of the following **British Cycling** activities have you participated in?
(Available in all 3 Cornwall areas)
Please select all that apply

- BC Breeze
- BC Limitless
- BC guided rides
- BC Sofa to Saddle
- BC Confidence (Currently only available in Penzance)
- None of the above (exclusive option)

Q9.3 is a routing question [Response is compulsory]
9.3) Where do you live?

- Bodmin (or the surrounding area) > Q9.4 9A (Bodmin activities)
- St Austell (or the surrounding area) > Q9.6 9B (St Austell activities)
- Penzance (or the surrounding area) > Q9.8 9C (Penzance activities)

Block 9A - Bodmin activities
9.4 - 9A) Which of the following **GLL Leisure** activities have you participated in?
(Bodmin & St Austell only)
Please select all that apply

- GLL Wellbeing walks
- GLL BEAT programme
- None of the above (exclusive option)

Q9.5 - 9A is a routing question [Response is compulsory]

9.5 - 9A) Which of the following active travel activities have you participated in? (Bodmin)

Please select all that apply

- Active Cornwall (Wellbeing Walks)
- IntoBodmin
- National Trust (Landhydrock)
- RideOnEBikes
- Bosvena led walks
- Curious School of the Wild
- Eden
- Bus Pass
- None of the above (exclusive option)

At the end of Block 9A, Branching Logic > Block 10

Block 9B - St Austell activities

9.6 - 9B) Which of the following **GLL Leisure** activities have you participated in? (Bodmin & St Austell only)

Please select all that apply

- GLL Wellbeing walks
- GLL BEAT programme
- None of the above (exclusive option)

Q9.7 – 9B is a routing question [Response is compulsory]

9.7 – 9B) Which of the following active travel activities have you participated in? (St Austell)

Please select all that apply

- Active Cornwall Wellbeing Walks
- Wild Wonder & Wisdom
- RideOnEBikes
- Mencap

- Volunteer Cornwall Beautiful Day Out
- Eden
- Bus Pass
- Beryl Bikes
- None of the above (exclusive option)

At the end of Block 9B, Branching Logic > Block 10

Block 9C - Penzance activities

Q9.8 – 9C is a routing question [Response is compulsory]

9.8 – 9C) Which of the following active travel activities have you participated in? (Penzance)

Please select all that apply

- RideOnEBikes
- Sustainable PNZ
- Whole Again Communities (WAC)
- Parkwood Leisure
- Bus Pass
- Beryl Bikes
- None of the above (exclusive option)

At the end of Block 9C, Branching Logic > Block 10

Block 10 – Evaluation of ATSP

These questions are about your experiences of taking part in the ATSP pilot.

10.1) Please rate how much you agree with the following statement:
The support from the activity provider(s) helped me to reach my active travel goals.
(Scale: strongly disagree ; disagree ; undecided ; agree ; strongly agree)

10.2) Which aspects of the support you received from the activity provider(s) did you find the most helpful in reaching your active travel goals?

- Learning new skills
- Encouragement
- Learning active travel routes
- Bike maintenance
- None of the above (exclusive option)

10.3) Is there anything about the active travel social prescribing programme that you think could be improved?

Your feedback is very useful for us.

Open text response_____

Block 11 - Impacts on travel behaviours

Finally, a few questions about whether the pilot has helped you to use active ways to travel.

Q11.1 is a routing question [Response is compulsory]

11.1) Have you used active travel for one or more journeys in the past month?

- Yes > 11.2
- No > 11.4

Q11.2 is a routing question [Response is compulsory]

11.2) Here is a list of typical day-to-day journeys. In the past month, which of these journeys have you used active modes of travel for?

(i.e., you have used active travel at least once in the past month for this type of journey). *Please select all that apply.*

- Commuting to my place of work or study

- Going to the shops, doctors, library, cinema etc.
- Leisure or exercise
- Visiting family or friends
- The school run
- Business-related travel (e.g., visiting clients, making deliveries)
- Other_____ (Please indicate which other type of journey)

The selected options from Q11.2 are presented in Q11.3. Participants then rate the change in each activity separately.

11.3) Since taking part in the active travel social prescribing pilot, to what extent have you noticed a **change in your use of active travel** for the following activities:

- *Activity 1* (My use of active travel has decreased ; My use of active travel has not changed ; My use of active travel has slightly increased ; My use of active travel has moderately increased ; My use of active travel has significantly increased)
- *Activity 2*…

11.4) Please consider the following **barriers** to active travel. To what extent, if at all, has taking part in the ATSP pilot helped you to overcome these barriers?

(Scale: not at all ; a little ; somewhat ; a lot)

- Safety concerns
- Low confidence to use active travel
- Lack of awareness of walking/wheeling/cycle routes in your area
- Low fitness levels
- Low cycling ability

Q11.5 is a routing question [Response is compulsory]

11.5) Aside from the barriers listed in the previous question, have you experienced **any other barriers** to using active travel?

- Yes____ (please could you describe this other barrier(s) and how it affects you?) > 11.5 C
- No > 11.6

11.6) To what extent has taking part in the ATSP pilot helped you to overcome this other barrier(s)?
(Scale: not at all ; a little ; somewhat ; a lot)

- Other barrier 1
- Other barrier 2 (if applicable)
- Other barrier 3 (if applicable)

11.7) Has your participation in the ATSP pilot provided any of the following **benefits**:
Please select all that apply

- Saving money (e.g., on petrol or diesel)
- Spending more time outside
- More opportunities for social interaction
- Exploring or learning about my local area
- Helping me access other social support services
- Other_____ (Please specify which other benefit(s) you have experienced)
- None of the above (exclusive option)

Block 8 - Debrief

8.1 B) Do you have any comments about the survey, or anything to add about the topics you were asked about:
Open text response_____

Thank you for completing this survey!

If answering any of the questions in this survey has caused you to experience distress, please be aware there are a number of support services available. This includes your GP, and two charities: **Mind** and **Samaritans.**

Please click 'NEXT'

_____

Debrief

Further information

This study is a collaboration between Cornwall Council and researchers at the University of Bath. The aim of the study is to evaluate the Council's Active Travel Social Prescribing pilot (ATSP pilot). Your responses to the survey questions will be used to understand how successful the ATSP pilot is in encouraging active ways to travel (i.e. walking, cycling, or wheeling) and improving health.

This information will be used by the Wellbeing and Public Health team at Cornwall Council to improve their service. This research is funded by Active Travel England.

If you have any questions about the evaluation study, please contact the research team: Mark Wilson (mw2640@bath.ac.uk) or Lorraine Whitmarsh (lw2253@bath.ac.uk).

If you have concerns about your participation in this study or you wish to make a complaint, please contact the University of Bath Research Governance and Compliance Team (research-ethics@bath.ac.uk). The REC reference number is: 0996-1586

Privacy Notice: Your data will be used only for the purposes set out in the information sheet and consent form. Your consent is conditional upon the University complying with its duties and obligations under current UK data protection legislation. The University of Bath privacy notice can be found **here**.

Your Health Improvement Practitioner will send you a copy of the information sheet.

Please click **'DONE'** to submit your responses:

6.8.3 Semi-structured interview protocol – ATSP pilot clients

Introduction

My name is Helen Frankland and I'm the monitoring and evaluation lead for the Active Travel Social Prescribing pilot programme.

I understand that you were referred to the Active Travel Social Prescribing programme and you've been working with *HIP 1/HIP 2/HIP 3 (anonymised)*. I am contacting you as I understand that you have agreed to take part in this interview. Thank you for agreeing to this. The aim of our interview today is to discuss your experience on the programme. The interview is likely to last in the region of one hour, is this OK?

You may already be aware of this, but the programme is one of 11 pilots being run across England. Our programme's findings are contributing towards a national-level evaluation, funded by Active Travel England. Supporting us in the Evaluation process are researchers from the Centre for Climate Change & Social Transformations (CAST) at the University of Bath. What we discuss will be transcribed and anonymised prior to us sharing data with the University of Bath.

Our participant information sheet details information regarding the process and aim of our interview today, and I would just like to highlight some key information from it.
Can I double check that you have received a copy of the Participant Information sheet?
Could you confirm that you have read it and that you consent to taking part in the interview today?

It's important that you are aware that you do not have to answer specific questions if you do not want to. You have the right to withdraw from the evaluation at any point, and further to what I've mentioned previously, in order for the interview's data to be transcribed and anonymised our discussion is going to be recorded. This recording will be permanently deleted once we have transcribed the interview. I would just like to check that you are happy with this?

Finally, an important part of the pilot is to learn of the impact it has had on the residents of Cornwall. To capture this learning, we are producing case studies to illustrate real people's experiences. Would you consent to be used for a case study? The case study will be anonymised.
OK great.

To begin with it would be helpful if I could ask you a few questions to help provide me with a little bit of background information about yourself, if that's OK?
Super, thank you.

Background

1. Age?

2. Ethnicity?

3. Health conditions?

4. Marital status?

5. Family responsibilities that may affect mode of travel?

6. Employment situation?

7. Income?

8. Thinking more generally since you were referred in to the ATSP programme, has anything changed that may have impacted your ability to engage fully with the support you have received (for example, circumstances related to health, medication, employment, family situation, relationships etc)?

Thank you for that background information, that's really helpful.

Referral Experience

9. So, I understand that you were referred to our service through xxxxxxxxxxx. Could you please tell me about your experience of being referred in to the ATSP pilot?

10. What barriers, if any, did you face in accessing support?

11. Is there anything that could have improved your experience?

HIP Support

I understand you first met with *HIP 1/HIP 2/HIP 3 (anonymised)* on xxxx. Since then you have attended x further sessions and taken part in x activity/activities (if relevant).

12. Thinking about the ATSP programme as a whole, could you tell me about your experience?

13. Thinking specifically about the support you received from your HIP, what was your experience of this one-to-one support?

14. Did you set an AT goal at the beginning, either with your HIP or on your own? If so, how did you find this?

15. If you completed a personalised travel plan, did you find this a useful tool? If so, how? If not, why not?

Provider Experience

16. One aspect of the HIP role is to link clients to activities/support/equipment in their local community. What was your experience of this?

17. Thinking about the x activity that you were referred to, could you tell me about your experience of this please?

18. How did the provider support you in working towards your goals?

Active Travel Attitudes & Behaviours

19. The aim of the ATSP programme has been to improve client's engagement in active travel. Thinking about Active Travel, what is your understanding of this concept?

20. Active travel refers to getting from A to B by means of walking/wheeling/cycling/e-cycling, or by such methods being incorporated within a longer journey. What are your feelings on Active Travel?

21. Prior to taking part in this programme, what do you feel got in the way of you travelling actively (activity provision/support/infrastructure/social norms)?

22. Do you perceive there to be any stigma associated with walking rather than driving?

23. Do you feel this programme has supported you to think differently about active travel? If so, how?

24. Has the programme encouraged you to use existing infrastructure, such as cycle paths and foot paths, more than you used to? Could you share any examples?

25. Thinking overall about the ATSP programme, do you feel it has helped you overcome any barriers to you engaging in active travel? If so, how?

26. Do you feel this programme has helped you to incorporate active travel into your everyday life? If so, how?

27. Do you foresee any barriers to you continuing to engage in active travel in the future (activity provision/support/infrastructure)?

28. How do you feel in terms of your confidence and ability to engage in active travel? Do you feel this has changed since starting the programme?

AT Barriers & Enablers

29. Thinking about Active Travel in Cornwall, do you feel there are any specific barriers specific to the region when it comes to the residents engaging in Active Travel?

30. Thinking about enablers, do you feel there's anything specific to where you live, that enables or helps people to engage in Active Travel?

Health & Wellbeing

31. If we could think about your current situation, how would you describe your overall health and wellbeing?

32. How does this compare to your overall health and wellbeing when you started the programme?

33. Sometimes being more active can have indirect benefits on aspects of our life, for example by reducing pain or reducing the number of visits to the GP. Do you feel you

have experienced any indirect benefits to your health and wellbeing, and if so, how?

34. Thinking about your general physical activity, how physically active would you say you are currently?

35. Do you feel this level has changed since starting the programme?

36. Thinking about the overall impact of the pilot, has it supported you with improving other areas of your health and wellbeing, such as, your energy levels, your mood, doing more exercise due to feeling stronger?

37. In terms of social interactions, hobbies, general lifestyle changes, do you feel the pilot has supported changes in these areas of your life?

Travel Behaviour

For the next few questions, I'd like you to think about your day-to-day life, specifically the typical journeys you make in a week, the distance you travel for each of these journeys and the mode of transport that you use for each journey. I will break the week down into days to make it hopefully a bit easier for you.

38. **Monday**. So, starting with Monday, what journeys do you do on a typical Monday?

39. What is the purpose (shopping, commuting etc) for each of these journeys?

40. What's the distance you travel on this/each journey?

41. For each journey what is the mode of transport that you use?

42. Has this/these ways to travel changed since prior to you beginning the programme?

43. **Tuesday**. Thinking about Tuesday, what journeys do you do on a typical Tuesday?

44. What is the purpose (shopping, commuting etc) for each of these journeys?

45. What's the distance you travel on this/each journey?

46. For each journey what is the mode of transport that you use?

47. Has this/these ways to travel changed since prior to you beginning the programme?

48. **Wednesday**. Thinking about Wednesday, what journeys do you do on a typical Wednesday?

49. What is the purpose (shopping, commuting etc) for each of these journeys?

50. What's the distance you travel on this/each journey?

51. For each journey what is the mode of transport that you use?

52. Has this/these ways to travel changed since prior to you beginning the programme?

53. **Thursday**. Thinking about Thursday, what journeys do you do on a typical Thursday?

54. What is the purpose (shopping, commuting etc) for each of these journeys?

55. What's the distance you travel on this/each journey?

56. For each journey what is the mode of transport that you use?

57. Has this/these ways to travel changed since prior to you beginning the programme?

58. **Friday**. Thinking about Friday, what journeys do you do on a typical Friday?

59. What is the purpose (shopping, commuting etc) for each of these journeys?

60. What's the distance you travel on this/each journey?

61. For each journey what is the mode of transport that you use?

62. Has this/these ways to travel changed since prior to you beginning the programme?

63. **Saturday**. Thinking about Saturday, what journeys do you do on a typical Saturday?

64. What is the purpose (shopping, commuting etc) for each of these journeys?

65. What's the distance you travel on this/each journey?

66. For each journey what is the mode of transport that you use?

67. Has this/these ways to travel changed since prior to you beginning the programme?

68. **Sunday**. Thinking about Sunday, what journeys do you do on a typical Sunday?

69. What is the purpose (shopping, commuting etc) for each of these journeys?

70. What's the distance you travel on this/each journey?

71. For each journey what is the mode of transport that you use?

72. Has this/these ways to travel changed since prior to you beginning the programme?

73. Has your participation in this programme resulted in any other changes to your travel behaviour?

Evaluation

74. Thinking about the programme overall, the support you have received and the activities, how would describe your overall experience? What do you feel went well? What could be improved?

75. Do you have any other comments that you would like to share with me regarding the ATSP programme?

Closing Remarks

76. Do you have any questions for me about your participation in this research project?

Thank you so much for your time and participation today.

6.8.4 Qualitative feedback survey – ATSP pilot delivery team

All of the questions in this survey are open-ended, qualitative response.

1. What is your name?

All of your responses will be anonymised.

2. What is your role and your organisation?

Introduction

This is a 'test and learn' pilot and so we are interested in learnings which could inform the design and delivery of future pilots. Please provide as much detail as you can in your responses.

The target groups of the ATSP pilot:	Intended outcomes:
— Adults seeking to improve their mental health and wellbeing — Adults with poor physical health (including long-term health conditions) — Disabled people (adults) — Unemployed adults — Adults aged 50+	— Increased physical activity — Improved physical health — Improved wellbeing/mental health — Reduced psychological barriers to using active travel — Reduced inequalities in access and mobility — Fewer motorised vehicles and trips

3. The ATSP pilot has several intended outcomes for the target groups, shown in the table above.

Reflecting on the active travel activities and community support you have provided, which of these outcomes have been successfully achieved, and which have been less successful?

Please explain the reasons why these outcomes have or have not been achieved.

4. The intervention model combines one-to-one Health Improvement Practitioner support with community-based active travel service provision.

What are the main benefits and drawbacks of this approach for:

a) the clients

b) the ATSP delivery team and activity providers ?

5. Please provide feedback on the referral process - how could it be improved to identify and reach more people in these target groups, in particular those who are currently less engaged in active travel?

6. From your experience of working with the clients, do the main constraints to using active travel relate to infrastructure, psychological barriers, or personal circumstances?

Do you have any suggestions for how to overcome these barriers?

7. Do you have any suggestions for how to motivate or support clients to continue using active travel after the activity or support finishes?

8. Do you have any suggestions for maximising the legacy of the pilot?
For example, this could relate to sharing resources or learning among providers, improving active travel infrastructure, increasing volunteer engagement, reducing inequalities in access and mobility, or anything else?

9. Is there anything else you would like to add about your experience of the ATSP pilot?

6.8.5 Qualitative feedback survey – ATSP pilot steering group

All of the questions in this survey are open-ended, qualitative response.

1. What is your name?

All of your responses will be anonymised.

2. What is your role and your organisation?

Introduction

This is a 'test and learn' pilot and so we are interested in learnings which could inform the design and delivery of future pilots. Please provide as much detail as you can in your responses.

Please consider the following aspects of the ATSP pilot:
— The pilot's set up process
— Referral process
— The ATSP Fund
— Pilot delivery
— The range of providers and community activities
— Reaching the target groups
— Barriers/Enablers to Active Travel in Cornwall

3. Do you have any feedback that you would like to share on the design or delivery of the ATSP pilot?

4. Were there any unexpected benefits and/or challenges which emerged during the pilot?

5. Do you have any suggestions for maximising the legacy of the pilot?

For example, this could relate to sharing resources or learning among providers, improving active travel infrastructure, increasing volunteer engagement, reducing inequalities in access and mobility, or anything else?

6. Do you have any suggestions on how future pilots could be improved?

This could relate to active travel pilots, or community-based provision approaches more generally.

7. Is there anything else you would like to add?

6.8.6 Qualitative feedback survey – Activity providers

All of the questions in this survey are open-ended, qualitative response.

1. What is your name?

All of your responses will be anonymised.

2. What is your role and your organisation?

Introduction

This is a 'test and learn' pilot and so we are interested in learnings which could inform the design and delivery of future pilots. Please provide as much detail as you can in your responses.

The target groups of the ATSP pilot:	Intended outcomes:
— Adults seeking to improve their mental health and wellbeing — Adults with poor physical health (including long-term health conditions) — Disabled people (adults) — Unemployed adults — Adults aged 50+	— Increased physical activity — Improved physical health — Improved wellbeing/mental health — Reduced psychological barriers to using active travel — Reduced inequalities in access and mobility — Fewer motorised vehicles and trips

3. The ATSP pilot has several intended outcomes for the target groups, shown in the table above.

Reflecting on the active travel activities and community support you have provided, which of these outcomes have been successfully achieved, and which have been less successful? Please explain the reasons why these outcomes have or have not been achieved.

4. Please provide feedback on the referral process - how could it be improved to identify and reach more people in these target groups, in particular those who are currently less engaged in active travel?

5. What are the main challenges you experienced in the delivery of your active travel activities? *For example, identifying clients' needs, recruiting staff, coordinating with the Council or other local organisations, or anything else?*

6. If you had to adapt your delivery to meet the needs of your clients, how easy or otherwise did you find this process?

7. Do you have any suggestions for how to motivate or support clients to continue using active travel after the activity or support finishes?

8. Do you have any suggestions for maximising the legacy of the pilot?
For example, this could relate to sharing resources or learning among providers, improving active travel infrastructure, increasing volunteer engagement, reducing inequalities in access and mobility, or anything else?

9. Is there anything else you would like to add about your experience of the ATSP pilot?